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Launching a new movement for mental health



Despite the great attention western countries pay to the mind and human consciousness in philosophy and the arts, disturbances of mental health remain not only neglected but also deeply stigmatised across our societies. Viewed through a global lens, this marginalisation is only amplified still further. Yet the fragile—and utterly fragmented for the most disadvantaged—state of mental health services in many countries is not for the want of trying.

In 2001, for example, WHO devoted its *World Health Report* to mental health, with the optimistic message “new understanding, new hope”. Gro Harlem Brundtland wrote: “As the world’s leading public health agency, WHO has one, and only one option—to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason.”¹ As Director-General, she set a deservedly high standard for WHO and others to follow and be judged by.

Since then, WHO has continued to publish reports on mental health.² But somehow the agency, through its leadership and partnerships, has been unable to convert fine words into tangible actions at country level. Partly this is because WHO has not backed its words with resources. And partly it is because WHO’s leadership has failed to build a sustainable mechanism across global and country institutions to hold itself and others accountable for its recommendations. This paralysis is surprising. Many low-income countries and civil society groups are crying out for help.

WHO is not the only institution with a responsibility to strengthen mental health services. The World Bank, country donors (such as the USA, UK, and European Union), foundations (such as the Gates and Rockefeller Foundations), research funding bodies (eg, the US National Institutes of Health), and professional associations all share a duty to make mental health a central theme of their strategies and financial flows. For the most part, these organisations have done far too little, if anything at all. In the past, *The Lancet* has tried to draw attention to mental health services in particular countries.^{3,4} With a Series of papers launched today from an internationally diverse *Lancet* Global Mental Health Group, to whom we owe a deep debt of thanks, together with a call to action and a commitment to track and monitor progress across a range of mental health



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indicators in the run up to a global summit on mental health in 2009, we aim to change this culture of lost opportunity.

The key messages from our Series are clear. First, mental health is a neglected aspect of human well-being, which is intimately connected with many other conditions of global health importance. Second, resources for mental health are inadequate, insufficient, and inequitably distributed. Third, there is already a strong evidence base on which to scale up mental health services. Fourth, most low-income and middle-income countries currently devote far too few resources to mental health. Fifth, there are critical lessons to learn from past successes and failures—for political leadership and priority setting, for increasing financial support, for decentralising mental health services, for integrating mental health into primary care, for increasing health workers trained in mental health, and for strengthening public health perspectives in mental health. Finally, any call to action demands a clear set of indicators to measure progress at country level.

During the next 2 years, *The Lancet* will make mental health one of its campaign focal points. We urge partners to join the broad new social movement we are launching to strengthen mental health.

Richard Horton

The Lancet, London NW1 7BY, UK

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Stigma and mental health

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The stigma attached to mental illness is the main obstacle to the provision of care for people with this disorder. Stigma does not stop at illness: it marks those who are ill, their families across generations, institutions that provide treatment, psychotropic drugs, and mental health workers. Stigma makes community and health decision-makers see people with mental illness with low regard, resulting in reluctance to invest resources into mental health care. Furthermore, stigma leads to discrimination in the provision of services for physical illness in those who are mentally ill,¹ and to low use of diagnostic procedures when they have physical illness.²

Stigma of mental illness can be defined as the negative attitude (based on prejudice and misinformation) that is triggered by a marker of illness—eg, odd behaviour or mention of psychiatric treatment in a person's curriculum vitae. The presence of stigma starts a vicious circle that leads to discrimination in all walks of life,³ decreasing self-esteem and self-confidence (resulting at least partly from the experience of a person with mental illness), a low treatment effect or high probability of relapse for those in remission, and thus to a reinforcement of the negative attitudes and discrimination.⁴ This model of the vicious circle⁴ suggests that there can be various strategies for those who wish to fight stigma. We can think of ways of reducing the visibility of markers (eg, by provision of treatment that

is not associated with extrapyramidal side-effects), ways of reducing discrimination, interventions that will help raise the self-esteem of people with mental illness, education of families, and more investment in treatment that rapidly reduces the severity of illness or that prevents relapses.

