The mental health treatment gap

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Declaration of interests: current grants

- Big Lottery
- British Occupational Health Research Foundation
- Comic Relief
- Department of Health
- European Union
- Guys’ & St. Thomas’ Charity
- Medical Research Council
- National Institute for Health
- National Institute for Health Research
- Wellcome Trust
Plan

1. Treatment gap

2. Key resources
Plan

1. Treatment gap

2. Key resources
The global context of mental health care

Film on the WHO Mental Health Global Action Programme (mhGAP)
<table>
<thead>
<tr>
<th>Rank</th>
<th>Worldwide</th>
<th>High-income countries</th>
<th>Low- and middle-income countries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cause</td>
<td>DALYs‡ (millions)</td>
<td>Cause</td>
</tr>
<tr>
<td>1</td>
<td>Unipolar depressive disorders</td>
<td>65.5</td>
<td>Unipolar depressive disorders</td>
</tr>
<tr>
<td>2</td>
<td>Alcohol-use disorders</td>
<td>23.7</td>
<td>Alzheimer’s and other dementias</td>
</tr>
<tr>
<td>3</td>
<td>Schizophrenia</td>
<td>16.8</td>
<td>Alcohol-use disorders</td>
</tr>
<tr>
<td>4</td>
<td>Bipolar affective disorder</td>
<td>14.4</td>
<td>Drug-use disorders</td>
</tr>
<tr>
<td>5</td>
<td>Alzheimer’s and other dementias</td>
<td>11.2</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>6</td>
<td>Drug-use disorders</td>
<td>8.4</td>
<td>Bipolar affective disorder</td>
</tr>
<tr>
<td>7</td>
<td>Epilepsy</td>
<td>7.9</td>
<td>Migraine</td>
</tr>
<tr>
<td>8</td>
<td>Migraine</td>
<td>7.8</td>
<td>Panic disorder</td>
</tr>
<tr>
<td>9</td>
<td>Panic disorder</td>
<td>7.0</td>
<td>Insomnia (primary)</td>
</tr>
<tr>
<td>10</td>
<td>Obsessive–compulsive disorder</td>
<td>5.1</td>
<td>Parkinson’s disease</td>
</tr>
<tr>
<td>11</td>
<td>Insomnia (primary)</td>
<td>3.6</td>
<td>Obsessive–compulsive disorder</td>
</tr>
<tr>
<td>12</td>
<td>Post-traumatic stress disorder</td>
<td>3.5</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>13</td>
<td>Parkinson’s disease</td>
<td>1.7</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>14</td>
<td>Multiple sclerosis</td>
<td>1.5</td>
<td>Multiple sclerosis</td>
</tr>
</tbody>
</table>

*Data from ref. 1. Examples of MNS disorders under the purview of the Grand Challenges in Global Mental Health initiative.

†World Bank criteria for income (2009 gross national income (GNI) per capita): low income is US$995 equivalent or less; middle income is $996–12,195; high income is $12,196 or more.

‡A disability-adjusted life year (DALY) is a unit for measuring the amount of health lost because of a disease or injury. It is calculated as the present value of the future years of disability-free life that are lost as a result of the premature deaths or disability occurring in a particular year.
Treatment gap: key facts

- 20-30% of global population has mental illness each year
- > 66% of people with mental illness receive no treatment
- Under-treatment occurs in all countries: in USA 67%, in Europe 74% and in Nigeria up to 98% receive no treatment
- By comparison only 8% of people with type 2 diabetes mellitus in Europe receive no care

Treatment gap: treated prevalence in high, medium & low resource settings

<table>
<thead>
<tr>
<th></th>
<th>High income % treated</th>
<th>Low &amp; middle income % treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>94%</td>
<td>77%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>78%</td>
<td>51%</td>
</tr>
<tr>
<td>Asthma</td>
<td>65%</td>
<td>44%</td>
</tr>
<tr>
<td>Mental disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>29%</td>
<td>8%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>29%</td>
<td>13%</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>33%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Gap in treatment
Severe cases receiving no treatment during the last 12 months

