42 - 37 World Aspects of Psychiatry

01 - 37 World Aspects of Psychiatry

37 World Aspects of Psychiatry

37

World Aspects of Psychiatry Mental disorders are highly prevalent in all regions of the world and represent a major source of disability and social burden worldwide. Treatments for all of these disorders are available and have been found to be efficacious in both developed and developing countries. However, mental disorders are remarkably undertreated worldwide, especially in low-income countries. National mental health policies are lacking in several countries, especially low-income ones. Resources for mental health care are scarce and unequally distributed. World psychiatry focuses on these and other issues such as the stigma attached to mental disorders, the relationships between mental and physical diseases, and the ethics of mental health care. PREVALENCE AND BURDEN OF MENTAL DISORDERS WORLDWIDE The World Health Organization (WHO) estimates that more than 25 percent of individuals worldwide develop one or more mental disorders during their lifetime. Among people seen by primary health care professionals, more than 20 percent have one or more current mental disorders. In a study carried out by the WHO at 14 sites in Africa, Asia, the Americas, and Europe, the average current prevalence of any mental disorder was 24 percent, without consistent differences between low- and high-income countries. The most common diagnoses were those of depression (average, 10.4 percent) and generalized anxiety disorder (average, 7.9 percent). Female rates were 1.89 times higher than male rates for depression, but male rates were higher for alcohol-related disorders, so that there was no sex difference in the proportion of people having at least one mental disorder. Physical ill health and educational disadvantage were both significantly associated with a diagnosis of mental disorder. To quantify the burden of the various diseases and injuries, the WHO, in collaboration with the Harvard School of Public Health and the World Bank, introduced the disability-adjusted life year (DALY). DALYs for a given disease or injury are the sum of the years of life lost due to premature mortality plus the years lost due to disability for incident cases of that disease or injury in the general population. In the original estimates for the year 1990, mental and neurological disorders accounted for 10.5 percent of the total DALYs lost due to all diseases and injuries. The estimate for the year 2000 was 12.3 percent, with two mental disorders (depression and alcohol use disorders) and suicide ranking in the top 20 causes of DALYs for all ages. In the estimates for the year 2005,

mental and neurological disorders accounted for 13.5 percent of all DALYs in the world (27.4 percent in high-income countries, 17.7 percent in middle-income countries, and 9.1 percent in low-income countries), being the main contributor to burden among noncommunicable diseases (27.5 percent compared with 22 percent for cardiovascular diseases and 11 percent for cancer). According to the updated estimates for the year 2030, mental and neurological disorders will account for 14.4 percent of

all DALYs in the world and 25.4 percent of those due to noncommunicable diseases. Depression will rank number 2 in the percentage of total DALYs in that year (5.7 percent), following HIV/AIDS and preceding ischemic heart disease (Table 371). It will be number 1 in high-income countries (9.8 percent), number 2 in middle-income countries (6.7 percent), and number 3 in low-income countries (4.7 percent). Table 37-1 Leading Causes of Disability-Adjusted Life Year (DALYs) Worldwide As Estimated for the Year 2030 The WHO estimates that one of four families worldwide has at least one member with a mental disorder. The objective and subjective burden related to caring for people with severe mental disorders (in terms of disruption of family relationships; constraints in social, leisure, and work activities; financial difficulties; negative effect on physical health; feelings of loss, depression, and embarrassment in social situations; and the stress of coping with disturbing behaviors) has been reported to be substantial and significantly higher than that related to caring for people with long-term physical diseases such as diabetes and heart, kidney, or lung diseases. Cross-cultural differences have been reported in some dimensions of family burden. Suicide is among the ten leading causes of death for all ages in most of the countries for which information is available. In some countries (e.g., China), it is the leading cause of death for people between 15 and 34 years of age. According to WHO estimates, about 849,000 people died from suicide worldwide in the year 2001. In that year, the number of suicide deaths overtook the number of deaths by violence (500,000) and war (230,000). In 2020, approximately 1.53 million people will die from suicide worldwide based on current trends, and 10 to 20 times more people will attempt suicide. Reported suicide rates vary considerably across countries; for instance, annual suicide rates of 48.0 to 79.3 per 100,000 have been reported in many Eastern and Central European countries, and rates of less than 4.0 per 100,000 have been found in Islamic and several Latin American countries. More than 85 percent of suicides are reported to occur in lowor middle-income countries, but this figure may represent an underestimate due to the low reliability of official statistics in those countries: When surveillance with validated verbal autopsy was used in South India, the observed rates for suicide exceeded official national estimates tenfold. In the Asia-Pacific region, 300,000 cases of suicide per year are estimated to occur by self-poisoning with pesticides. Suicide rates are higher in men than in women (3.2:1 in 1950, 3.6:1 in 1995, and an

