Global mental health: Current policy and service issues

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Outline

- Core concepts

- Key milestone publications

- Burden of mental and substance use disorders

- Global policy and resource challenges – the treatment gap

- Cycle of poverty and mental illness

- Links with the SDGs

- Recent innovations: PRIME

- Acknowledgements

Core concepts

Definitions

- **Health:** *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (WHO, 1978)

- **Mental health:** *"the capacity of thought, emotion and behaviour that enables every individual to realize their own potential in relation to their developmental stage, to cope with the normal stresses of life, to study or work productively and fruitfully, and to make a contribution to their community."*

- **Mental disorder:** *"disturbances of thought, emotion, behaviour, and/or relationships with others that lead to significant suffering and functional impairment in one or more major life activities, as identified in the major classification systems such as the WHO International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM)."*

(adapted from WHO, 2001)

Complexity: Social and cultural determinants

Milestone publications in global mental health

- World Mental Health (1995)
- WHO World Health Report 2001
- WHO Mental Health Policy Guidance Package (2003-2005)
- Lancet series on Global Mental Health (2007)
- Launch of Movement for Global Mental Health (2007)
- WHO mhGAP (2008)
- PLoS Med series on Packages of care (2009)
- WHO Mental Health and Development report (2010)
- 2nd Lancet series on Global Mental Health (2011)
- Nature article: Grand Challenges in Global Mental Health (2011)
  - Significant new research funding: DFID, NIMH, EU, GCC, WT (2011-present)
- WHO Mental Health Action Plan (2013-2020)
- Coming soon: Lancet Commission on Global Mental Health and Sustainable Development: September 2018
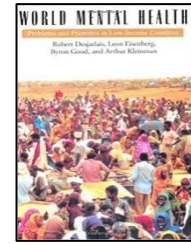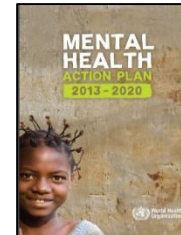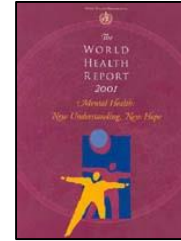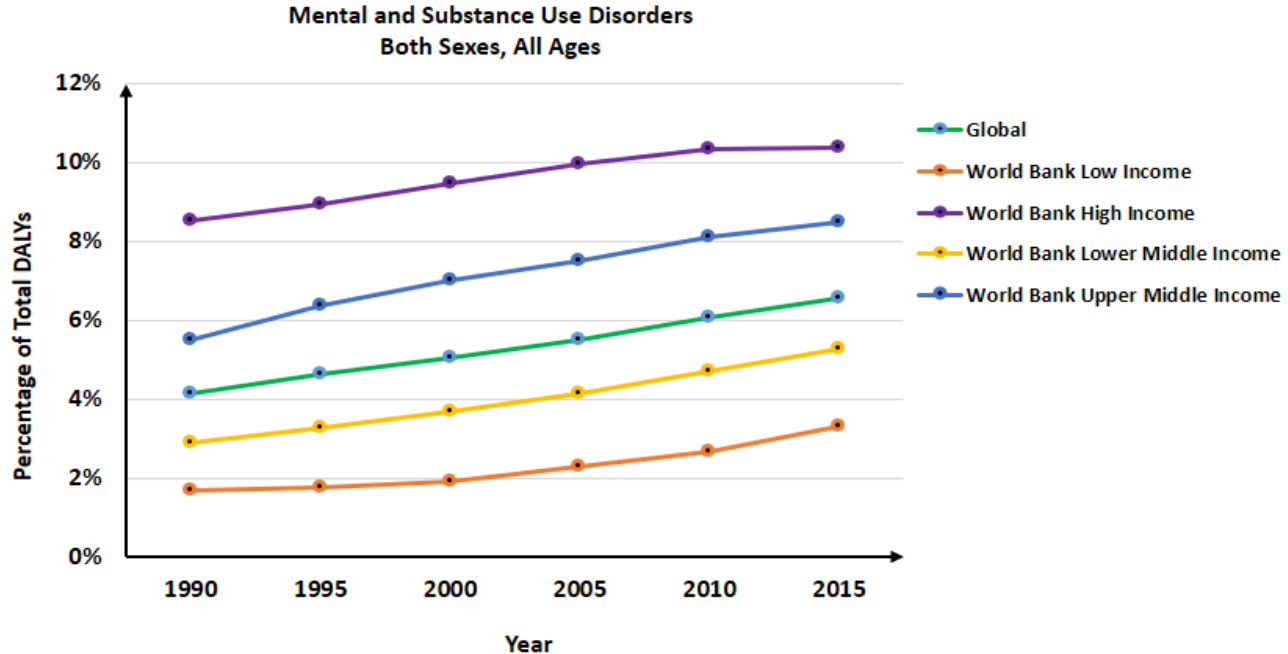
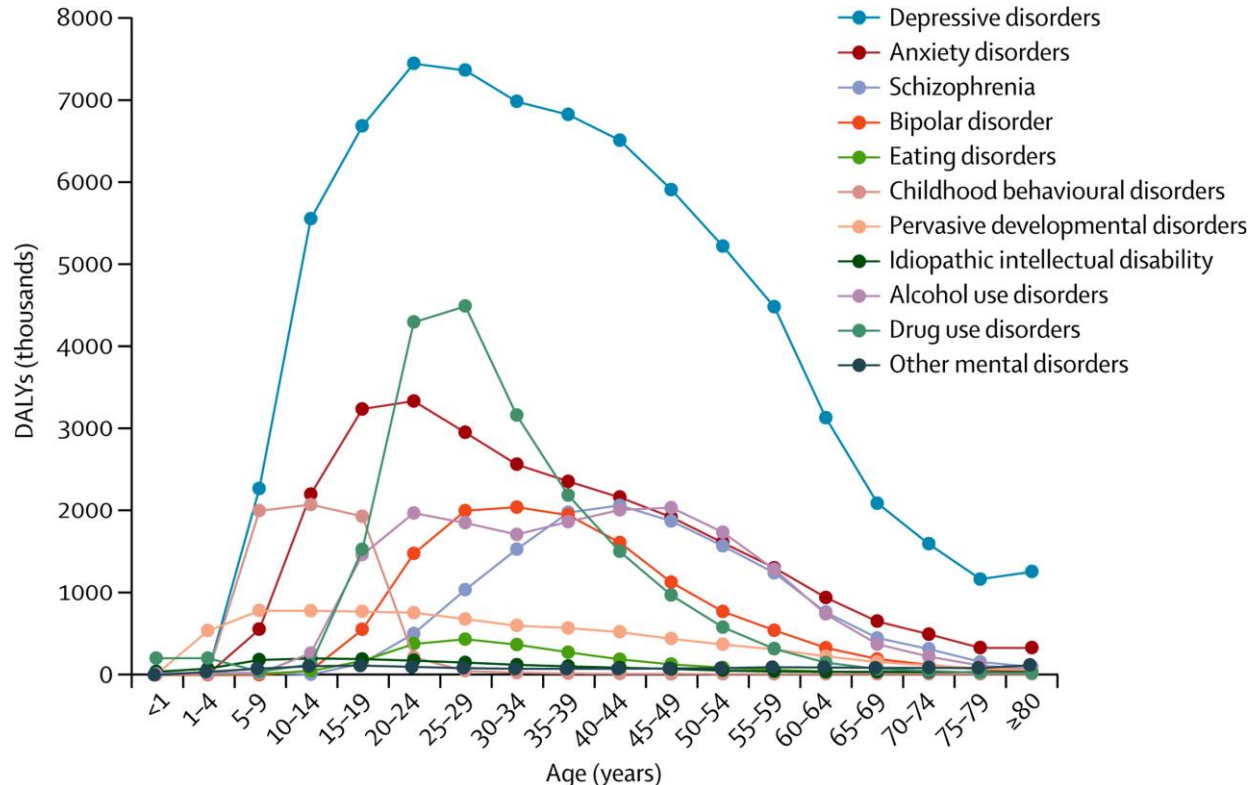# Burden of mental disorders

Global Burden of Disease 1990-2015: Rising Burden of Mental and substance use disorders (DALYs)

Mental and Substance Use Disorders
Both Sexes, All Ages

- Global
- World Bank Low Income
- World Bank High Income
- World Bank Lower Middle Income
- World Bank Upper Middle Income

Disability-adjusted life years (DALYs) for each mental and substance use disorder in 2010, by age