Developed countries
- Lower range: 35%
- Upper range: 50%

Developing countries
- Lower range: 76%
- Upper range: 85%

WHO World Mental Health Consortium, 2004
Size of the gap between levels of mental disorder and treatment

• while neuropsychiatric disorders contribute to 13% of global burden of disease (WHO, 2008), mental health budgets receive only 3% of health budgets

• this means that a considerable gap exists between level of mental disorder and service provision in all parts of the world
The size and burden of mental disorders and other disorders of the brain in Europe 2010

H.U. Wittchen a,*, 1, F. Jacobi a, 1, 2, J. Rehm a, b, A. Gustavsson c, M. Svensson d, B. Jönsson e, J. Olesen f, C. Allgulander g, J. Alonso h, C. Faravelli i, L. Fratiglioni j, P. Jennum k, R. Lieb l, A. Maercker m, J. van Os n, M. Preisig o, L. Salvador-Carulla p, R. Simon q, H.-C. Steinhausen l, r, s
• a recent review found that 38.2% of the EU population experiences a mental disorder each year (Wittchen et al 2011)

• only 25% received any professional help and 10% receive notionally adequate treatment (Wittchen et al, 2011)
Mental Disorders by prevalence (and estimated number of persons affected in millions)

- OCD: 0.7 (2.9m)
- Eating disorder: 0.9 (1.5m)
- Cannabis dependence: 1.0 (1.4m)
- Psychotic disorder: 1.2 (5.0m)
- Personality dis.: 1.3 (4.3m)
- PTSD: 2.0 (7.7m)
- Conduct dis.: 3.0 (2.1m)
- Alcohol dependence: 3.4 (14.6m)
- Somatoform disorders: 4.9 (20.4m)
- ADHD/Hypercin. dis.: 5.0 (3.3m)
- Dementia: 5.4 (6.3m)
- Unipolar depression: 6.9 (30.3m)
- Insomnia: 7.0 (29.1m)
- Anxiety disorders: 14.0 (61.5m)

Neurological disorders: Number of persons affected (in millions)

- Headache*: 152,8
- Sleep Apnoea: 12,50
- Stroke: 8,24
- Dementias**: 6,34
- Traumatic brain injury: 3,75
- Epilepsy: 2,64
- Parkinsons Disease: 1,25
- Multiple Sclerosis: 0,54
- Neuromuscular dis.: 0,26
- Brain Tumours: 0,24

Fig. 1  Note 1: Except for dementia estimates for neurological disorders are not included in the overall prevalence estimate (*) for mental disorders. Note 2: Only a few selected neurological conditions covered in the “Cost of Disorders of the Brain” project are listed here. Note 3: Several mental disorders presented in the text are not listed in the figure, because of space restrictions. (*) Might overlap with somatoform disorders in mental disorders. (**) Dementia is listed among mental and neurologic disorders.
England 1

• in England, the most recent national psychiatric morbidity surveys for children, adolescents and adults (Green et al, 2005; McManus et al, 2009) also show most people with a mental disorder except psychosis receive no intervention

• 28% of parents of children with a conduct disorder had sought advice from a mental health specialist (Green et al, 2005)

• 24% of adults with a common mental disorder had treatment for an emotional or mental problem, usually medication (McManus et al, 2009)

• 81% of people with probable psychosis received some form of treatment (medication and/or counselling) compared to 85% in 2000. However, only 65% of people with ‘psychotic disorder’ in the past year received treatment (McManus et al, 2009)


