

SEA-Ment.-123
Distribution: General

Mental Health and Substance Abuse, including Alcohol in the South-East Asia Region of WHO

WHO Project: ICP MNH 001



World Health Organization
Regional Office for South-East Asia
New Delhi
July 2001

© World Health Organization 2001

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

CONTENTS

	<i>Page</i>
1. INTRODUCTION	1
2. MAGNITUDE OF BURDEN FROM MENTAL AND NEUROLOGICAL DISORDERS AND SUBSTANCE ABUSE, INCLUDING HARM FROM ALCOHOL.....	3
2.1 Demographic, Epidemiological and Health Transition.....	3
2.2 Magnitude of Burden from Mental and Neurological Disorders Low and Middle Income Countries	4
2.3 Magnitude of Burden from Substance Abuse, including Harm from Alcohol.....	6
2.4 Social and Economic Impact of Mental and Neurological Disorders.....	9
3. MENTAL HEALTH SERVICES IN THE SOUTH -EAST ASIA REGION.....	10
3.1 Resources available to meet the needs of Member Countries	10
4. STRATEGIES FOR CONTROL OF MENTAL AND NEUROLOGICAL DISORDERS AND SUBSTANCE ABUSE, INCLUDING HARM FROM ALCOHOL.....	13
4.1 Regional Strategy	13
4.2 Special Projects Initiated by the Regional Office.....	14
5. SUGGESTED ACTIONS BY MEMBER COUNTRIES TO PROMOTE MENTAL HEALTH AND CONTROL SUBSTANCE ABUSE, INCLUDING HARM FROM ALCOHOL.....	18
BIBLIOGRAPHY	21

1. INTRODUCTION

Historically, disease burden has been based on mortality statistics. However, these statistics underestimate the burden from non-fatal conditions such as neuropsychiatric disorders, which include both mental and neurological diseases. These conditions have been ignored for long as they are absent from 'cause of death' lists. When disease burden measurement includes time lived with disability, several of the neuropsychiatric disorders become leading causes of disease burden worldwide.

Globally, some 400 million people suffer from mental and neurological disorders or from psychosocial problems such as those related to alcohol and drug abuse. A large proportion of these people are in the WHO South-East Asia Region. As reported in the Global Burden of Disease, five out of the ten most disabling disorders in the world are psychiatric in nature. To highlight this important concern, the World Health Organization has devoted 2001 to creating awareness about mental health. The theme for this year's World Health Day focused on mental health, the World Health Assembly discussed the issue of mental health in four round table meetings during its sessions in May 2001 and the World Health Report 2001 will be devoted to mental health.

In the South-East Asia Region, there are many myths and beliefs which are a barrier to the treatment of the mentally ill. Psychotic illnesses are considered a "curse from Gods" or manifestations of evil spirits or punishment for sins in the past life. Generally, people do not sympathize with a mentally ill person, because they impart a character value to the patient, and believe that the person lacks the will power to pull himself or herself up and is just not making an effort. Many times patients are ignored, isolated or taken to sorcerers and faith healers and treated with rituals rather than with appropriate medications.

The fact is, mental ill health causes much suffering, disability and death. Some patients are unable to work, some suffer overwhelming fears, others grapple with constant negative thoughts, and may turn to alcohol. In some

cases, the patient is driven to suicide. It also gravely burdens families and communities. As Dr Gro Harlem Brundtland, WHO Director-General says, "Many of them suffer silently, and beyond the suffering and beyond the absence of care lie the frontiers of stigma, shame, exclusion and, more often than we care to know, death".

There are several reasons for the emergence of mental and neurological disorders as important causes of morbidity. There is a complex interaction between several factors which cause mental and neurological disorders. The reasons could be genetic, biological, psychological and sociocultural. Links have been found between some mental disorders and adverse social conditions such as poverty, unemployment, illiteracy, homelessness and gender discrimination. In some illnesses, brain imaging has revealed underlying structural defects. Depression is associated with changes in brain chemicals; genes have been linked to some cases of schizophrenia and Alzheimer's disease; and alcohol dependence is now linked both to the social environment and to genes. A major biological cause of mental retardation is the lack of iodine, which is vital to the growth and development of a human being.

Recently, WHO has developed a new global policy and strategy for work in the area of mental health. Launched by Dr Gro Harlem Brundtland in November 1999, the policy emphasizes three priority areas of work:

- (1) Advocacy to raise the profile of mental health and fight discrimination;
- (2) Policy to integrate mental health into the general health sector, and
- (3) Effective interventions for treatment, prevention and their dissemination. The WHO Regional Office for South-East Asia is totally committed to promoting this policy.

In the past, mental health programmes in the countries of the South-East Asia Region have generally concentrated on hospital-based psychiatry. However, there is increasing awareness in these countries of the need to shift the emphasis to community-based mental health programmes. The WHO Regional Office is concentrating on supporting Member Countries in the development of community-based mental health programmes as well as programmes for prevention of harm from alcohol and substance abuse. The programmes will be gender and cultural appropriate and reach out to all segments of the population, including marginalized groups.

The focus on control of substance abuse will be directed towards demand reduction and prevention of harm to substance abusers. Such programmes are inter-disciplinary and involve not only many departments within WHO but also other UN agencies such as UNDCP, UNICEF, ILO, many government agencies and NGOs. Because of extensive coverage and programmes already dedicated to the control of substance abuse, this topic will not be discussed in detail in this paper.