estimated 3.9:1 in 2020). China is the only country where suicide rates in women are consistently higher than those in men, especially in rural areas. Over the past few decades, suicide rates have been reported to be stable worldwide, but a rising trend among young men ages 15 to 19 years has been observed. A systematic review covering 15,629 cases in the general population worldwide estimated that 98 percent of those who committed suicide had a diagnosable mental disorder, with mood disorders accounting for 35.8 percent, substance-related disorders for 22.4 percent, personality disorders for 11.6 percent, and schizophrenia for 10.6 percent of cases. TREATMENT GAP AND PROJECTED POPULATION-LEVEL TREATMENT EFFECTIVENESS WORLDWIDE The efficacy of pharmacological and psychosocial treatments for mood, anxiety, psychotic, and substance-related disorders has been convincingly proved by clinical trials carried out in low- and

middle-income, as well as in high-income, countries. However, the treatment gap is substantial for all mental disorders worldwide, particularly in low-income countries. In the World Mental Health Surveys, failure and delays in treatment seeking were generally greater in low-income countries, older cohorts, men, and cases with earlier ages of onset. The earlier treatment contact of people with mood disorders might be partly due to the fact that these disorders have been targeted by educational campaigns and primary care quality improvement programs in several countries. RESOURCES FOR MENTAL HEALTH CARE WORLDWIDE According to the Mental Health Atlas 2005, only 62.1 percent of countries worldwide, accounting for 68.3 percent of the world population, have a mental health policy (i.e., a document of the government or ministry of health specifying the goals for improving the mental health situation of the country, the priorities among those goals, and the main directions for attaining them). A mental health policy is present in 58.8 percent of low-income and 70.5 percent of high-income countries. In Africa, only 50 percent of countries have a mental health policy. In Southeast Asia, only 54.5 percent of countries have a mental health policy, and 76.4 percent of the population is not covered by such a policy (Table 37-2). Table 37-2 Presence of a Mental Health Policy in the Countries of Each Region of the World Health Organization (WHO)

Community care facilities exist in only 68.1 percent of the countries (51.7 percent of low-income and 93 percent of high-income countries). Only 60.9 percent of the countries report providing treatment facilities for severe mental disorders at the primary care level (55.2 percent of low-income and 79.5 percent of high-income countries). About one fourth of low-income countries do not provide even basic antidepressant medications in primary care settings. In many others, the supply does not cover all regions of the country or is very irregular. Because medicines are often not available in health care facilities, patients and families are forced to pay for them out of pocket. Whereas 61.5 percent of European countries spend more than 5 percent of their health budget on mental health care, 70 percent of countries in Africa and 50 percent of countries in Southeast Asia spend less than 1 percent. Out-of-pocket payment is the most important method of financing mental health care in 38.6 percent of countries in Africa and 30 percent of countries in Southeast Asia, but it is not the primary method of financing mental health care in any European country (Table 37-3). All countries with out-of-pocket payment as the dominant method of financing mental health care belong to low-income or lower middle-income categories, but almost all countries with social insurance as the dominant method of financing belong to high-income or upper middleincome categories. Table 37-3 Countries in Which Out-of-Pocket Payment Is the Most Common Method of Financing Mental Health Care in Each Region of the World Health Organization (WHO) The median number of psychiatrists per 100,000 population ranges from 0.04 in Africa and 0.2 in Southeast Asia to 9.8 in Europe (Table 37-4). It is 0.1 in low-income countries compared with 9.2 in high-income countries. Two thirds of lowincome countries have less than one psychiatrist per 100,000 population. Chad, Eritrea, and Liberia (with populations of 9, 4.2 and 3.5 million, respectively) each has just one psychiatrist per 100,000 population. Afghanistan, Rwanda, and Togo