Many people contribute to the development and reinforcement of stigma. Health-care workers commonly use words that are stigmatising—eg, speaking of schizophrenics, or use of pejorative terms for mental illness instead of speaking of the person who has the illness. Medical personnel may refuse to treat physical illness or injury in those with mental illness. Psychiatrists and mental health personnel are no exception in this general unawareness of how their behaviour contributes to stigma.⁵ People who have mental illness and who have lost much of their self-confidence over time contribute to the image of the person with mental illness who does not try to contribute to their health and sustenance. Governments make statements or take action that reinforce prejudice—eg, by proposing sterilisation of people with mental illness or retardation without their consent, or by avoiding parity in reimbursement for treatment of mental illness.

However, there is good news. The global programme against stigma and discrimination because of schizophrenia⁴ was successfully implemented in more than 20 countries worldwide. Furthermore, local initiatives have successfully removed or reduced stigma. The European Union's recent consultation about mental health promotion identified the fight against stigma as an important area of work for European countries.⁶ WHO has highlighted the need to combat stigma and to foresee appropriate measures in national mental health policies.⁷

Moreover, experience over the past two decades has identified the main parts of successful action against stigma. These are: consultation of people with mental illness and their families about targets for action against stigma and their involvement in relevant programmes; conception of the fight against stigma as a long-term endeavour that is incorporated into health and other social services; involvement of all stakeholders in the programme, including government, health-service personnel, and the media; and a focus on specific problems that result from stigma (eg, discrimination



against people with mental illness) rather than generic approaches to change people's attitudes.

Stigma attached to mental illness is the main obstacle to the success of programmes to improve mental health. It is fortunate that determined action can remove stigma, to a large extent.

Norman Sartorius

Association for the Improvement of Mental Health Programmes,
1209 Geneva, Switzerland
sartorius@normansartorius.com

I declare that I have no conflict of interest.

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Promotion of mental health in poorly resourced countries



The call for action on treatment and prevention of mental disorders¹ needs to be matched by a call to integrate mental health into public-health action, otherwise it will send incomplete messages to professionals, ministries, and donors. The connections between mental health and other aspects of health and productivity make mental health promotion in low-income countries a necessity—far from the luxury it is often portrayed as.

Public health is the organised worldwide and local effort to promote and protect the health of populations and reduce health inequities.² Mental health is intrinsic to health and linked to behaviour, as shown by the several connections between mental disorders and other conditions.³

Mental health is a set of positive attributes in a person or a community. WHO describes it as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.⁴ Poor mental health is associated with social disadvantage, human-rights abuses, and poor health and productivity, as well as increased risk of mental disorders.⁵ Promoting and satisfying mental health needs optimally involves fulfilling several other requirements—eg, interventions to assist low-income women with breastfeeding will simultaneously address infant-nutrition needs.⁶ Conversely, human-rights abuses, conflict, and emergencies associated with wars and civil unrest are associated with poor mental health outcomes and poor physical health and social conditions.⁷

Mental health is promoted through population-based public-health measures, alongside health-system

change.⁸ Notions that are fundamental to public health are crucial to the improvement of mental health—eg, the causes of individual differences in health status might not be the same as the causes of differences between populations.⁹ Evidence is emerging for the effectiveness of mental health promotion in public health.^{4,10} However, services, governments, and non-governmental organisations tend to concentrate solely on the neglected needs of people with established illnesses and disabilities. The health-promotion strategies of advocacy, communication, policy and legislative changes, community participation, and research and assessment can promote mental health together with physical health and productivity.⁴

Activities to promote mental health take place at several levels. Some are distant from the individual, such as

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Psychologist gives advice and counselling on weekly radio programme in Banda Aceh, northern Sumatra

policies to tax alcohol products, whereas others are closer to the individual, such as home-visiting health-promotion programmes.⁸ Effective interventions across the lifespan include support for parents of infants, school-based interventions, workplace and unemployment programmes for adults, and activity programmes for elderly people. Working to achieve occupational justice—the extent to which all individuals have access to participation in a range of fulfilling tasks—is an example of such an intervention.¹¹ We need to understand more about the potential value of mental health promotion of everyday activities and use this understanding to develop and assess promotion initiatives.