Alcohol abuse is an emerging problem in many Member Countries. Alcohol abuse especially amongst the poor is particularly deleterious as precious wages are wasted on alcohol rather than on food, education and health. As for other substances of abuse, WHO programmes in the Region will concentrate on prevention of harm from alcohol rather than on supply reduction, which is a complex issue involving many government agencies.

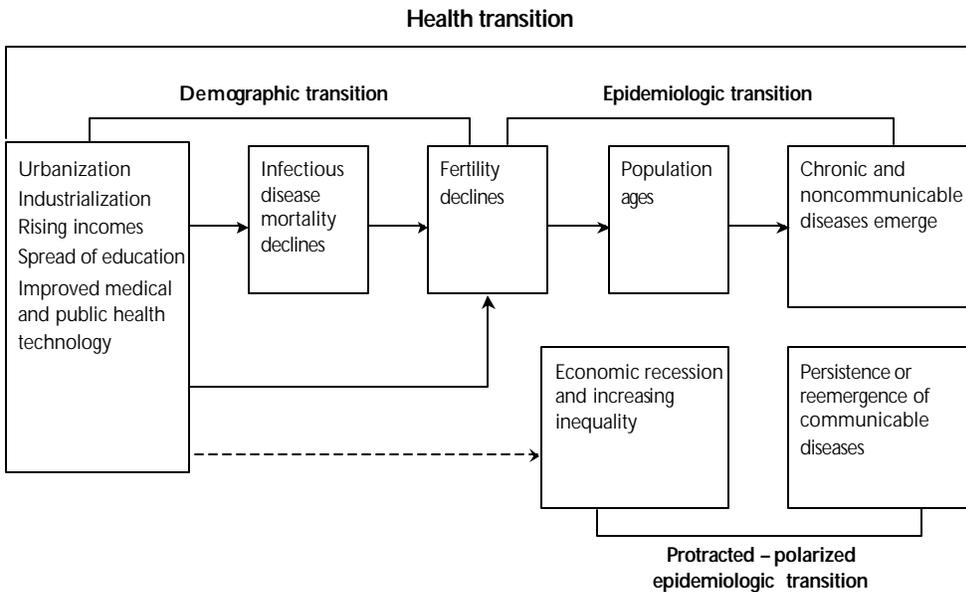
2. MAGNITUDE OF BURDEN FROM MENTAL AND NEUROLOGICAL DISORDERS AND SUBSTANCE ABUSE, INCLUDING HARM FROM ALCOHOL

2.1 Demographic, Epidemiological and Health Transition

Most of the Member Countries of the Region are undergoing significant social and demographic changes. There is rapid urbanization; increased industrialization; rising incomes; expanded education, including among girls, and improved health care. Improved medical and public health measures have resulted in the control of many infectious diseases, and reduction in mortality and fertility. These demographic changes have led to an ageing population. An aged population with reduced risk of communicable diseases leads to the emergence of noncommunicable diseases (NCDs) as important causes of morbidity and mortality. These changes are illustrated graphically in Figure 1.

Thus, Member Countries face a double burden of disease with the persistence of communicable diseases and emergence of chronic and noncommunicable diseases. It is important to plan appropriate strategies to address issues related to both communicable and noncommunicable diseases, accord priority based on government policy to each and develop innovative programmes.

Figure 1. Relationships among Demographic, Epidemiologic and Health Transitions

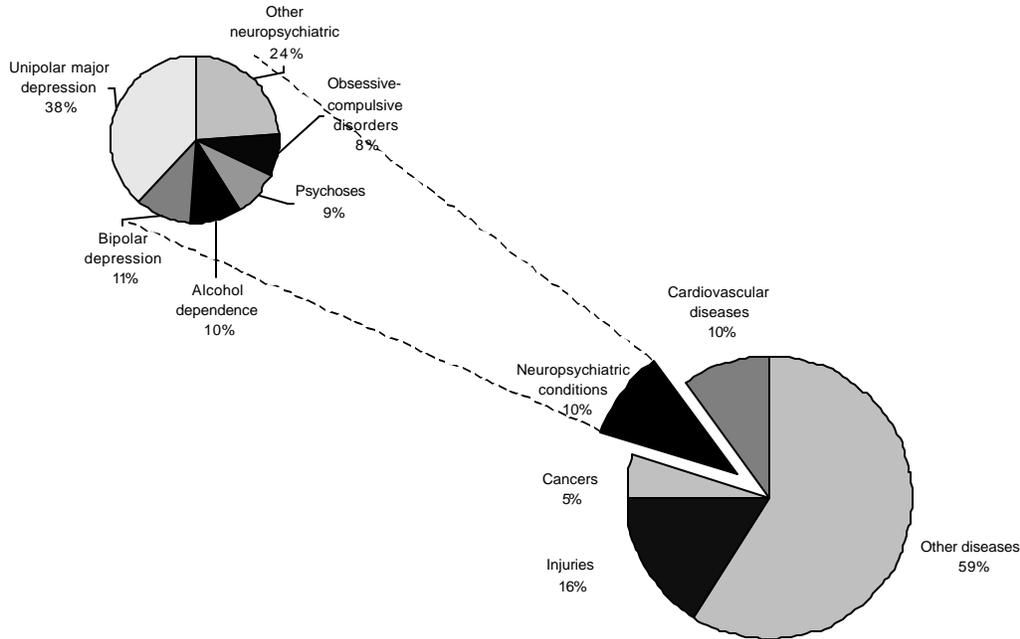


Source: Disease Control Priorities in Developing Countries, Jamison et al (1993)

2.2 Magnitude of Burden from Mental and Neurological Disorders Low and middle income countries

According to the World Health Report 1999, an estimated 43 per cent of all Disability Adjusted Life Years (DALYs) lost globally in 1998 were attributable to noncommunicable diseases. In low and middle-income countries, this figure was 39 per cent. Neuropsychiatric conditions accounted for 10 per cent of the burden from noncommunicable diseases measured in DALYs in these countries. In high-income countries, one out of every four DALYs was lost due to neuropsychiatric conditions, while in low and middle-income countries this group of conditions was responsible for one out of ten DALYs lost. DALYs attributable to noncommunicable diseases and neuropsychiatric disorders in the low and middle-income countries, as estimated for 1998, are given in Figure 2.

