How effective are treatments for burdensome psychiatric conditions?

There is considerable literature concerning the efficacy and effectiveness of a wide range of pharmacological, psychosocial and care management strategies for treating both psychiatric disorders and addiction. Figure 12 on opposite page illustrates the reduction in disability following pharmacological and psychosocial treatment, alone or in combination. As can be seen, the extent of improvement over no treatment at all is as much as 50%. Thus, while currently available interventions do not completely cure the disability associated with these conditions, they have a substantial advantage over no treatment at all, which unfortunately, is often the case. This raises the question of the costs involved in realizing these health improvements.

Figure 13 illustrates the effectiveness of treatment, provided through community outreach care (low-cost drug therapy and basic psychosocial support), on the economic burden and disability of untreated schizophrenia in India; not only did disability improve dramatically, but the overall costs associated with the condition (which included care-giving time by family members) also fell. These effects were sustained over an 18-month follow-up period.

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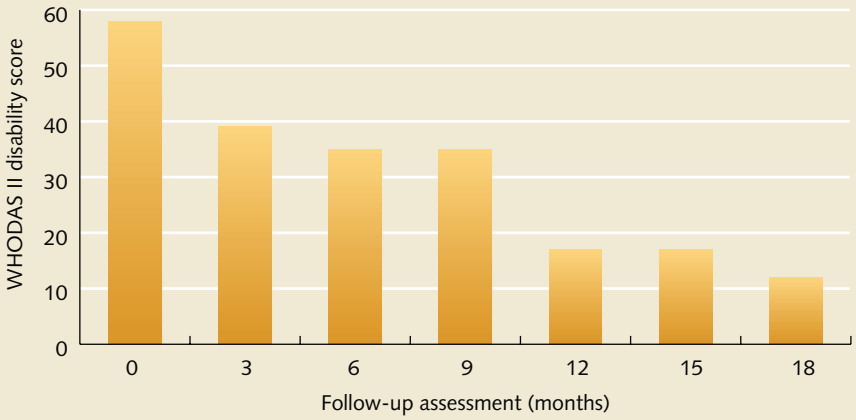
Changes in disability following community outreach treatment of untreated schizophrenia in rural India



What are the costs of effective treatment?