Tackling important social and health issues, such as prevention of HIV infection, maternal and child health, violence at home and in the streets, substance abuse, and gender equity, needs interventions that focus on developing assertiveness and self-reliance and appropriate participation, which are in turn components of mental health. For instance, mental health promotion is being used and assessed as a deliberate strategy for prevention of HIV infection.¹²

The evidence for practice and policy needs strengthening worldwide, especially in low-income countries and areas affected by conflict where the need is greatest. Changes in mental health status with health and social interventions need to be measured and monitored. The call for action¹ notes that mental disorders have an effect on several outcomes, ultimately affecting the development potential of society. Equally important are the opportunity costs of poor mental health, and research and evaluation to support ways to avoid these costs.

The actions needed in all countries include research and assessment of public mental health interventions, development and monitoring of indicators of population mental health, and advocacy to make public-health pro-

fessionals, politicians, and government officials in all social sectors aware of the effectiveness of acting at a population and non-health sector level to promote mental health. Mental health concerns everyone and is not the preserve of health professionals and the health services. These actions are vital, alongside treatment and prevention of mental illness, for improved population mental health, and hence social and economic development in countries.

**Helen Herrman, Leslie Swartz*

Department of Psychiatry and School of Population Health, University of Melbourne, Carlton, Victoria 3101, Australia (HH); and University of Stellenbosch, Stellenbosch, South Africa (LS) h.herrman@unimelb.edu.au

We declare that we have no conflict of interest.

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Mental health and human rights

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The *Lancet* Series on global mental health draws attention to a long neglected health and social policy issue. This concern is particularly needed today, because social conditions, especially widespread poverty, disasters, violence, and war, can precipitate the breakdown of vulnerable individuals and social systems.

In this context we note how groups such as the People's Health Movement (PHM), a coalition of several groups working in many countries, have evolved an approach to mental health that is qualitatively different from expert-driven strategies. This approach is exemplified by the *Peoples Charter for Health*¹ and subsequent documents² based on peoples' experiences and aspirations.³ Just as

people living with HIV/AIDS have provided input into policy and practice, there is a need to give a greater centrality to those living with mental illness. Such an opportunity is afforded by the UN Convention on the Rights of Persons with Disabilities, which has had the active participation of individuals with disabilities, including those living with mental illness.

The right to life and liberty is primary in human rights discourse. However, for people with mental illness, deprivation of liberty by forced institutionalisation might be justified on grounds of danger to themselves and others. This justification does not take into account the people who have died or been permanently scarred by loss of liberty or basic human dignity. User-survivors narrate the experience graphically, and seek a total embargo on forced interventions.⁴ The UN Convention recognises that all people have rights to both life and liberty and to physical and mental integrity. However, it neither expressly bans nor explicitly permits forced intervention. This stalemate affords an opportunity to revisit forced interventions from the standpoint of people with mental illness.⁵

Scholars have argued that personal effectance (the opportunity to act or function) is essential for human beings to fulfil their potential.⁶ The right of all individuals

to be recognised in law as having the capacity to act promotes such personal effectance; however, the capacity to act has been regarded as questionable for people with mental illness. Consequently, there is legal provision to enable arrangements that protect the interests of such people, although such arrangements have been viewed as legal reinforcement of social stigma.⁷ The UN Convention on the Rights of Persons with Disabilities has further questioned this process of disqualification. Article 12 of the Convention recognises the full legal capacity of all people with disability, and that the capacity to act is an integral component of this legal capacity. Yet the article does not negate the need for support—instead, in acceptance of human interdependence, the Convention recognises the right to seek support, and in acceptance of human frailty, it establishes the standards for providing support and safeguards against abuse. The mechanisms of support for people with mental illness need not be based on the all-or-nothing theory of guardianship. The personal ombudsperson system in Sweden⁸ and the restricted guardianship procedures of India⁹ are steps in that direction.¹⁰