Figure 2. DALYs attributable to noncommunicable diseases and neuropsychiatric disorders in low and middle-income countries, 1998



Source: World Health Report, 1999

Table 1 shows the rank of selected neuropsychiatric conditions relative to all causes of disease burden based on 1998 estimates as published in the World Health Report 1999.

In young adults (15-44 year age group), of the ten leading causes of disease burden, four were neuropsychiatric disorders. More specifically, unipolar major depression was the fourth leading cause of overall disease burden in 1990, while in adults aged 15-44 years it was the leading cause of DALYs lost, both in high-income and in low and middle-income countries. Alcohol dependence, bipolar disorder, and psychosis were among the other leading causes of disease burden in this age group in 1998. Disability in this most productive age group has serious social and economic implications.

Table 1: Rank of selected conditions among all causes of disease burden, 1998

Disease or injury	World	High-income countries	Low and middle-income countries
Unipolar major depression	4	2	4
Alcohol dependence	17	4	20
Bipolar disorder	18	14	19
Psychoses	22	12	24
Obsessive-compulsive disorder	28	18	27
Dementia	33	9	41
Drug dependence	41	17	45
Panic disorder	44	29	48
Epilepsy	47	34	46

Source: World Health Report 1999

Situation in the South-East Asia Region

There are very few population-based studies of mental health morbidity in Member Countries of the Region.

Mental health disorders, such as dementia, depression and schizophrenia, generally affect the elderly. The proportion of elderly people - 60 years and above - is expected to increase from 5.3 per cent in 1980 to 12.4 per cent in 2025 for the whole Region. In some Member Countries, the number of elderly is huge, e.g. in India it is estimated that there will be approximately 142 million elderly, defined as those over 60 years, by 2025. There are three mega countries in this Region (those with a population 100 million and over). Thus, SEAR will be faced with a huge burden from mental health morbidity. It is estimated that 45 per cent of the increase in schizophrenia from 1985 to 2000 is based on ageing of the populations.

2.3 Magnitude of Burden from Substance Abuse, including Harm From Alcohol

Substance abuse

Since time immemorial, in most countries of the South -East Asia Region, drugs have traditionally been used, in addition to alcohol, for ritual, religious and recreational purposes. These drugs were mainly cannabis products and

opium. The apparent social acceptance of the use of such substances stemmed largely from the fact that there was no abuse. Where there was, it was severely ostracized. Society had very clearly drawn the line and there was no question of condoning any abuse.

The South-East Asia Region is particularly affected by the problem of substance dependence. India has become a major transshipment point for hard drugs from Pakistan to the West. Injecting illicit drugs has been fuelling the AIDS epidemic in many countries of the Region. The sharing of contaminated equipment to inject drugs has been a key factor in the spread of HIV/AIDS and other infections among drug users.

Seven Member Countries already have substance abuse policies (Table 2).

Table 2. Countries having an official substance abuse policy

Country	Yes/No	Year Formulated
Bangladesh	Yes	1990
Bhutan	Yes	1998
India	No	
Indonesia	Yes	1997
Maldives	Yes	1997
Myanmar	Yes	1993
Nepal	Yes	1994
Sri Lanka	No	
Thailand	Yes	1998

Source: National Reports

Unfortunately, there seems to be a virtual epidemic of drug dependence on a global scale. A disturbing trend is that more and more young people are being drawn to this devastating addiction.

WHO's strategy to address the situation for substance abuse will concentrate on demand reduction and prevention of harm to the user from the substances of abuse.

Harm from Alcohol

There is clear evidence that alcohol-related morbidity and mortality is high in most countries of the Region. Impairment due to excess alcohol use also adds to other negative consequences such as accidents due to drunken driving,

domestic violence and reduced productivity. Methanol poisoning due to adulterated alcoholic beverages is also a problem in the Region. A phenomenon which is commonly seen is "pay-day binge drinking". Some wage earners spend their entire month's earnings on alcohol. Frequently, vendors wait outside places of employment on pay day to entice workers to buy alcohol as they leave their place of work.

According to a WHO study, alcohol is responsible for 3.5 per cent of the global burden of disease. Alcohol use is currently the leading cause of disability among men in the developed countries and the fourth leading cause of disability in developing countries. The situation is likely to become worse as multinational alcohol manufacturers are now aggressively targeting the developing countries, particularly in South-East Asia.

In India, in the mid-1990s, the adult male per capita consumption was 5-6 litres and the prevalence of alcohol dependence syndrome was estimated to be 3.2 million. The total alcohol production more than doubled to 800 million litres between 1993 and 1996. Fifty per cent of all home and farm accidents were estimated to be related to regular alcohol consumption.