England 2

- 20% of adults who screened positive for ADHD were receiving medication, counselling or therapy for a mental health or emotional problem (McManus et al, 2009)
- 14% of alcohol dependent adults were receiving treatment for a mental or emotional problem (McManus et al, 2009)
- 14% of adults who were dependent on cannabis, and 36% of those dependent on other drugs, were receiving treatment for a mental or emotional problem (McManus et al, 2009)
- One in six of older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment (Chew-Graham et al, 2004)
A new mental health strategy for England
Implementation is the next step

Until 1999 mental health services in England enjoyed wide ranging freedoms to decide how to provide services, a form of “localism” that is now once again central to governmental thinking on public policy. The consequence was no overall pattern of service, variations in the standard of care, and dissatisfaction by service users and carers. This situation was transformed by the 1999 National Service Framework for Mental Health, which set out national standards requiring that care and treatment should be provided consistently across England. Unusually for a national strategy, this framework was substantially put into practice, largely through strong and financially incentivised performance management methods.

The coalition government has now published its new long term mental health strategy for England. Its six main “shared objectives” are: more people will have good mental health; more people with mental health problems will recover; more people with mental health problems will have good physical health; more people will have a positive experience of care and support; fewer people will suffer avoidable harm; and fewer people will experience stigma and discrimination. Few people could quibble with these headline aspirations. The strategy “sets out our ambition to mainstream mental health, and establish parity of esteem between services for people with mental and physical health problems.”

The strategy includes several elements that will be welcomed by many people with mental illness and by the wider mental health sector. Firstly, the commitment to invest £640m (£606m; £659m) over the next four years to strengthen psychological treatments. The Improving Access to Psychological Treatments (IAPT) programme is expected to cover children and young people, older people and their carers, people with long term physical health problems, and those with severe mental illness.

Secondly, the strategy explicitly states that the government will “commit to supporting and working actively with Time to Change and other partners on reducing stigma for people of all ages and backgrounds.” This is timely because it is now well established that many people with mental illness experience profound forms of social exclusion and injustice. It is also good to see a clear statement of support for the United Nations Convention on the Rights of Persons with Disabilities (which the United Kingdom has now ratified), given that violations of human rights can occur in psychiatric institutions.

Thirdly, drawing on a review of the literature, the focus on early stage interventions, not only for people with first episode psychotic disorders “but across all ages” is a move to mental health practitioners to focus more on the earliest stages of prodromal or syndromic conditions, with the intention of improving the long term course and outcome. Yet the strategy also has several shortcomings. It does not seriously consider the degree of neglect facing many people with mental illness. Although mental illnesses are surprisingly common, affecting about 20% of the population this year, only a quarter of mentally ill people across Europe receive any form of healthcare, compared with about 80% of people with diabetes. Although the IAPT programme may have modestly increased the proportion treated, at the population level we still disregard the treatment needs of most people with mental illness, despite the recent well argued call to action by the World Health Organization. More specifically, recent evidence indicates that people with psychotic, affective, personality, drug related, and alcohol related disorders die on average about 20 years earlier than their mentally well counterparts. Although the strategy does refer to this problem of “diagnostic over-shading” (the systematically worse physical healthcare given to people known also to have a mental illness) it provides no discernible practical plan to tackle it. Further indication of the longstanding problems with mental health services is that people in black and ethnic minority groups often have a worse experience of care. Although the strategy acknowledges this fact, again there is a lack of specificity about precisely what needs to be done and the evidence base, at a time when use of the Mental Health Act is increasing across England.

Strategies likely to succeed not on what actions will be taken, by whom, when, with which resources, and with which lines of reporting and accountability. The early indications here are not promising, and the reader is given fair warning in the initial “reader box” document description, which states that the “action required” and “timing” are “N/A,” and it is not clear whether this means not available or not applicable. Indeed, the only financial undertaking given in the whole strategy is that for the IAPT programme. Overall, this strategy details what is to be achieved, but not how. In my view, what is now needed at the national level is an implementation plan that sets out the details of exactly how these aims will be put into routine practice nationwide.