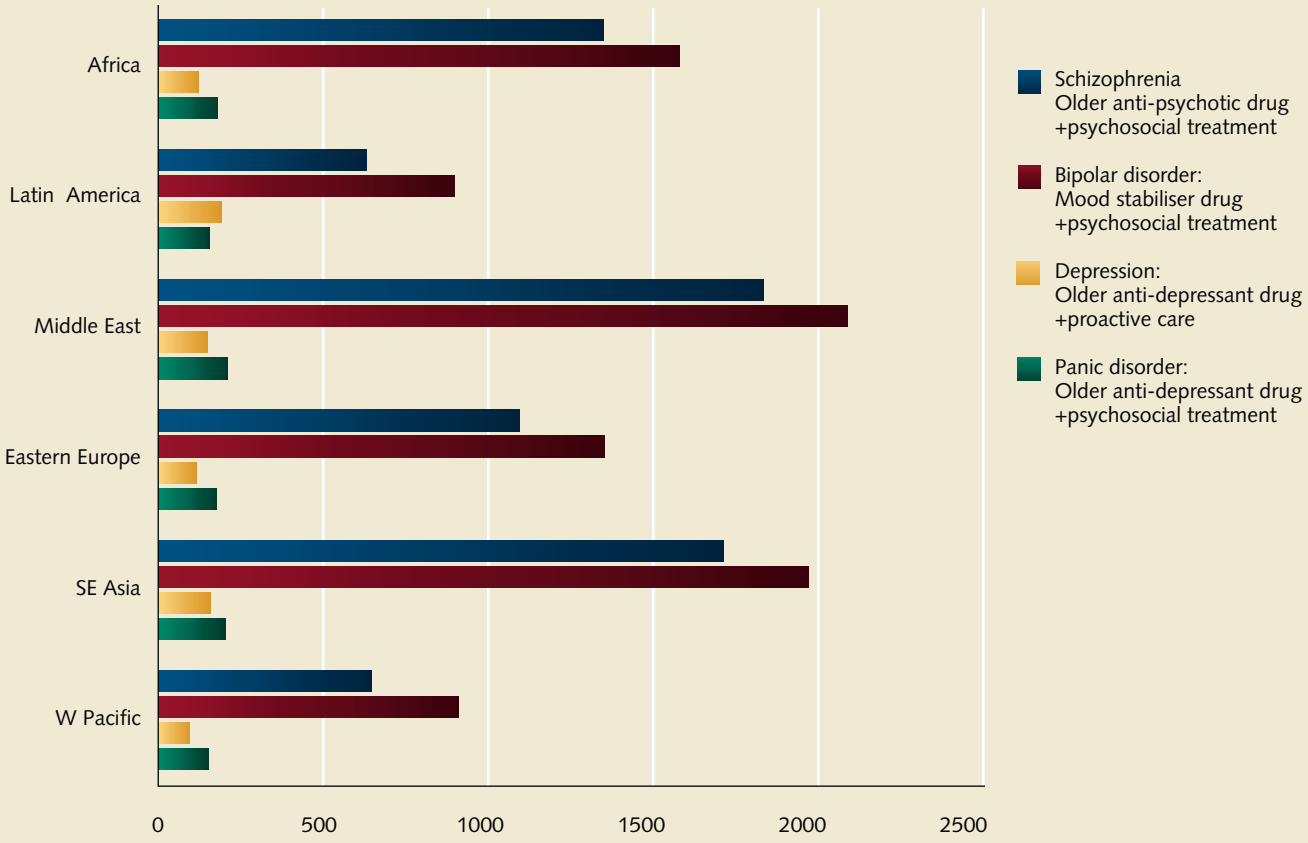
The alarmingly low level of resources available in developing countries to treat mental health problems, relative to the affected population for which the resources are needed, has been highlighted by the WHO ATLAS project (WHO, 2001). The generation of a more evidence-based approach to mental health budgetary planning, resource allocation and service development represents an underdeveloped but much needed component of national mental health policy in developing regions of the world.

WHO has embarked upon the worldwide collection of such an evidence base by means of its WHO-CHOICE project, including estimation of the cost and efficiency of a range of key treatment strategies for burdensome mental disorders. Figure 14 below

14

The annual cost per case (or episode) of evidence-based psychiatric treatment

Cost per treated case (in international dollars, I$)



shows the estimated cost of first-line treatment of schizophrenia and bipolar disorder on a hospital outpatient basis, and also the cost of primary care of depression and panic disorder, based on estimated use of health care resources that would be required to produce the expected reduction in disability. Costs are expressed in international dollars (I$), which take into account the purchasing power of different countries. It is clear that more severe psychiatric conditions such as schizophrenia require substantially greater resource inputs (mainly because a proportion of cases need to be hospitalized or provided with residential care outside hospital). By contrast, the cost of effectively treating an episode of depression is estimated to be in the region of I$ 100–150.

Cost-effectiveness should be just one of several criteria used in the decision-making process for funding prevention/treatment of mental disorders.

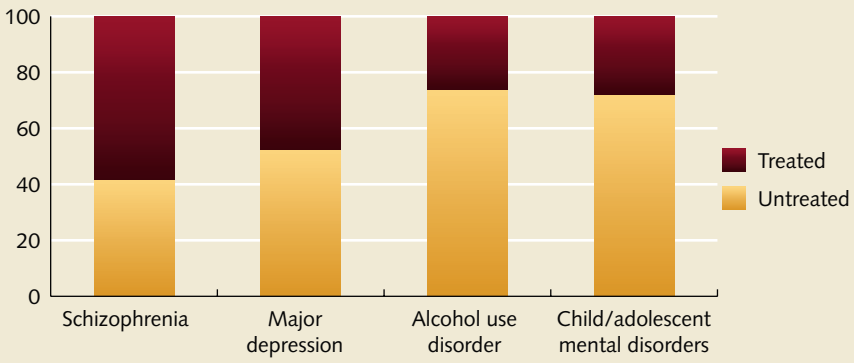
These economic evaluations should be supplemented by other arguments. For example:

- People with mental disorders are more at risk of human rights violations and are more likely to be discriminated against in accessing treatment and care;
- Achievement of physical health targets, such as:
  - Infant and child mortality can be reduced through improved treatment of postnatal depression;
  - HIV/AIDS infection rates for the 17-24 year-old age group are reduced because improved mental health reduces unsafe sex and drug use;
  - There is better adherence to treatments for other ailments (e.g. tuberculosis, HIV/AIDS, hypertension, diabetes and cancer treatments);
- Caregivers benefit from a lower burden of care, which means better quality of life and fewer work days lost, and thus less loss of income;
- Employers benefit from better working environment, reduced absenteeism and higher productivity;
- Governments benefit from less cost-shifting and transfer payments;
- Mental health is a key variable in successful programmes for sustainable development and poverty reduction.

The gap between the burden of mental disorders and resources

15

Treatment gap rates (%) by disorder (world)



Even though mental, brain and substance-use disorders can be managed effectively with medication and/or psychosocial interventions, only a small minority of patients with mental disorders receives even the most basic treatment. Initial treatment is frequently delayed for many years. In developed countries with well-organized health care systems, between 44% and 70% of patients with depression, schizophrenia, alcohol-use disorders and child and adolescent mental illnesses do not receive treatment (Figure 15) in any given year. In developing countries, where the treatment gap is likely to be closer to 90% for these disorders, most individuals with severe mental disorders are left to cope as best they can.

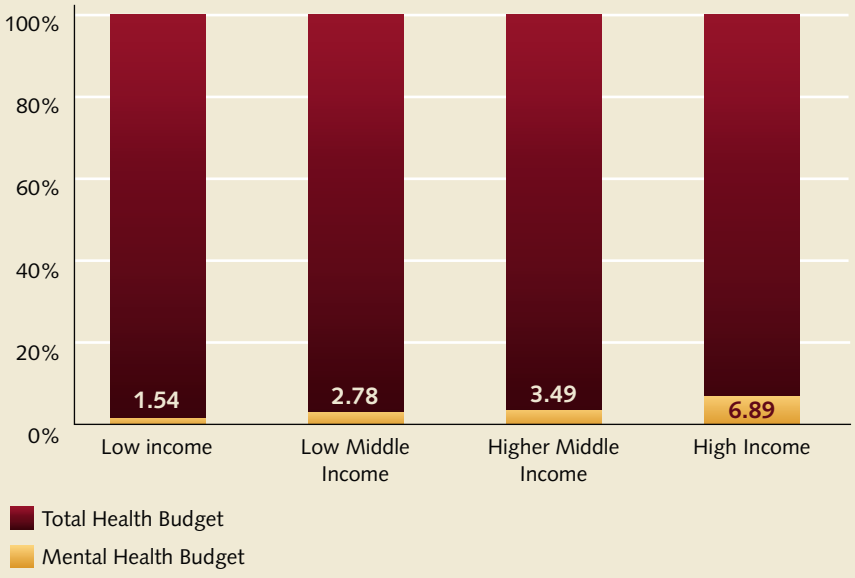
More than 40% of all countries worldwide have no mental health policy and over 30% have no mental health programme. Over 90% of countries have no mental health policy that includes children and adolescents. Out-of-pocket expenditure was the primary method of financing mental health care in many (16.4%) countries. Even in countries where insurance cover is provided, health plans frequently do not cover mental and behavioural disorders at the same level as other illnesses; this creates significant economic difficulties for patients and their families.

Mental health budget in low-income countries: non-existent or inadequate

In spite of the importance of a separate mental health budget within the overall health budget, 32% of countries included in the ATLAS study (WHO, 2001) reported not having a specific governmental budget for mental health. Of those that actually reported having one, 36.3% spent less than 1% of their total health budget on mental health. Countries categorized on the basis of income levels (World Bank classification) differ considerably in terms of the proportion of their governmental budget for mental health to their total health budget (Figure 16). The poorer countries have small health budgets, from which they spend a lower percentage on mental health, resulting in very few resources being available. Poor provision of mental health care results in poor outcomes, avoidable relapses and insufficient rehabilitation.