In Sri Lanka, the adult per capita alcohol consumption increased from 3.79 to 5.11 litres between 1990 to 1997. A survey in the mid -1990s revealed that 43 per cent of urban shanty dwellers and 60 per cent of estate workers consumed alcohol.

A 1991 survey in Thailand revealed that 31.4 per cent of those over 14 years consumed alcohol (54 per cent of males and 10 per cent of females). Thailand showed an 11-fold increase in beer production between 1970 and 1993.

In the Democratic People's Republic of Korea, the per capita consumption is reported to be 3 litres. In Myanmar, 10 per cent of all admissions to the Yangon Psychiatry Hospital in 1994-96 were due to alcohol dependence. Cirrhosis of the liver, possibly related to excess alcohol consumption, has been reported as the third most common cause of death in Bhutan.

Systematic research aimed at estimating and understanding the nature and extent of public health problems related to alcohol use in the Region is required. Meanwhile, there is a need to implement effective strategies for prevention of harm from alcohol to users of alcohol. These strategies, which are being developed and implemented include strategies for early identification and services for alcohol abuse and dependence, campaigns aimed at reducing specific problems like drunken driving and industrial accidents, and increasing public awareness about the harmful effects of alcohol abuse.

2.4 Social and Economic Impact of Mental and Neurological Disorders

The stigma associated with mental and neurological disorders leads to various negative consequences not only for the sick person but also for his/her family members. These include rejection, denial of equal opportunities and participation in various aspects of life, humiliation and isolation. Persons with mental disorders are at high risk of human rights violations. Despite the significant public health impact of mental disorders on morbidity, disability and mortality, policy-makers and health care administrators worldwide accord low priority to the development of mental health services. A large proportion of persons with mental disorders do not receive any meaningful care and have to face undue suffering and disability.

Mental disorders have a wide-ranging, long-lasting and significant economic impact. Measurable causes of economic burden include health and social service needs, impact on families and care givers (indirect costs) due to lost employment and lost productivity, crime and public safety, and premature death. Studies from countries with established economies have shown that mental disorders consume more than 20 per cent of all health service costs. The aggregate annual cost of mental disorders in 1990 for USA was estimated at US\$ 148 000 million. Estimates for other regions are not available, but even in countries where the direct treatment costs are low, it is likely that the indirect costs due to "productivity loss" account for a large proportion of the overall costs. Future increases in the prevalence of mental disorders will pose serious social and economic handicaps to global development unless substantive action is taken now.

Socioeconomic factors influence mental health in significant and complex ways. They are highly correlated with an increase in the prevalence of serious disorders such as schizophrenia, major depression, antisocial personality disorders and substance abuse. Most of these disorders are about twice as common among the poorest sections of society as in the richer ones. In addition, malnutrition, infectious diseases and lack of access to education can be risk factors for mental disorders and can worsen existing mental problems. These findings are consistent in countries across income levels, and illustrate the broader concept of poverty, which includes not only economic deprivation but also the associated lack of opportunities for accessing information and services. With the health of a nation increasingly being seen as a critical component of development, mental health, as a key aspect of public health, needs to be acknowledged as a priority for overall social development.

3. MENTAL HEALTH SERVICES IN THE SOUTH-EAST ASIA REGION

3.1 Resources available to meet the needs of Member Countries

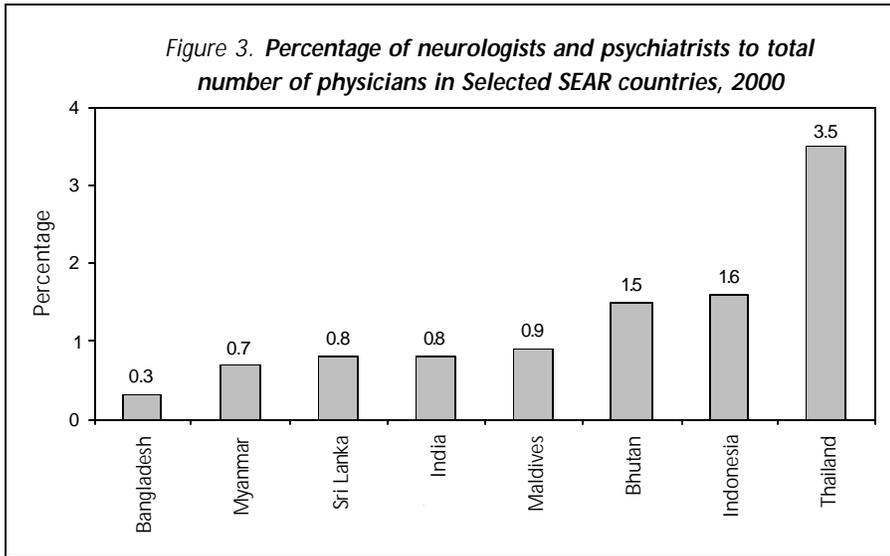
Eight out of ten Member Countries have a mental health policy, law or programme (Table 3) underlining the importance accorded to mental health by them. However, some of the policies/laws/programmes are old and based on outdated knowledge and these need to be updated, keeping in mind advances in medical sciences. Some Member Countries are already in the process of revising their mental health policy, law or programme. The Regional Office accords high priority to assisting Member Countries in the development, modification or implementation of an appropriate mental health policy, law and programme.