(with populations of 25, 8.5, and 5 million respectively) each has just two psychiatrists per 100,000 population. Largescale migration of psychiatrists from low- and middle-income to high-income countries, as part of the larger picture of migration of health professionals in general, has been consistently documented. India and some sub-Saharan African countries are the most important contributors to the mental health workforce in the United Kingdom, although the United Kingdom

has 110 psychiatrists per million population, but India has 2 per million and sub-Saharan Africa less than 1 per million. The median number of psychologists working in mental health care per 100,000 population ranges from 0.03 in Southeast Asia and 0.05 in Africa to 3.1 in Europe. Approximately 69 percent of low-income countries have less than one psychologist per 100,000 population. The median number of psychiatric nurses per 100,000 population ranges from 0.1 in Southeast Asia and 0.2 in Africa to 24.8 in Europe. Table 37-4 Median Number of Mental Health Professionals per 100,000 Population in Each Region of the World Health Organization (WHO) From these figures, it is clear that resources for mental health care are grossly inadequate compared with the needs, and that inequalities across countries are substantial, especially between low- and high-income countries. Moreover, resources tend to be concentrated in urban areas, especially in low-income countries, leaving vast regions without any form of mental health care. Even worse is the situation concerning child and adolescent mental health care. According to the WHO, only 7 percent of countries worldwide have a specific child and adolescent mental health policy. In less than one third of all countries is it possible to identify an institution or a governmental entity with an overall responsibility for child mental health. School-based services are almost exclusively present in high-income countries, and even in Europe only 17 percent of countries have a sufficient number of these services. There are no pediatric beds for mental health identified in low-income countries, but such beds are identified in 50 percent of high-income countries. In all African countries outside South Africa, fewer than 10 psychiatrists could be found who were trained to work with children. In European countries, the number of child psychiatrists ranges from one per 5,300 to one per 51,800. In more than 70 percent of countries worldwide, there is no list of essential psychotropic medications for children. In 45 percent of countries worldwide, psychostimulants are either prohibited or unavailable for use in children with attention-deficit/hyperactivity disorder.

PRINCIPLES FOR MENTAL HEALTH PROGRAM DEVELOPMENT AND BARRIERS TO CHANGE WORLDWIDE According to the WHO, the development of mental health programs worldwide should be guided by the following principles: (1) providing treatment in primary care; (2) making psychotropic medications available; (3) giving care in the community; (4) educating the public; (5) involving communities, families, and consumers; (6) establishing national policies and legislations; (7) developing human resources; (8) linking with other relevant sectors; (9) monitoring community mental health; and (10) supporting more research. The guiding principles proposed for the prevention of suicide worldwide include (1) reducing access to means of suicide (e.g., pesticides, firearms), (2) treating people with mental disorders, (3) improving media portrayal of suicide, (4) training primary health care personnel, (5) implementing school-based programs, and (6) developing hotlines and crisis centers. The most significant barriers to the implementation of the foregoing principles worldwide, according to the WHO, include the following: (1) some stakeholders may be resistant to the changes; (2) health authorities may not believe in the effectiveness of mental health interventions; (3) there may be no consensus among the country’s stakeholders about how to formulate or implement the new policy; (4) financial and human resources may be scarce; (5) other basic health priorities may compete with mental health care for funding; (6) primary care teams may feel overburdened by their workload and refuse to accept the introduction of the new policy; and (7) many mental health specialists may not want to work in community facilities or with primary care teams, preferring to remain in hospitals. The suggested solutions include (1) adopting an “all-winners approach” that ensures that the needs of all stakeholders are taken into account, (2) developing pilot projects and evaluating their effect on health and consumer satisfaction, (3) asking for technical reports from international experts, (4) focusing the