1. Whiteford et al (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet

Comorbidity

- HIV/AIDS:
  - People with mental disorders at increased risk of contracting HIV/AIDS
  - Among HIV positive individuals prevalence of mental disorder is higher than general population eg depression (OR 2.0, 95% CI 1.3-3.0)[1]
  - Adherence to ART is adversely affected by depression, cognitive impairment and substance abuse
  - Treating depression improves ART adherence and CD4 count[2]
  - HIV-Associated Neuro-cognitive disorder among patients commencing ART in Cape Town:[3]
    - Mild neuro-cognitive disorder: 42.4%
    - HIV-Dementia: 25.4%

1. Prince, M. et al (2007). No health without mental health. *Lancet, 370*, 859-877.
2. Horberg, M.A. et al. (2008). Effects of depression and selective serotonin reuptake inhibitor use on adherence to highly active antiretroviral therapy and on clinical outcomes in HIV- infected patients. *Journal of Acquired Immune Deficiency Syndromes*, 47(3): 384-390.
3. Joska et al (2010). Characterization of HIV-Associated Neurocognitive Disorders Among Individuals Starting Antiretroviral Therapy in South Africa. *AIDS Behav* (2011) 15:1197–1203

Maternal mental health

- Consequences of maternal depression for infant and child development in LMIC:[2]

  - low birth-weight

  - sub-optimal mother-infant bonding

  - inadequate child care

  - impairments in behavioral, social, emotional, cognitive and physical child development (including stunting and underweight)

Pooled prevalence (%)[1]