Table 3. Countries having a mental health policy/law/programme

	BAN	BHU	IND	INO	MAV	MMR	NEP	SRL	THA
Policy	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes
Law	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No
Programme	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes

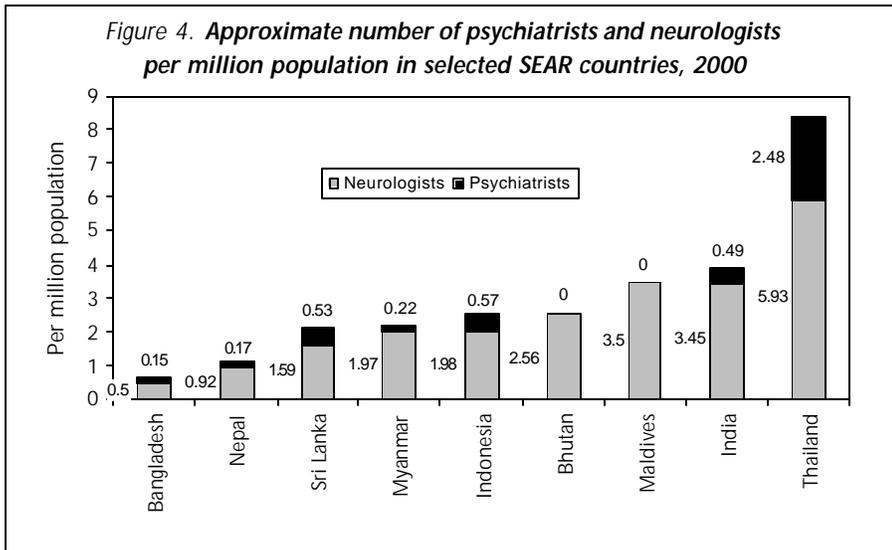
Source: National Reports

There are very few specialists in neurosciences in the Member Countries (Figures 3 and 4), so other community health care providers have to be trained to deliver services for mental and neurological disorders. Specialists in neurosciences, such as psychiatrists and neurologists, should form the tertiary care referral system in management of patients with severe mental and neurological disorders. Community health care providers who deliver health care to the community, are already established and respected by the community, but need to be trained in the identification and appropriate treatment of basic neuropsychiatric conditions. This way, at least minimum services in mental and neurological disorders will be delivered to remote areas and marginalized populations. Some Member Countries have already initiated training of general practitioners and primary care workers in mental health services. The Regional Office is committed to developing appropriate training modules and assisting Member Countries in adapting these modules to their specific needs.



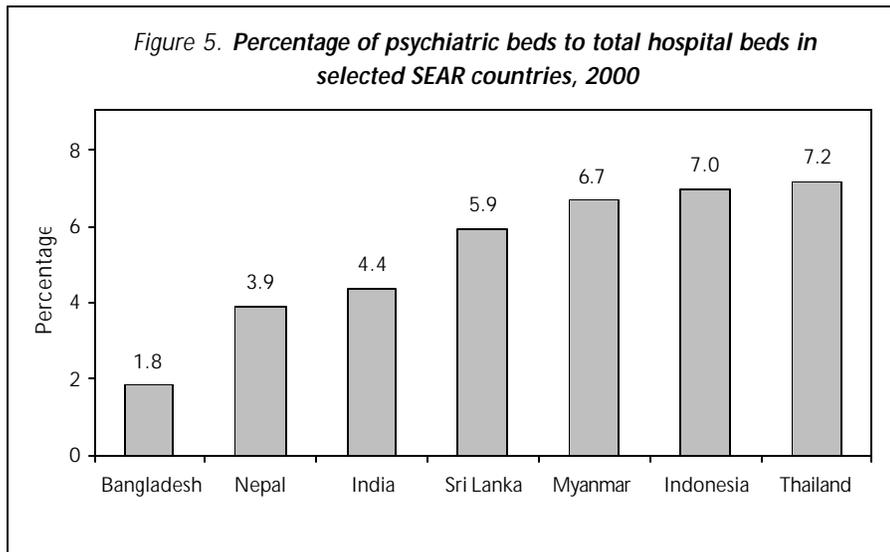
Sources: 1. WHO/SEARO, Health Situation in the South-East Asia Region 1994-1997
 2. WHO/HQ/SEARO, Social Change and Noncommunicable Diseases Department, Phase-one questionnaire on country resources for mental health, 2000

Note: Data are estimates based on sources above
 **Data not available for DPR Korea and Nepal



Sources: 1. WHO/SEARO, Health Situation in the South-East Asia Region 1994-1997
 2. HO/HQ/SEARO, Social Change and Noncommunicable Diseases Department, Phase-one questionnaire on country resources for mental health, 2000

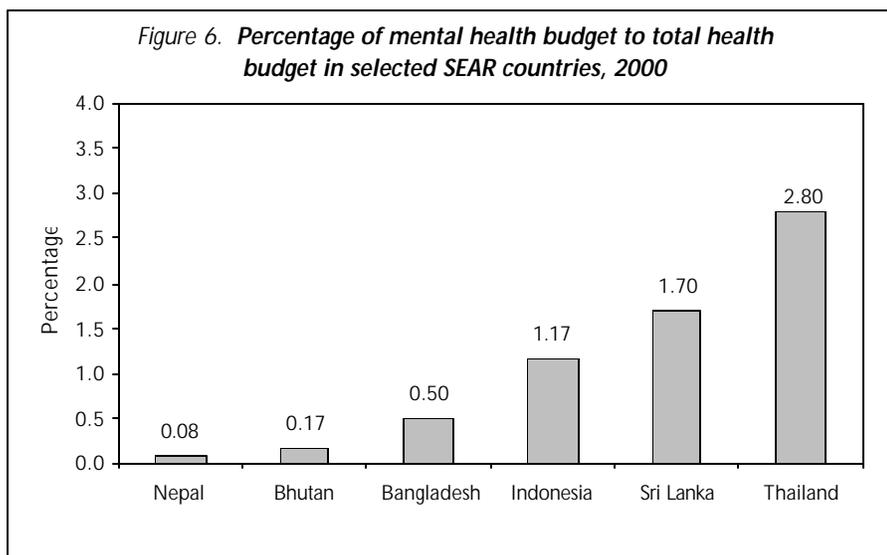
Note: Data are estimates based on sources above.
 ** Data not available for DPR Korea