implementation of the mental health policy on a demonstration area and performing cost-effectiveness studies, (5) linking mental health programs to other health priorities, and (6) showing primary care practitioners that people with mental disorders are already a hidden part of their burden and that the burden will decrease if these disorders are identified and treated. STIGMATIZING ATTITUDES TOWARD PEOPLE WITH MENTAL DISORDERS Stigmatizing attitudes toward people with mental disorders are widespread in the general public and even among mental health professionals. Although it has been suggested that stigma may be less severe in Asian and African countries, a study carried out in India within the Stigma Programme of the World Psychiatric Association (WPA), in which 463 persons with schizophrenia and 651 family members were interviewed in four cities, reported that two thirds of the respondents had experienced discrimination. Women and people living in urban areas were more stigmatized. Whereas men experienced greater discrimination in the job area, women experienced more problems in the family and social areas. Unlike people with physical disabilities, those with mental disorders are often

perceived by the public to be in control of their disabilities and responsible for causing them. The view that “weakness,” “laziness,” or “lack of willpower” contributes to the development of mental disorders has been reported in several countries, including Turkey, Mongolia, and South Africa. The stigmatization of people with mental disorders may result in public avoidance, systematic discrimination, and reduced help-seeking behavior. In a survey carried out in 1996 in a probability sample of 1,444 adults in the United States, more than half of the respondents reported to be unwilling to spend an evening socializing with, work next to, or have a family member marry a person with mental illness. Although most countries have some provision for disability benefits, people with mental illness are often specifically excluded from such entitlements. Moreover, mental disorders are frequently not considered in social and private insurance schemes for health care. Shame is reported to be one of the main barriers from seeking help for mental disorders in both developed and developing countries. Strategies for addressing stigmatization of people with mental disorders have been subdivided into three groups: protest, education, and contact. There is some evidence that protest campaigns may be effective in reducing stigmatizing behaviors against people with mental disorders. Education may promote a better understanding of mental illness, and educated people may be less likely to endorse stigma and discrimination. An inverse relationship between having contact with a person with mental illness and endorsing stigmatizing behaviors has been documented. RELATIONSHIPS BETWEEN MENTAL AND PHYSICAL DISEASES Mortality due to physical illness is significantly increased in people with severe mental disorders compared with the general population. In a follow-up study carried out in the United Kingdom, the standardized mortality ratio (SMR) for natural causes in people with schizophrenia was 2.32 (i.e., death was more than twice higher than in the general population). The SMR for causes “avoidable by appropriate treatment” was 4.68. The highest SMRs were those for endocrine, nervous, respiratory, circulatory, and gastrointestinal diseases. Increased nonsuicide all-cause mortality has been also reported for bipolar disorder (SMR 1.9 for men and 2.1 for women) and dementia (relative risk [RR] 2.63; 95 percent confidence interval [CI] 2.17 to 3.21). A meta-analysis of 15 population-based studies of the effect of a diagnosis of depression on subsequent allcause mortality yielded a pooled odds ratio of 1.7 (CI 1.5 to 2.0). Evidence from lowincome countries is limited, but a large population study conducted in Ethiopia found high mortality rates for major depression (SMR 3.55, 95 percent CI 1.97 to 6.39) and schizophrenia (almost 5 percent per year). The prevalence of several physical diseases is increased in people with mental disorders compared

with the general population. In a study carried out in the United States, people with psychotic disorders were found to be more likely than other people to develop diabetes, hypertension, heart disease, asthma, gastrointestinal disorders, skin infections, malignant neoplasms, and acute respiratory disorders. The rate was increased even when only patients without a concomitant substance use disorder were