1. Woody et al (2017) A systematic review and meta-regression of the prevalence and incidence of perinatal depression. *Journal of Affective Disorders*. http://dx.doi.org/10.1016/j.jad.2017.05.003.
2. Gelaye et al (2016) Epidemiology of maternal depression, risk factors, and child outcomes in low-income and middle-income countries. *Lancet Psychiatry.*;3(10):973-982.
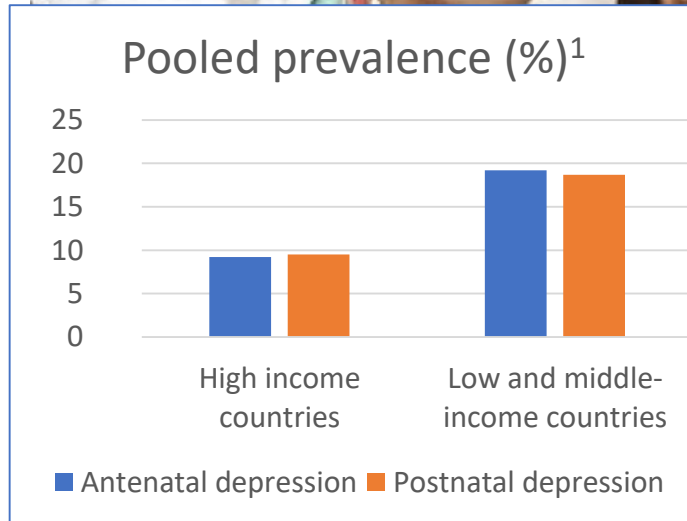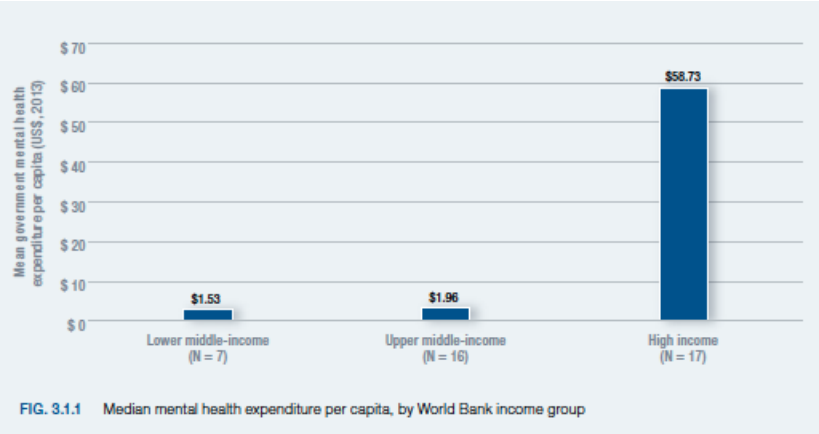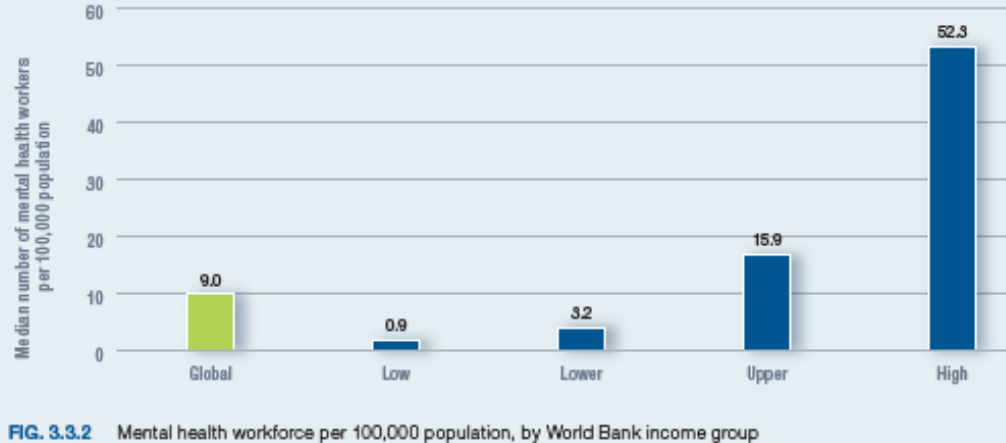
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Lack of policy commitment and resources – the treatment gap
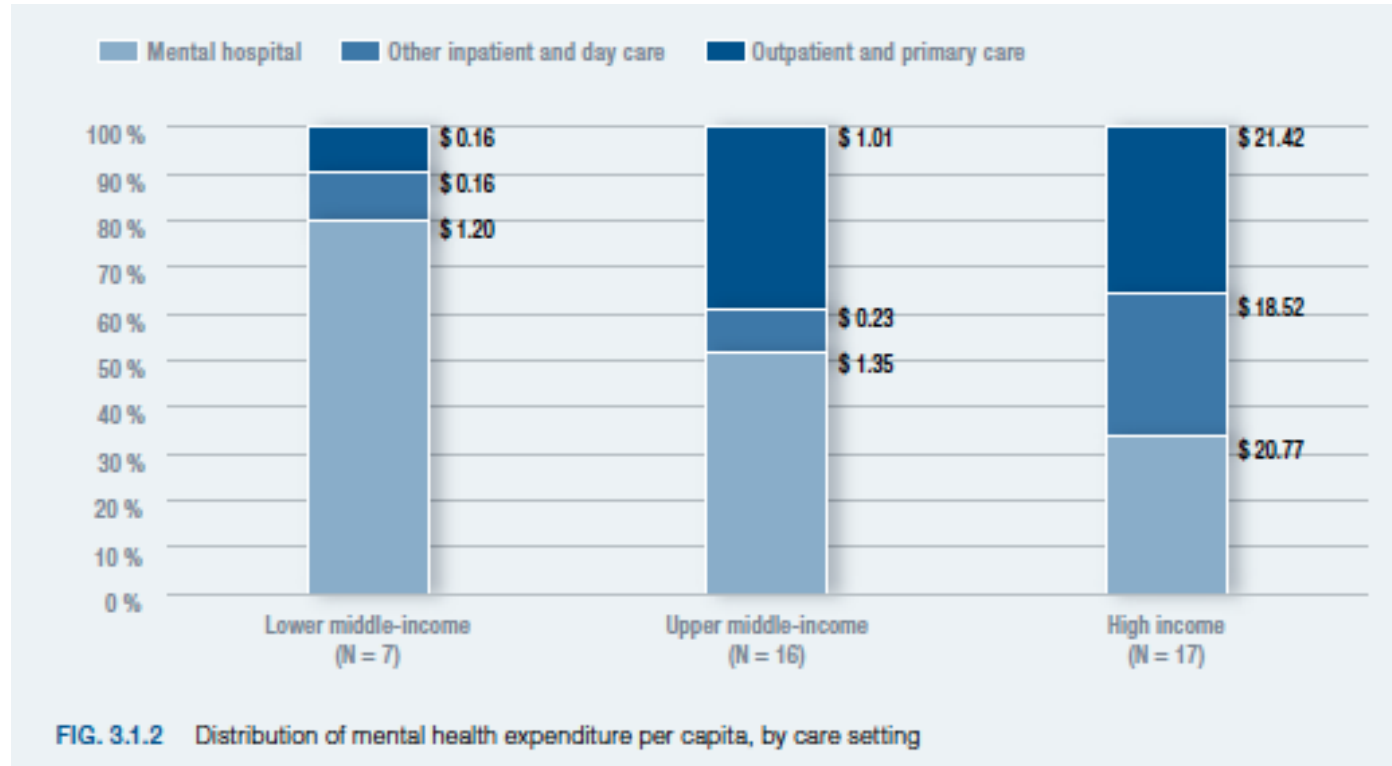
Mental Health Expenditure per capita[1]