Sources: 1. WHO/SEARO, Health Situation in the South-East Asia Region 1994-1997
2. WHO/HQ/SEARO, Social Change and Noncommunicable Diseases Department, Phase-one questionnaire on country resources for mental health, 2000
Note: Data are estimates from sources above]
** Data not available for Bhutan, DPR Korea, and Maldives

In some Member Countries, a disproportionately large proportion of total hospital beds is assigned to mental health (Figure 5). In the 19th and 20th centuries, patients with mental disorders were considered dangerous to the society and were thus isolated in mental hospitals, frequently restrained and locked up in rooms. Thus, because of historical reasons, there are too many inpatient beds in mental hospitals in many Member Countries. With advances in medical sciences, discovery of appropriate medications for mental disorders, and the awareness that patients have a right to enjoy good quality of life, there has been a shift from inpatient to outpatient care in the community. Thus, bed strength in mental hospitals needs to be curtailed in a phased manner. WHO will assist Member Countries in developing appropriate programmes for community-based care and rehabilitation of the patients.

In most Member Countries, the budget for mental health is very small (Figure 6). Governments of Member Countries may wish to consider enhanced allocation of budget to mental health, particularly supporting new and innovative community-based programmes. The role of other sources of financing mental health services, such as, private insurance, also needs to be considered.



Source: WHO/HQ/SEARO, Social Change and Noncommunicable Diseases Department, Phase-one questionnaire on country resources for mental health, 2000

Note: Data are estimates based on source above

**Data not available for DPR Korea, India, Maldives and Myanmar

In most Member Countries, people spend large amounts of money in rituals and faith healers for the management of patients with mental and neurological disorders. Unfortunately, this money is frequently wasted. With education, the same money or perhaps even less, will need to be spent for appropriate medical treatment.

4. STRATEGIES FOR CONTROL OF MENTAL AND NEUROLOGICAL DISORDERS AND SUBSTANCE ABUSE, INCLUDING HARM FROM ALCOHOL

4.1 Regional Strategy

The Regional Office is developing strategies for community-based programmes based on five 'A's: Availability, Acceptability, Accessibility, Affordable medications and Assessment.

Availability: Services which will address at least the minimum needs of populations in mental and neurological disorders should be available to

everyone regardless of where they live. The key questions are: what are the minimum services needed and who will deliver them?

Acceptability: Large segments of populations in Member Countries continue to perpetuate superstitions and false beliefs about mental and neurological illnesses. Many believe that these illnesses are due to “evil spirits”. Thus, even if appropriate medical services are made available, they would rather go to sorcerers and faith healers. Populations need to be informed and educated about the nature of neuropsychiatric illnesses.

Accessibility: Services should be available to the community, in the community, and at convenient times. If a worker has to give up his daily wages and travel a substantial distance to see a medical professional who is only available for a few hours a day, he/she is unlikely to seek these services.

Affordable medications: Frequently, medications are beyond the reach of the poor. Every effort should be made to provide essential medications uninterruptedly and at a reasonable cost. Thus, government policies in terms of taxes on medications and the role of the pharmaceutical industry in distribution and pricing become critical.

Assessment: Being new, these programmes need to be continuously assessed to ensure appropriateness and cost-effectiveness. Changes in the ongoing programmes based on impartial evaluations are essential.

4.2 Special Projects Initiated by the Regional Office

The Regional Office has initiated some projects to assist Member Countries in controlling certain priority mental and neurological disorders.

Development of mental health legislation

During the last few decades, there have been significant developments in the field of mental health, mental health care and organization of mental health services. Similarly, considerable developments have taken place in the field of human rights and social expectations in relation to the care of the mentally ill. People with mental illness have benefited significantly from these developments.

In 1991, the UN General Assembly adopted resolution 46/119 entitled “Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care”. However, in many countries of the Region, mental health legislation does not reflect these developments. It is

therefore essential to review the existing legislation and incorporate new developments with a view to improving the quality of mental health care.

Mental health policies are important because they coordinate, through a common vision and plan, all programmes and services related to mental health. In the absence of such policies, mental disorders are likely to be treated in an inefficient and fragmented manner.

The Mental Health Policy and Service Development Unit of the Department of Mental Health and Substance Dependence at WHO headquarters has launched an initiative entitled Mental Health Policy Project. The goal of this project is to bring together the latest information on mental health policy and planning, compile it into a guidance package, distribute it to Member Countries, and assist with its implementation. The project will help countries to create policies and then put them into practice, which, in turn, should lead to improved mental health care, treatment and promotion.

Some Member Countries (Bangladesh, India, Indonesia, Sri Lanka) have already initiated steps to develop mental health legislation based on current thinking. Workshops have been held and drafts prepared. Member Countries could benefit from the experience of other Member Countries in the finalization of these drafts.