People living with mental illness have always faced difficulties in participating in society because of pressure



to conform to normal social and legal standards. This pressure has been eased by the Convention, which accepts the principle of reasonable accommodation and allows the norms to be modified to accommodate people's diversity. The Convention also recognises that people with disabilities, including those living with mental illness, have a right to be consulted in the formulation of all policies, laws, and practices that affect them. There is thus a duty to recast psychiatric practice and procedure in active consultation with its users.

In addition to medical interventions, an important demand being voiced by civil society representatives is for the creation of support networks for human distress and illness that are wider than the medical establishment.¹¹ A cue could be taken from innovative community-based work by non-governmental organisations and professional groups. The groups include: BasicNeeds,¹² working in several countries; CBR Forum (community-based rehabilitation), partnered with 90 organisations across India; and the Women's Health Empowerment Programme, supported by WHO. Various creative strategies have evolved, such as: the setting up of self-help groups, including people with mental illness and their support networks; addressing issues of livelihood; promotion of life-skills education and parenting skills; and studying and using local healing traditions, including spiritual traditions.¹³ These methods, combined with the psychiatric care offered by the medical establishment, could make for a mental health policy that is holistic and consonant with human rights.

The UN Convention on the Rights of Persons with Disabilities and the People's Movement for Mental

Health require that the stereotypes of mental health law and policy be revisited. Because law and policy do not exist in isolation from society, this is a mandate to re-examine their implications for social interactions, in therapy, and in clinical decision-making.

*Amita Dhanda, *Thelma Narayan*

National Academy of Legal Studies and Research, Hyderabad, Hyderabad, India (AD); Community Health Cell, Bangalore, Karnataka 560034, India (TN)
thelma@sochara.org

We declare that we have no conflict of interest.

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Mental health and global movement of people

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Migration is a key part of globalisation,¹ and the social, cultural, economic, and political forces of globalisation have substantially changed the determinants and consequences of migration. 170 million people live outside their country of origin, and every year more than 700 million people cross national boundaries.² The public-health importance of this massive movement of people is apparent for communicable diseases, and, although less visible, is no less important for mental health.

Although globalisation promises universal economic and social benefits, it leads to increased marginalisation,

unemployment, erosion of job security, increased poverty, reduced access to health care and education, and reduced social provision for people who are ill or unemployed. Many factors that lead to permanent and temporary migration are products of globalisation, and are determinants of mental health and illness.^{3,4} Rapidly emerging market economies need cheap labour, which might involve women from rural areas with poor education who have been separated from their family and who have access to few legal protections. High-income countries (ie, those in Europe, North America, and Australia and New Zealand)



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with declining and ageing populations need immigrants, but are often ambivalent about them when they come. Complex emergencies and human-rights abuses produce large flows of asylum seekers and refugees, mostly into neighbouring low-income countries that have little capacity to receive and to care for them. Poverty fuels the deadly trade of people-trafficking, and is the major engine for undocumented immigration. The decline of rural economies everywhere and rapidly escalating global ecological problems will substantially increase the pressure on people to move.

The encounter between people and cultures is mediated by a global flow of commodities,⁵ information, and, increasingly, direct contact between people. Most migration occurs from poor, generally sociocentric (ie, collectivist) cultures to those that are richer and egocentric (ie, individualist).⁴ Acculturation, which occurs when different cultural groups are in sustained contact with one another,⁶ might lead to distress and dysfunction in some individuals and to tension between cultural groups. The power of institutional or individual racism over the mental health of immigrants must not be ignored.