considered. In a study conducted in Nigeria, 55.2 percent of persons with schizophreniaspectrum disorders referred for the first time to a psychiatric clinic had at least one physical disease, but in persons with neurotic disorders, the rate was 11.8 percent. A strong prospective association has been documented between depression and coronary heart disease outcomes, including fatal myocardial infarction; on the other hand, the incidence of depression is increased after myocardial infarction, especially in the first month after the event. Depression also increases the risk for type II diabetes. In South Asia, an association between maternal perinatal depression and infant malnutrition and stunting at 6 months has been repeatedly reported. People with severe mental disorders are at increased risk of contracting HIV infection, although prevalence rates vary substantially worldwide. A large multicenter study conducted in sub-Saharan Africa, Asia, Latin America, Europe, and the United States reported a higher prevalence of depressive disorder among symptomatic HIVseropositive people than in asymptomatic HIV-seropositive cases and seronegative control participants. Evidence from both developed and developing countries shows that adherence to highly active antiretroviral therapy (HAART) is negatively affected by depression, cognitive impairment, and substance abuse. In a study carried out in the United Kingdom, people with severe mental illness were significantly more likely to be obese (body mass index higher than 30) and morbidly obese (body mass index higher than 40) than the general population: The respective figures were 35.0 versus 19.4 percent and 3.7 versus 1.3 percent. When these figures were broken down by age and sex, 28.7 percent of men with severe mental illness between 18 and 44 years of age were obese compared with 13.6 percent in the general population, and 3.7 versus 0.4 percent were morbidly obese. Even more striking were the figures concerning women of the same age: 50.6 versus 16.6 percent and 7.4 versus 2.0 percent, respectively. In a meta-analysis of worldwide studies, a highly significant association between schizophrenia and current smoking was confirmed: The weighted average odds ratio was 5.9; it was 7.2 in men and 3.3 in women. The association remained significant when controls with severe mental illness were used (odds ratio, 1.9). Heavy smoking and high nicotine dependence were also more frequent in people with schizophrenia than in the general population. The quality of physical health care received by patients with severe mental illness is often worse than the general population. A study conducted in the United States found that adverse events during medical and surgical hospitalizations were significantly more frequent in patients with schizophrenia than in the other people, including infections due to medical care, postoperative respiratory failure, postoperative deep venous thrombosis or pulmonary embolism, and postoperative sepsis. All of these adverse events were associated with a significantly increased odds of admission to an intensive care unit and of death. The decreased access of people with mental disorders to medical services has been related to several factors concerning the health care system. The effect of lack of insurance and cost of care is well documented. In a study carried out in the United

States, people with mental disorders were twice as likely as those without mental disorders to have been denied insurance because of a preexisting condition (odds ratio, 2.18). Having a mental disorder conferred a greater risk of having delayed seeking care because of cost (odds ratio, 1.76)

and of having been unable to obtain needed medical care (odds ratio, 2.30). Even when people with mental illness are seen by a doctor, their physical diseases often remain undiagnosed. Primary care providers may misperceive the medical complaints of people with mental disorders as “psychosomatic” or be unskilled or feel uncomfortable in dealing with this population. An underlying stigmatization may be involved. Moreover, during hospitalizations in medical and surgical wards, health care professionals may not be experienced in dealing with the special needs of patients with schizophrenia, may minimize or misinterpret their somatic symptoms, and may make an inappropriate use of restraints or sedative drugs or fail to consider possible interactions of psychotropic drugs with other medications. On the other hand, many psychiatrists are unable or unwilling to perform physical and even neurological examinations or are not up to date on the management of even common physical diseases. To address this situation, the first step is raising awareness of the problem among mental health care professionals, primary care providers, and patients with schizophrenia and their families. Education and training of mental health professionals and primary care providers is a further essential step. Mental health professionals should be trained to perform at least basic medical tasks. They should be educated about the importance of recognizing physical illness in people with severe mental disorders and encouraged to become familiar with the most common reasons for underdiagnosis or misdiagnosis of physical illness in these patients. On the other hand, primary care providers should overcome their reluctance to treat people with severe mental illness and learn effective ways to interact and communicate with them; it is not only an issue of knowledge and skills but also most of all one of attitudes. Another essential step is the development of an appropriate integration between mental health and physical health care. A well-identified professional should be responsible for physical health care in each person with a severe mental disorder. Mental health services should be able to provide at least a standard routine assessment of their patients to identify or at least suspect the presence of physical health problems. Guidelines about the management of patients receiving antipsychotic drugs should be known and applied by all mental health services. Patients should be involved as much as possible; for instance, mental health professionals should encourage patients to monitor and chart their weight. Dietary and exercise programs should be routinely provided by mental health services. Flexible smoking cessation programs, which have shown some degree of success, could be considered in some settings. ETHICAL ISSUES IN MENTAL HEALTH CARE The protection and promotion of the human rights of people with mental disorders are emerging as a priority worldwide. In 1991, the United Nations (UN) issued Resolution