Control of epilepsy

Epilepsy, which is probably the oldest recorded medical illness, has evoked varied reactions ranging from mystery to fear. It has even been seen as messages from the supernatural. People with epilepsy and their families have suffered ostracism by society and have been deprived of treatment, leading to frequent injuries and, sometimes, death.

At the global level, it is estimated that there are nearly 50 million persons suffering from epilepsy of which three-fourths, i.e. 35 million are in the developing countries, many of them in the South-East Asia Region. It is estimated that India alone has approximately 8-10 million people suffering from epilepsy.

Advances in medical sciences have enhanced the understanding of epilepsy as a medical problem. We now know why it occurs, in some cases what causes it, how to treat it and how best to care for the patient. Unfortunately, despite the availability of effective and inexpensive medicines and treatment regimens, many patients in the Region are not getting the full benefit of appropriate treatment.

The World Health Organization, in partnership with the International League against Epilepsy, and the International Bureau for Epilepsy, has launched a worldwide programme, "Out of the Shadows", to create awareness, remove myths and misconceptions and make available appropriate care and treatment to people with epilepsy worldwide. The South-East Asia Regional Office of the World Health Organization is committed to this partnership. The prime objective is to support countries in the Region to reach even remote and rural areas and marginalized populations, to help people with epilepsy lead normal lives.

About 70 to 80 per cent of people with epilepsy can lead normal lives if properly treated. However, 80 to 90 per cent of people with epilepsy are not being treated at all. This situation must change through appropriate and urgent action, and only then will people with epilepsy emerge from the shadows.

Suicide prevention

Countries of the Region are witnessing rapid changes in population growth, socioeconomic development and health profiles. They are passing through a major revolution in social, economic, health, demographic, information and technological spheres. In their quest for modernization, traditional value systems are being replaced by modern paradigms of liberalization.

Suicide is now being recognized as a major public health problem in the complex scenario of development and lifestyle changes. In the socioculturally diverse communities of SEAR, suicide is a very important issue cutting across diverse disciplines and sectors such as health, religion, spirituality, law and welfare.

While the problem of suicide has grown significantly, countries are yet to realize its impact. The problem needs to be understood in its totality, resources have to be shared and generated, and interventions prioritized. Even at the global level, successful programmes are very few and cannot be transferred as such to developing countries as the situation, problems, patterns and methods are very different. Further, while developing interventions, the social, economic, political and cultural factors need to be considered. Some of the major strategies likely to yield significant and positive results are: reducing access to organophosphorus compounds and drugs; training of primary health care physicians (early recognition and treatment of depression); developing social support networks, specially for those at risk; establishing crisis intervention centres; changing public attitudes about

suicide, and augmenting social reforms across societies. The need of the hour is to develop national suicide prevention strategies along with early implementation and evaluation. Successes and failures have to be shared across and within countries.

Community-based rehabilitation of those with mental illness

Rehabilitation and community integration of persons with mental illness and associated disabilities (particularly those in the early years of life) is effectively done at home or in a community setting, such as the school. This not only minimizes cost of rehabilitation, but also permits service provision in a familiar and caring environment. A major problem with the community-based approach in the past has been that the knowledge about rehabilitation was often thought to be the exclusive preserve of professionals who were senior and available only in hospitals. Families and community bodies responsible for the care of persons with disabilities often feel the need for guidance from trained personnel to implement even the existing programmes. A major difficulty faced by most Member Countries in the Region appears to be the lack of trained personnel. Training community workers for basic disability work in an attempt to expand services and improve the quality of life for persons with mental illness and associated disabilities requires urgent consideration.

There is a need to develop and implement a course for holistic training in the community for people with mental disabilities by adapting to local situations, changing needs over the course of time, make the content user-specific and more relevant to the 'trainer and the trained' for the community.

Promotion of mental health among adolescents

Adolescence is a sensitive and impressionable period in the life-cycle of a person. Healthy habits (eating a balanced diet, exercise, abstinence from alcohol and tobacco), formed at this stage, can protect from many lifestyle-related diseases later in life. Similarly, promotion of positive mental health during this period can afford protection from mental and neurological disorders later in life.

Strategies for the promotion of mental health include life skill development in coping with stress, self-esteem enhancement, problem-solving, development of interpersonal relationships and conflict resolutions. Practical and easy-to-implement modules for these strategies should be developed for implementation in the community.

Community-based strategies for prevention of harm from alcohol

Though the production and consumption of alcohol has increased alarmingly in the Region, alcohol-related data are scarce and there have been few scientific studies on prevention of harm from abuse of alcohol. Beside licit alcohol, there is the serious problem of illicit alcohol, which is extremely toxic and harmful for health. Unfortunately, alcohol is considered a major source of revenue for governments.

To plan community-based intervention strategies, the first step is to assess the magnitude of the problem in relation to the production, marketing and consumption patterns in the community. Based on this, countries can plan culturally appropriate strategies for prevention of harm from alcohol.

5. SUGGESTED ACTIONS BY MEMBER COUNTRIES TO PROMOTE MENTAL HEALTH AND CONTROL SUBSTANCE ABUSE, INCLUDING HARM FROM ALCOHOL

Political commitment

Today, mental health does not receive the priority or the resources that are needed. Increased attention to mental health problems throughout the Region is urgently needed. Political will and commitment of governments of Member Countries is crucial.

Mental health legislation

It is important for governments to enact legislation to support community-based care as well as upgrade mental health institutions. It is time that defunct and outdated laws on mental health are updated and, most importantly, the human rights of the mentally ill upheld.