Fragmentation and erosion of identity, the loss associated with displacement from familiar contexts and support networks, the difficulties of settlement, and the pressures on accustomed family structures and relationships can increase vulnerability to mental illness.⁷

Sociocentric individuals who migrate from sociocentric societies to those that are egocentric are likely to develop distress—especially if they do not have access to a community of people with similar backgrounds.⁸ An additional source of stress on immigrants is that host societies have generally failed to respond effectively to the reality of ethnic, cultural, and linguistic diversity.⁹ Pilot programmes that show effective delivery of a mental health programme to immigrants who are in the minority have little effect on mainstream mental health services.¹⁰

The effect of movement of trained and professional individuals and their families around the world cannot be underestimated. The cost of training a doctor or an engineer in a low-income country may be proportionately low, but the brain drain can cost millions of dollars, especially in countries that can ill afford to lose such skills. Therefore the treatment gap in low-income countries

will probably widen, and there have been recent calls for developed countries to refund donor countries.¹¹ The money that migrants send back to their country of origin may compensate, but this is not the full story. The mental health of people who are left behind and who have poor resources, the potential resulting resentment, and the role of acculturation on the health of migrants need urgent wider discussion.

*Dinesh Bhugra, Iraklis Harry Minas

Section of Cultural Psychiatry, Institute of Psychiatry, King's College London, London SE5 8AF, UK (DB); and Centre for International Mental Health, School of Population Health, University of Melbourne, VIC, Australia (IHM)
d.bhugra@iop.kcl.ac.uk

We declare that we have no conflict of interest.

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Nurses and mental health services in developing countries

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Some of the barriers to progress identified in this *Lancet* Global Mental Health Series concern challenges in the implementation of mental health care in primary care settings in low-income and middle-income countries, and the few professionals who are appropriately trained and supervised in mental health care. We believe that training, employing, and adequately supporting nurses is a readily achievable solution for improving

mental health services in these countries. According to the 2006 *World Health Report*¹ there are more nurses than any other category of health-care provider; the International Council of Nurses (ICN) estimates that there are more than 13 million nurses worldwide. Furthermore, nurses provide almost all primary health care in most low-income and middle-income countries. However, most nurses do not have the expertise to assess and treat mental health disorders.² Often nurses' ability to function in a wide scope of practice, including prescriptive authority, is limited by outdated practice acts that are not aligned to the mental health needs of populations.¹

A recently completed survey of nurses and mental health in countries around the world, done by WHO and the ICN, confirms that, in many low-income and middle-income countries, nurses provide most mental health services.³ However, many nurses have no mental health training and few have had training experience in a community mental health setting (in which most mental health services should be provided).

Analysis of the 178 completed questionnaires (from WHO member states and other entities representing 98% of the world population) showed substantial variations across countries with different income levels. For example, there are over 100 times more nurses per



Red Cross nurse counsels mother whose child was killed in Beslan school siege, North Ossetia

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head in mental health settings in high-income countries than in low-income countries; there are over 66 more nurses trained in mental health per head in high-income countries than in low-income countries. Moreover, the level of training of mental health nurses is usually less in low-income countries than in high-income countries. There are fewer community mental health facilities in low-income and middle-income countries than in high-income countries. These deficiencies make provision of mental health community services very difficult for low-income and middle-income countries.

Nurses have more authority to prescribe and continue drug prescriptions in countries in Africa, southeast Asia, and the western Pacific than they do in other regions. This difference could be attributable to recognition of the need to make psychoactive drugs more available in countries where other mental health services are scarce.³

Comments in response to the open-ended questions in the survey³ suggest that an overall nursing shortage contributes to insufficient numbers of nurses in mental health care. Respondents say that this shortage is even more acute for nurses in this sector because of the few incentives for nurses to be trained to provide specialised services. There are few financial incentives for nurses either to receive mental health training or to provide mental health services. The stigma of mental illness also contributes to this problem by limiting

the number of nurses willing to make mental health nursing a career.

Nurses are a crucial component in almost every health-care system worldwide. They will need to be involved in any attempt to reduce the huge burden of disease for mental disorders. As the WHO and ICN report indicates,³ one important step toward reducing the burden of disease for mental disorders and improving access to mental health services is to increase training for nurses and to increase the number of nurses specialising in this sector. At the same time, the survey results suggest that expansion of the scope of practice of nurses will encompass authority to assess, identify, and treat common mental health disorders.