16

Share of mental health budget in total health budget of countries by income level (%) (World Bank classification)



The relationship between the burden of mental disorders and spending is clearly inappropriate.

A wide gap between the burden of neuropsychiatric disorders and the mental health budget

Mental and behavioural disorders are estimated to account for 13% of the global burden of disease, yet, on average, the mental health budgets of countries constitute only 2% of their total health expenditures (Figure 17).

17

Burden of neuropsychiatric disorders vs budget

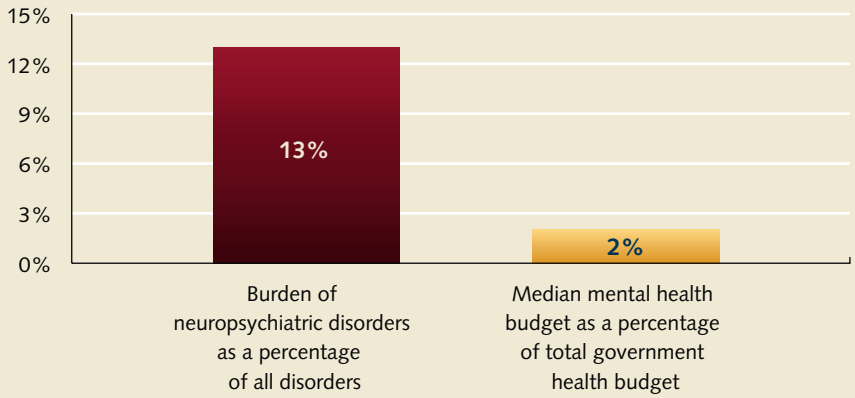


Photo: © A. Mohit

Urgent action is needed to close the treatment gap and to overcome barriers which prevent people from receiving appropriate care.

There are several barriers to people's access to appropriate mental health care

Stigma

Around the world, many people with mental disorders are victimized for their illness and become the targets of unfair discrimination. Access to housing, employment and normal societal opportunities is often compromised.

Discrimination in insurance coverage for mental disorders

In many countries, since mental disorders are not covered by health insurance schemes, many people cannot afford treatment. One-quarter of all countries do not provide disability benefits to patients with mental disorders. One-third of the world's population – 2 billion people – lives in countries that spend less than 1% of their health budgets on mental health.

Lack of drugs

Though 85% of countries have an essential drugs list that countries use as a basis for procuring therapeutic drugs, almost 20% of countries do not have at least one common antidepressant, one antipsychotic, and one antiepileptic in primary care.

Wrong priorities

Too many countries (mainly developed countries) still spend most of their resources on a few large mental asylums, which focus only on a small fraction of those who need treatment; even these institutions generally provide poor quality care and often inhumane conditions and treatment.

Lack of skills at the primary health care level

Too few doctors and nurses know how to recognize and properly treat mental disorders. In 41% of countries there are no mental health training programmes for primary health care professionals.

Lack of rational and comprehensive mental health policies and legislation

- 40% of countries do not have a mental health policy;
- 25% of countries do not have mental health legislation; and
- 30% of countries do not have a national mental health programme.

WHO Global Action Programme (mhGAP)