Completing the unfinished revolution in mental health
New report recommends strengthening community services to reduce poverty and social exclusion

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Hot on the heels of the new coalition government’s mental health strategy for England comes a report on mental health in the United Kingdom, written by the Centre for Social Justice (CSI), called Completing the Revolution: Transforming Mental Health and Tackling Poverty.1 The CSI is an independent think tank that was established in 2004 by Iain Duncan Smith (a Conservative Party politician who is now a cabinet minister). The report is sponsored by the Doha International Institute for Family Studies and Development; Partnerships in Care (a for-profit provider of secure mental health facilities); and St Andrew’s Healthcare (a charity that provides mental healthcare). The striking headline of the report is that, “There is an unfinished revolution in mental health care that began half a century ago when the mentally ill were moved out of asylums... to help them achieve as full a recovery as possible, but this shift has stalled and many needs currently go unmet.”

The review is the culmination of written and oral evidence collected over the course of more than a year, and it sets out 38 recommendations across six areas: firstly, how to tackle mental ill health and stigma through a public health approach; secondly, trauma and the mental health of military veterans; thirdly, the mental health needs of children and young people; fourthly, the mental health needs of black and minority ethnic groups; fifthly, the role of primary care; and lastly, specialist mental health services.

Much in the report is welcome and progressive, most notably the focus on the often devastating effects of mental illness on family and economic life. The complex inter-relationships between poverty and mental health are correctly analysed, as are the implications for providing more evidence-based opportunities to enter the workforce.2 Similarly, the disregard by the previous UK government for the evidence about community treatment orders is corrected with a call for “a major review of the use and impact of the 2007 Mental Health Act.”3 More specifically, the report endorses an important legal matter—the need to revoke discriminatory legislation,4 such as the sections of the act that prevent some people who have had treatment for mental illness from serving on a jury, as a company director, or as a member of parliament, as recently proposed by Dennis Stevenson (a member of the House of Lords).

The report has several notable omissions—most importantly it does not discuss the fact that most people with mental disorders in the UK receive no relevant healthcare, despite a well developed primary care sector and, by international standards, a sophisticated range of hospital and community based specialist mental health services. Indeed, this problem of limited coverage, which the World Health Organization has described as the “mental health gap” is a new and global iteration of the “inverse care law,” in that about a third of people with mental disorders in high income countries are treated, while in many low income countries about two thirds of people with non-communicable diseases receive treatment.5 Other major challenges are discussed but not fully worked through. For example, recent European data show that men with mental disorders live 20 years less, and women 15 years less, than the general population.6 Although the report identifies encouraging people with mental disorders to stop smoking as one important response to this challenge, an integrated approach to such massive and persisting inequalities in life expectancy also needs to tackle the discrimination that people with mental health problems experience when trying to access physical healthcare.7 Similarly, although the report correctly analyses the lack of progress made in the UK in providing mental healthcare in ways that black and ethnic minorities find acceptable, it could go further and propose that new models of care are customised for this purpose, because evidence is emerging that this can be done cost effectively.8 The ideological aspices of the report also become visible from time to time, especially in those sections that are less evidence based—for example, in the call to promote a mixed economy of service provision, where it says “that clinical commissioning groups... should... vigorously use the new paradigm of competition, choice, and payment by results to increase access... and drive up quality.” Important quality deficits are also identified—for example, the survey commissioned by the CSI for this report found, remarkably, that more than half of people who had received psychiatric inpatient care did not think that the settings and facilities had helped their recovery.9 Yet many will agree that the answer is to provide less coercive and more therapeutic alternatives, rather

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2011 WHO Atlas highlights that resources for treatment of mental disorder are insufficient:

• Globally spending on mental health averages US$1.63 per person per year and less than 25 cents in low income countries
• 2.8% of government health budget is spent on mental health - LAMICs spend 0.5% while high income countries spend 5.1%
• Inequitably distributed: mental health expenditure per person is more than 200 times greater in high income countries than low income countries
• Only 36% of people living in low income countries are covered by mental health legislation compared to 92% for high income countries
Low Income Countries 2