46/119 for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. In that resolution, the human rights of people with mental disorders and their right to treatment were codified for the first time in a UN document. The 25 principles covered the following areas: definition of mental illness; protection of confidentiality; standards of care and treatment, including involuntary admission and consent to treatment; rights of persons with mental disorders in mental health facilities; protection of minors; provision of resources for mental health facilities; role of community and culture; review mechanisms providing for the protection of the rights of offenders with mental disorders; and procedural safeguards protecting rights of persons with mental disorders. National governments were invited to promote the principles of the resolution by appropriate legislative, juridical, administrative, educational, and other provisions. However, violations of the human rights of people with mental disorders are still reported in many countries, and in a substantial number of low- and middle-income countries, patients in mental hospitals are physically restrained or secluded for long periods. In Latin America, an influential

document has been the Declaration of Caracas, adopted in 1990 by the Regional Conference on Restructuring Psychiatric Care in Latin America, which states that resources, care, and treatment for people with mental disorders should safeguard their dignity and human and civil rights and strive to maintain them people in their communities. The Declaration also states that mental health legislation should safeguard the human rights of people with mental disorders and that services should be organized so that these rights can be enforced. In Africa, the Banjul Charter on Human and People's Rights, a legally binding document supervised by the African Commission on Human and People's Rights, in Article 5 addresses the right to respect for the dignity inherent in human beings and the prohibition of all forms of degradation, including cruel, inhuman, or degrading treatment. According to the WHO, mental health legislation should cover the following issues: access to basic mental health care, least restrictive care, informed consent to treatment, voluntary and involuntary admission to treatment, competence issues, periodical review mechanism, confidentiality, rehabilitation, accreditation of professionals and facilities, and rights of families and caregivers. Specific legislation in the field of mental health is present in 74 percent of low-income countries versus 92.7 percent of high-income countries. In 1996, the WPA released the Madrid Declaration, which contains the ethical principles by which all national psychiatric societies are expected to abide. The Declaration includes seven general guidelines focusing on the aims of psychiatry: (1) psychiatrists must serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles and should devise therapeutic interventions that are the least restrictive to the freedom of the patient; (2) it is the duty of psychiatrists to keep abreast of scientific developments of their specialty and to convey updated knowledge to others; (3) the patient should be accepted as a partner by right in the therapeutic process, and the therapist–patient relationship must be based on mutual trust and respect, to allow the patient to make free and informed decisions; (4) treatment must always be in the best interest of the patient, and no treatment should be provided against the patient's will, unless withholding treatment would endanger life of the patient or those who surround him or her; (5) when psychiatrists are requested to assess a person, it is their duty to inform the person being assessed about the

purpose of the intervention; (6) information contained in the therapeutic relationship should be kept in confidence and used exclusively for the purpose of improving the mental health of the patient; and (7) because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy, as well as their mental and physical integrity. INTERNATIONAL ORGANIZATIONS ACTIVE IN THE MENTAL HEALTH FIELD Many international organizations are active in the mental health field. They include the WHO, which is the world's leading public health agency; some professional associations, among which the largest is the WPA, representing the psychiatric profession worldwide; and several organizations with a membership of users and families (such as the World Fellowship for Schizophrenia and the Global Alliance of Mental Illness Advocacy Networks [GAMIAN]) or of both mental health professionals and users and families (such as the World Federation for Mental Health [WFMH]). The WHO is a UN agency with 192 member states, grouped into six regions (Africa, the Americas, European Mediterranean, Europe, Southeast Asia, and Western Pacific). It has a Department of Mental Health and Substance Abuse at its headquarters in Geneva and advisors for mental health in each of its regional offices. Its main functions are direction and coordination of international health work and technical cooperation with countries. Among the numerous recent WHO activities in the mental health field, of special interest are the release of the World Health Report 2001 and the