Year of Mental Health: 2001

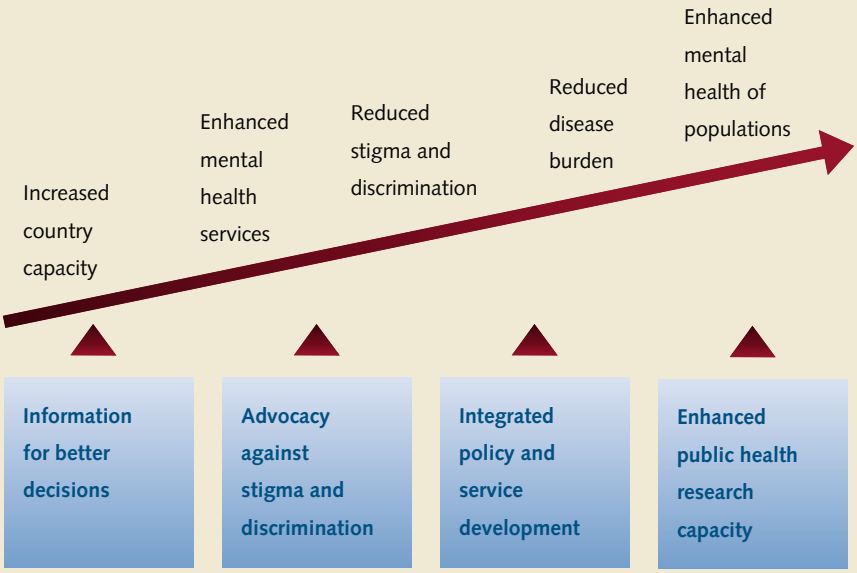
WHO declared 2001 the Year of Mental Health and that year's World Health Day was a resounding success. Over 150 countries organized important activities, including major speeches by political leaders and the adoption of new mental health legislation and programmes.

At the 2002 World Health Assembly, over 130 Ministers responded positively with a clear and unequivocal message: mental health, neglected for too long, is crucial to the overall well-being of individuals, societies and countries, and must be universally regarded in a new light. The theme of the World Health Report 2001 was mental health, and its 10 recommendations have been positively received by all Member States.

As a result of the activities in 2001, the **Mental Health Global Action Programme (mhGAP)** has been created. mhGAP is WHO's major new effort to implement the recommendations of the World Health Report 2001. The programme is based on four strategies (Figure 18) that should help enhance the mental health of populations.

18

Mental Health Global Action Programme (mhGAP): the four core strategies



Advocacy, information, policy and research are the key words underlying WHO's new global mental health programme, which aims at closing the gap between those who receive care and those who do not.

Strategy 1

Increasing and improving information for decision-making and technology transfer to increase country capacity.

WHO is collecting information about the magnitude and the burden of mental disorders around the world, and about the resources (human, financial, socio-cultural) that are available in countries to respond to the burden generated by mental disorders. WHO is disseminating mental health-related technologies and knowledge to empower countries in developing preventive measures and promoting appropriate treatment for mental, neurological and substance-abuse disorders.

Strategy 2

Raising awareness about mental disorders through education and advocacy for more respect of human rights and less stigma.

The World Health Organization is establishing the first all-inclusive global partnership of mental health-related constituencies: the Global Council for Mental Health. It will act as a forum for mental health, stimulating and lending support to activities aimed at promoting implementation of the 10 recommendations of the World Health Report 2001 in all regions. Professional NGOs, family members and consumer groups, leaders of religious groups, parliamentarians, labour and business organizations are all enthusiastic about pursuing activities for the improvement of mental health through this common platform led by WHO.

At the Executive Board meeting in January 2002 a resolution on mental health encouraging continued activity in this area was adopted. The resolution strongly supports the direction of mhGAP and urges action by Member States. The resolution was endorsed unanimously by the World Health Assembly in May 2002.

Strategy 3

Assisting countries in designing policies and developing comprehensive and effective mental health services. The scarcity of resource forces their rational use.

The *World Health Report 2001* and the *Atlas: Mental Health Resources in the World,* have revealed an unsatisfactory situation with regard to mental health care in many countries, particularly in developing countries. WHO is engaged in providing technical assistance to Ministries of Health in developing mental health policy and services. Building national capacity is a priority to enhance the mental health of populations.

WHO has designed a mental health policy and service guidelines to address the wide variety of needs and priorities in policy development and service planning, and a manual on how to reform and implement mental health law.