- Outpatient mental health facilities are 58 times more prevalent in high income compared to low income countries.
- Human resources working in mental health vary from 1.7 per 100,000 in Africa to 43.9 per 100,000 in Europe.
- Almost half the people in the world live in a country where there is one psychiatrist to serve 200,000 people or more.
- Inequality is highlighted by Burundi with one psychiatrist for 9 million compared to Switzerland with 3100 psychiatrists for the same population size.
- Median expenditures on medicines for mental and behavioural disorders in upper-middle and high income counties is approximately 340 times greater than median expenditures in low and lower-middle income countries.
- Inefficiently utilised: globally 63% of psychiatric beds are in mental hospitals and 67% of mental health spending is directed towards these, although institutional care is slowly reducing.
Examples of progress

- Ethiopia and Nigeria which have begun training their primary health care personnel to identify and treat priority mental disorders. The Ministries of Health of both countries have committed to sustain the programme for lasting impact.

- China has scaled up its programme to provide care for epilepsy patients to 19 provinces, building on successful experience in a small number of pilots in provinces. More than 40 million people are now covered by this programme.

- Jordan is making progress with a programme for priority mental disorders. Panama has begun training its primary care providers on a systematic basis.

- Large, developing countries like Brazil, India and Thailand are also preparing to make rapid advancements in scaling up care through their national health programmes.
Comparison between 2005 and 2011
WHO Mental Health Atlas

- mental health policy: 64% of countries reported having a policy in 2005 and 62% in 2011
- mental health plan: in 2005 it was 91% and in 2011 it was 95%
- mental health legislation: increase in the number of countries reporting a law related to mental health (from 75% to 93%).
- psychiatric beds: globally, the median decrease was -0.11 mental hospital beds per 100,000 population
- indicating that most countries decreased in their rate of mental hospital beds over this period with upper middle income countries showing greatest decrease
- Human resources: a small gain in mental health human resources between Atlas 2005 and 2011-not in LAMICs
Plan

1. Treatment gap

2. Key resources
WHO Mental Health Global Action Programme (mhGAP)
Mental Health Gap Action (mhGAP) Programme launched by WHO Director General on October 2008
mhGAP: objectives

- increase commitment of governments, NGOs & other stakeholders
- achieve significantly higher coverage of key interventions in low resource settings
- evidence based (93 systematic reviews)
- mhGAP Guideline Development Group led by Shekhar Saxena & Graham Thornicroft
mhGAP: priority conditions

1. depression
2. schizophrenia
3. suicide prevention
4. epilepsy
5. dementia
6. disorders due to use of alcohol
7. disorders due to illicit drug use
8. child mental disorders
9. Medically unexplained symptoms
mhGAP implementation: next steps

• National level adaptation
• Development training materials
• Learn from IMCI children’s guidelines
• Regional / district level implementation
• Use in students’ training curricula
www.who.int/mental_health/mhGAP/en/

or search for

mhGAP Implementation Guide
Why do we need to scale up services?

- 300-400 million worldwide disabled by mental and neurological disorders at any time globally
- 85% of these are in Low and Middle Income Countries
- Poverty and hunger, war, natural disasters, poor access to health care etc are significant exacerbating factors in many LAMIC
- Negative cycle of poverty and mental illness impedes economic development at all levels
What do we mean by scaling up?

“deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis”

Simmons R, Fajans P, Ghiron L. Scaling up health service delivery: from pilot innovations to policies and programmes. WHO 2007

SO:

• an increase in the number of people receiving services (coverage) or in the range of services offered;

• services that are built on a scientific evidence base, usually with a service model that has been shown to be effective in a similar context;

• services made sustainable through policy formulation, implementation, and financing (strengthening of health systems)