development of the report Mental Health: New Understanding, New Hope, which was completely devoted to mental health. It provided a summary of the current and projected impact of mental disorders and of the principles of mental health policy and service provision, as well as a set of recommendations for future action that can be adapted to the needs and resources of the various countries. Project Atlas aims to collect information on mental health resources across the world. Global and regional analyses of those resources were first published in 2001 and updated in 2005. Volumes focusing on resources for child and adolescent mental health and on psychiatric education and training worldwide (the latter in collaboration with the WPA) were released in 2005. The WPA is an association of national psychiatric societies aimed at increasing knowledge and skills necessary for work in the field of mental health and the care for the mentally ill. Its member societies number 134, spanning 122 countries and representing more than 200,000 psychiatrists. The WPA organizes the World Congress of Psychiatry every 3 years. It also organizes international and regional congresses and meetings and thematic conferences. It has 65 scientific sections, which are aimed at disseminating information and promoting collaborative work in specific domains of psychiatry. It has produced several educational programs and series of books and consensus statements (including the Declaration of Madrid on ethical principles for psychiatric practice). It has an official journal, World Psychiatry, which is produced in English, Spanish, and Chinese and is indexed in PubMed and Current Contents and reaches more than 33,000 psychiatrists worldwide. The WFMH is a multidisciplinary advocacy and education organization aimed at promoting the advancement of mental health awareness, prevention, advocacy, and best-practice recovery-focused interventions worldwide. Among its activities is the organization of the World Mental Health Day, observed every year on October 10, each time with a different theme. FUTURE PERSPECTIVES Several statements have been made by various groups and organizations about priorities

for future action in the mental health field at the international level. Of special interest is a document produced by 39 leaders comprising the so-called Lancet Global Mental Health Group. In this document, five main goals are identified: (1) placing mental health on the public health priority agenda, (2) improving the organization of mental health services, (3) integrating the availability of mental health into general health care, (4) developing human resources for mental health, and (5) strengthening public mental health leadership. Among the strategies proposed to place mental health on the public health priority agenda are the development and use of uniform and clearly understandable messages for mental health advocacy and the education of decision makers within governments and donor agencies on the evidence concerning the public health significance of mental disorders and the cost-effectiveness of mental health care. Strategies suggested to improve the organization of mental health services include, among others, the provision of incentive arrangements to overcome vested interests blocking change and the organization of international technical support to learn from countries that have experienced successful mental health reform. To integrate the availability of mental health in general health care, it is proposed that mental health professionals be appointed and trained specifically for supporting and supervising primary health care staff. To promote the development of human resources for mental health, it is suggested that the professional and specialist workforce be increased and diversified and that the quality of mental health training be improved to ensure that it is practical and occurs also in community or primary care settings. REFERENCES Belsky J, Hartman S. Gene-environment interaction in evolutionary perspective: differential susceptibility to environmental influences. World Psychiatry. 2014; 13(1):87–89. Biglu MH. 2565–Global attitudes towards forensic psychiatry (2006–2012). Eur Psychiatry. 2013;28:1. Golhar TS, Srinath S. Global child and adolescent mental

health needs: Perspectives from a national tertiary referral center in India. Adolesc Psychiatry. 2013; 3(1):82–86. Kirmayer LJ, Raikhel E, Rahimi S. Cultures of the Internet: Identity, community and mental health. Transcult Psychiatry. 2013;50(2):165–191. Leckman JF. What's next for developmental psychiatry? World Psychiatry. 2013; 12(2):125. Maj M. World aspects of psychiatry. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:4510. Malhi GS, Coulston CM, Parker GB, Cashman E, Walter G, Lampe LA, Vollmer-Conna U. Who picks psychiatry? Perceptions, preferences and personality of medical students. Aust N Z J Psychiatry. 2011;45(10):861–870. Marienfeld C, Rohrbaugh RM. Impact of a global mental health program on a residency training program. Acad Psychiatry. 2013;37(4):276–280. Pargament KI, Lomax JW. Understanding and addressing religion among people with mental illness. World Psychiatry. 2013;12(1):26–32. Pitel L, Geckova AM, Kolarcik P, Halama P, Reijneveld SA, van Dijk JP. Gender differences in the relationship between religiosity and health-related behaviour among adolescents. J Epidemiol Community Health. 2012;66(12):1122–1128. Robinson JA, Bolton JM, Rasic D, Sareen J. Exploring the relationship between religious service attendance, mental

disorders, and suicidality among different ethnic groups: Results from a nationally representative survey. Depress Anxiety. 2012;29(11):983–990. White R. The globalisation of mental illness. Psychologist. 2013;26(3):182–185.