**Tesfamicael Ghebrehiwet, Thomas Barrett*

International Council of Nurses, 1201 Geneva, Switzerland (TG); and Department of Mental Health and Substance Abuse, WHO, Geneva, Switzerland (TB)
tesfa@icn.ch

TG was involved in the questionnaire for the survey on mental health nursing, sending it out, and providing feedback on responses. TB declares that he has no conflict of interest.

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Users' networks for Africans with mental disorders



Users' networks for people with mental health disorders have emerged in Africa over the past 5 years, notably in Zambia, Uganda, Tanzania, Kenya, and South Africa.¹ These organisations believe in users' power to strengthen their sense of identity and improve the situation in their communities and countries. Users' networks organise activities such as awareness campaigns and self-help projects, and they contribute to the development of mental health services, springing from the desire to attain human freedom that governments and communities continue to ignore.²

In Lusaka, Zambia, where there is a population of 2 million, the number of registered members is 220 of the estimated 30 000 people with mental health disorders. The remaining people with mental disorders are being reached through a track and trace project in conjunction

with the government. The network in Zambia has a close working relationship with the government, which financially supports some programmes. However, funds to support the network's activities are still scarce, making it difficult to operate effectively.

According to the 2004 World Mental Health Survey,³ 200 000 people with mental health disorders (of an adult population of 5 million) in Zambia are not treated in an evidence-based manner. Most have been neglected, whereas others are hidden away by families that are ashamed of having a relative with such a disorder. A case study about stigma and discrimination against mentally ill people in the Lusaka community, which was done by the Zambian users' network and sponsored by the World Psychiatric Association, showed that people with mental health disorders are not treated with respect, are

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neglected by families, and are denied opportunities for self-development.⁴

Zambia has an extended family system that harbours several cultural beliefs and practices—eg, bewitchment, sorcery, demonic possession, and ritual cleansing—which have implications for the mentally ill and for people’s perceptions of mental illness.⁵ The community perception is that people with such disorders are violent and dangerous, and hence should be locked in institutions or excluded from society because they are regarded as being unable to lead a normal life.⁶ Unfortunately, these practices delay people from seeking mental health services and interfere with the modern treatment of mental illness, which can contribute to some patients becoming chronically ill. Subsequently, families tend to suffer the burden of care with the search for treatment consuming meagre resources. This burden of care becomes frustrating, leading to hostility towards people with mental disorder and promoting admission to hospital or abandonment.⁷

As Gro Harlem Brundtland said in the 2001 WHO report,⁸ scientific knowledge about mental illness is available and there is no need for communities to

still show ignorance, viewing mental illness from a cultural perspective that does not promote humane treatment.

Mental health care in Zambia does not have a well-coordinated system and is compounded by shortages of trained personnel, insufficient funds and facilities, and shortages of drugs, all of which have adversely affected quality of care.⁵ The archaic law also compounds the problem of stigma and discrimination by criminalising patients with mental health disorders, describing them as imbeciles or idiots and encouraging communities to characterise them in derogatory terms.⁶ This stigmatisation is seen in the violation of human rights that patients face in communities and by the promotion of admission to hospital.

To improve the situation in mental health care, governments should place mental health on the national agenda by developing new legislation, policies, and programmes that are based on scientific knowledge and human rights for people with mental health disorders.⁹ To achieve this goal, there is a need for political will to promote mental health and to secure funding for the sector. Furthermore, the involvement of consumers

and family members is crucial because they can assist in developing services that are tailored to people's needs.⁸ Community mental health should also be promoted so that this sector can tap into community resources to tackle mental health disorders, because they originate from societies themselves.