Manpower development

There is a great scarcity of trained manpower in neurosciences. This includes not only neurologists and psychiatrists but also paramedical staff such as counsellors and therapists. In addition, training programmes for general physicians and PHC doctors in mental health need to be developed and implemented on a large scale. Training for community health workers and other community health providers should also be considered.

Priority to community-based mental health activities

Member Countries may consider adopting the recent advances in mental health treatment, care and rehabilitation which emphasize the role of the family and community-based care. Although successful methods have been identified to involve the family and the community to help in recovery and reduce the suffering and accompanying disabilities, these are yet to be used extensively. Thus, many population groups still remain deprived of the benefits of advancement in medical sciences. As these services are developed, mental health hospital beds may gradually be converted to general medical beds. Also, the recent trend is to have mental health units in general hospitals rather than develop vertical programmes for mental health which are expensive, duplicate efforts and perpetuate stigma.

Availability of medications

Drugs for treating these disorders do not reach many people with mental and neurological illnesses. Governments need to address the issue of price, supply and distribution with appropriate tax laws for pharmaceuticals.

Support to marginalized populations

As the social fabric that has supported communities is stretched to breaking point, there are several groups of people who are at higher risk for mental illness. These include the socially isolated, ethnic minority groups, migrants, refugees, disaster victims as well as adults or adolescents with troubled family relations and the elderly whose numbers are rapidly increasing in the Region. Special attention needs to be paid to these marginalized populations.

Awareness campaign to remove stigma and discrimination

Besides this, there are many myths and beliefs prevalent in the Region which are a barrier to the treatment of the mentally ill. A key challenge in dealing with this serious problem of mental health and disability is the lack of public awareness and, in fact, misinformation. Psychotic illnesses are considered a "curse from Gods" or manifestations of evil spirits or punishment for past sins. People and communities need to recognize the medical nature of the ailments, to help remove the stigma, to ensure that patients are treated and given rehabilitation and a chance to live normally in society. It is imperative that the mentally ill are not isolated or ostracized. Stigma and discrimination continue to be the biggest obstacles facing mentally ill people today. It is

essential that information about the nature of the illness is widely disseminated through social awareness drives and through various channels of information, particularly the media.

The Regional Director for WHO South-East Asia Region has said: "Like any disease, mental illness can affect anyone at any age. It is time to lift the veil of myths and help to bring mental illnesses into the open so that patients with mental and neurological illnesses receive appropriate care and can live with dignity. Mental health care, unlike many other areas of health, does not generally demand costly technology. Rather, it requires the sensitive deployment of personnel who have been properly trained in the use of relatively inexpensive drugs and psychological support skills on an outpatient basis. What is needed, above all, is for all concerned to work closely to address the multi-faceted challenges of mental health".

BIBLIOGRAPHY

Mental health

- (1) *Setting the WHO Agenda for Mental Health*. Geneva; World Health Organization; 1999. Document number WHO/MNH/99.1
- (2) *The World Health Report 1999: Making a Difference*. Geneva; World Health Organization; 1999.
- (3) *Health Situation in the South-East Asia Region 1994-1997*. New Delhi: WHO South East Asia Regional Office; World Health Organization; 1999.
- (4) Jamison DT, Mosley WH, Measham AR, Bobadilla JL. *Disease Control Priorities in Developing Countries*. Washington DC: World Bank; 1993.
- (5) U.S Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Centre for Mental Health Services, National Institute of Health, National Institute of Mental Health; 1999.
- (6) Ustun TB, Sartorius N. *Mental Illness in General Health Care: An International Study*. Geneva: World Health Organization; 1995.
- (7) Sharma S. *Psychiatry in Primary Health Care*. Ranchi: Central Institute of Psychiatry; 1986.
- (8) Werner D. *Where There is no Doctor: A Village Health Care Handbook*. Palo Alto: The Hesperian Foundation; 1978.
- (9) Sartorius N, Goldberg D, de Girolamo G, Costa e Silva JA, Lecrubier Y and Wittchen HU, editors. *Psychological Disorders in General Medical Settings*. Toronto: Hogrefe & Huber; 1990.
- (10) National Institute of Mental Health and Neuro Sciences. *Mental Health Care by Primary Care Doctors*. Bangalore: NIMHANS; 1994.

Substance abuse, including alcohol

- (1) *The World Drug Report*. London: United Nations International Drug Control Programme; Oxford University Press; 1977.
- (2) *Volatile Solvents Abuse: A Global Overview*. Geneva: World Health Organization; 1999. Document number WHO/HSC/SAB/99.7
- (3) *"Good Practices" and Lessons: Reducing Illicit Drug Use in the Highlands of East Asia*. Bangkok: UNDCP Regional Centre for East Asia and the Pacific; United Nations International Drug Control Programme; 2000. Document number AD/RAS/96/B53
- (4) Integrating Psychoactive Substance Use Treatment Into Primary Health Care and Community Involvement in Health: A Synthesis of Experiences at the Zimbabwe and Nepal Sites. Geneva; World Health Organization; 2000. Document number WHO/MSD/MDP/00.20

- (5) *Surveys of Drinking Patterns and Problems in Seven Developing Countries*. Geneva; World Health Organization; 2001. Document number WHO/MSD/MSB/01.2
- (6) Jernigan DH. *Global Status Report: Alcohol and Young People*. Geneva: World Health Organization; 2001. (Document no. WHO/MSD/MSB/01.1)
- (7) *International Guide for Monitoring Alcohol Consumption and Related Harm*. Geneva; World Health Organization; 2000. Document no. WHO/MSD/MSB/00.4