To put plans into action, WHO is adapting the level and types of implementation to the general level of resources of individual countries. In the particular case of developing countries, where the gap between mental health needs and the resources to meet them is greater, WHO will offer differentiated packages of "achievable targets" for implementation **(Gap Reduction Achievable National Targets/GRANTs)** to countries grouped by at least three levels of resources (low, middle and relatively higher). These packages provide the minimum required set of feasible actions to be undertaken to comply with the 10 recommendations spelt out in the World Health Report 2001. Achievement of the identified targets will influence both health and social outcomes, namely mortality due to suicide or to alcohol/illicit drugs, morbidity and disability due to the key mental disorders, quality of life, and, finally, human rights.

Strategy 4

Building local capacity for public mental health research in poor countries.

Besides advocacy, policy assistance and knowledge transfer, mhGAP formulates in some detail the active role that information and research ought to play in the multidimensional efforts required to change the current mental health gap at country level.

WHO is developing several projects and activities to promote this strategy at country level, including a research fellowship programme targeting developing countries. A project on the cost-effectiveness of mental health strategies is being implemented in selected countries to generate real estimates on the costs and benefits of mental health interventions. These estimates will then be used to enhance mental health services at country level.

Much can be done; everyone can contribute to better mental health

Interventions can be implemented immediately and widely with existing knowledge and technology. The returns in terms of reducing disability and preventing premature death are enormous.

Prevention of childhood mental problem

Mother & child care
Adequate care during pregnancy and around childbirth prevents brain and mental disorders. Early childhood social stimulation also ensures better psychosocial development and prevents emotional and conduct disorders.

School-based programmes
Psychosocial interventions by teachers and counsellors can prevent depression, aggressive behaviours and substance abuse among students.

Suicide prevention

Media interventions
Mental health professionals can initiate codes of conduct for the mass media to ensure that they do not glamorize instances of suicide, so as to prevent further suicides in communities.

Restriction of means to commit suicide
It has been demonstrated that restrictions on the availability of means to commit suicide (e.g. pesticides) can be effective in their prevention. Laws and regulations could curb the availability of dangerous substances.

Prevention of alcohol-related problems

Higher taxation
Higher taxes on alcoholic beverages uniformly bring down the consumption levels, leading to substantial reduction in alcohol-related problems.

Brief interventions
Models of brief interventions applied within primary health care settings have proved to be effective for most people with alcohol-related problems (25% reduction in alcohol consumption).

Depression

Early identification of people suffering from depressive disorders
We know that even in high-income countries almost 50% of those suffering from depression are not identified. Early identification means more effective treatment and avoidance of disability and death by suicide.

Care in primary health services
Depressive disorders can be effectively treated, in most instances, with common and inexpensive medicines and simple psychosocial interventions. This is possible within primary health services with the provision of some basic training and appropriate medicines.

Schizophrenia

Maintenance on antipsychotic medicines
Once this disorder is diagnosed and treatment is begun, most patients need continued follow-up and regular medicines. This costs very little, but results in substantial reduction in disability and improvement in quality of life.

Involvement of family in care
Families are the most significant partners in the care of chronic mental disorders. Simple interventions delivered to the families can enhance the quality of life both of the patient and of the whole family. And relapse can be prevented.

Mental retardation

Iodinization of salt
Using iodized salt is the single most effective prevention activity in areas deficient in iodine. Millions of children can escape long-lasting intellectual deficits by this most inexpensive public health measure.

Training to parents
Parents can help children with mental retardation to achieve their full potential for development. Simple training to parents can go a long way in ensuring the best environment for children with mental retardation.

Epilepsy

Anti-stigma campaigns
The biggest barrier to treatment for epilepsy is stigma. Campaigns against stigma result in a larger proportion of those affected getting much-needed treatment as well as reintegration into schools and their communities.

Availability of medicines
Antiepileptic medicines cost very little, but their availability within health care services is limited. Ensuring regular availability of these medicines makes treatment possible, even in the poorest countries: up to 70% of newly diagnosed cases can be successfully treated.

Human rights

Legislation should be modernized. Monitoring of human rights violations should be put in place. Quality of basic care in psychiatric settings should be improved. All this will ensure a better quality of life and more dignity for patients. A substantial component of interventions for mental disorders is that of enabling patients to fully enjoy their rights of citizenship.