Sylvester Katontoka

Mental Health Users Network of Zambia, Lusaka, Zambia
usersmentalhealth@yahoo.com

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Mental health and the mass media: room for improvement



The mass media exerts a powerful influence on public attitudes about mental health. However, the message that often comes across reinforces negative stereotypes about people with mental illness: they are strange, unpredictable, and probably dangerous.^{1,2} Improvement of this situation will need effort on the part of both media and mental health professionals.

Earlier this year, an event in the small university town of Blacksburg, VA, USA, thrust mental health into the spotlight of the international media. On April 6, 2007, a student at Virginia Tech University opened fire in a dormitory and then a classroom, killing 33 people, including himself. A deluge of media coverage followed, much of it focused on issues related to the mental health of the shooter, Seung-Hui Cho. Several aspects of this coverage reflect broader themes common in media coverage of mental health.

"There's no way you can plan for a psycho and that's clearly what we're dealing with here", CNN commentator Jack Cafferty opined hours after the shootings,³ before the identity of the shooter (as well as information about his mental health) had been made public. The rush to link homicide with mental illness is not new⁴ and indicates the common misconception that mental illness goes hand in hand with violence. In fact, most people with psychiatric disorders are not violent,⁵ and although mental illness could have had a role in the Blacksburg rampage, this broader perspective was often lost in the ensuing coverage. Some reports gave the opposite impression. A week after the shootings,

the *Wall Street Journal* reported that the shootings at Virginia Tech had prompted business managers to "rethink an array of security issues, particularly how to identify mentally ill people in their midst before they harm others or themselves".⁶

In the days after the shootings, many media outlets ran stories on the reaction of the Korean-American community, members of whom were shocked and saddened that the killer was one of their own. Some feared that the shootings could lead to prejudice against them among the general public.⁷ However, few reporters sought the perspective of mental health consumers, many of whom presumably had similar fears of being judged guilty by association. As the discussion in the news media turned to issues about the rights of people with mental illness (eg, laws for involuntary psychiatric commitment, privacy of mental health records, and restrictions on purchasing firearms), the opinions of individuals with the most at stake were rarely heard.

Cafferty was hardly alone in using derogatory slang to refer to the killer. "Psycho penned poison plays" blared a headline in the *New York Post*⁸ days after the shooting. *The Sun*, a UK newspaper, variously referred to Cho as a crazed killer and a maniac.⁹ Criticism of such language in this case could be overzealous political correctness, yet it is worth asking why derogatory labels related to mental illness still appear in the media, whereas slurs based on race or physical disabilities are widely regarded as unacceptable, even in describing perpetrators of

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Media vehicles, Virginia Tech University

serious crimes.¹ The likely answer is that members of the media are susceptible to the same prejudices and misunderstandings about mental illness that prevail in the general public.

Despite such shortcomings, the media also have the power to bring about positive change. Media coverage of the Asian tsunami in 2004 and Hurricane Katrina in 2005 brought attention to the psychological effect of disasters and the paucity of mental health services in some of the affected areas. Several news and editorial articles in the *Oregonian* newspaper in 2005 led to the closure of a decrepit and overcrowded state psychiatric hospital, and helped persuade lawmakers to pass bills funding more community-based mental health services and to induce insurers to provide equal coverage for mental and physical illness (and won the *Oregonian* a Pulitzer Prize for editorial writing in 2006).

Those of us in the news media have an obligation to be accurate and fair in all that we cover. For mental health coverage, accuracy and fairness mean avoiding stereotypical and stigmatising language, and seeking the opinions of mental health consumers in matters that concern them. Journalists seeking guidance on these points can consult resources compiled by several governmental, professional, and advocacy organisations, including: SHIFT, an antistigma campaign sponsored by the National Institute of Mental Health in England;¹⁰ the US National Institute of Mental Health;¹¹ and the US Dart Center.¹² Mental health professionals and

consumers can help improve coverage of mental health issues by engaging and educating members of the media. Without open lines of communication, little will change.

Greg Miller

Science, San Francisco, CA 94110, USA
gmiller@aaas.org

I declare that I have no conflict of interest.

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