FIG. 3.1.1 Median mental health expenditure per capita, by World Bank income group

Mental Health workforce per 100,000 population[1]

FIG. 3.3.2 Mental health workforce per 100,000 population, by World Bank income group

1. WHO (2014) Mental Health Atlas 2014. Geneva: WHO.

Mental health expenditure by care setting[1]

Legend: Mental hospital | Other inpatient and day care | Outpatient and primary care

Lower middle-income (N = 7):
- $ 0.16
- $ 0.16
- $ 1.20

Upper middle-income (N = 16):
- $ 1.01
- $ 0.23
- $ 1.35

High income (N = 17):
- $ 21.42
- $ 18.52
- $ 20.77

FIG. 3.1.2 Distribution of mental health expenditure per capita, by care setting

1. WHO (2014) Mental Health Atlas 2014. Geneva: WHO.

The treatment gap
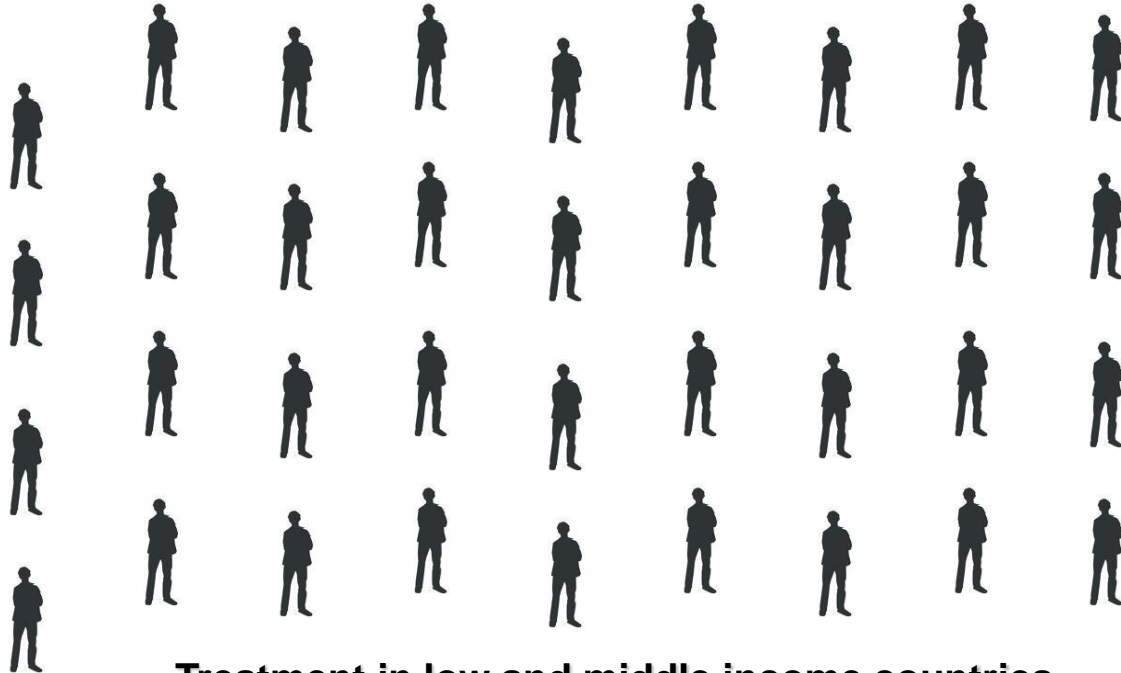
Treatment in low and middle income countries

Wang, P. S. et al (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet., 370*(9590), 841-850.
Williams, D. et al (2007). Twelve month mental health disorders in South Africa: prevalence, service use and demographic correlates. *Psychological Medicine*, 38: 211-220.

Cycle of poverty and mental illness

Poverty and Common Mental Disorders in Low and Middle-Income Countries

Is there an association between Common Mental Disorders and poverty?

- Most studies showed statistically significant association* between diverse measures of poverty and CMD

- Poverty strongly associated with higher rates of CMD across age ranges in rural and urban areas

- Poverty associated with:
  - Increased prevalence
  - Increased severity
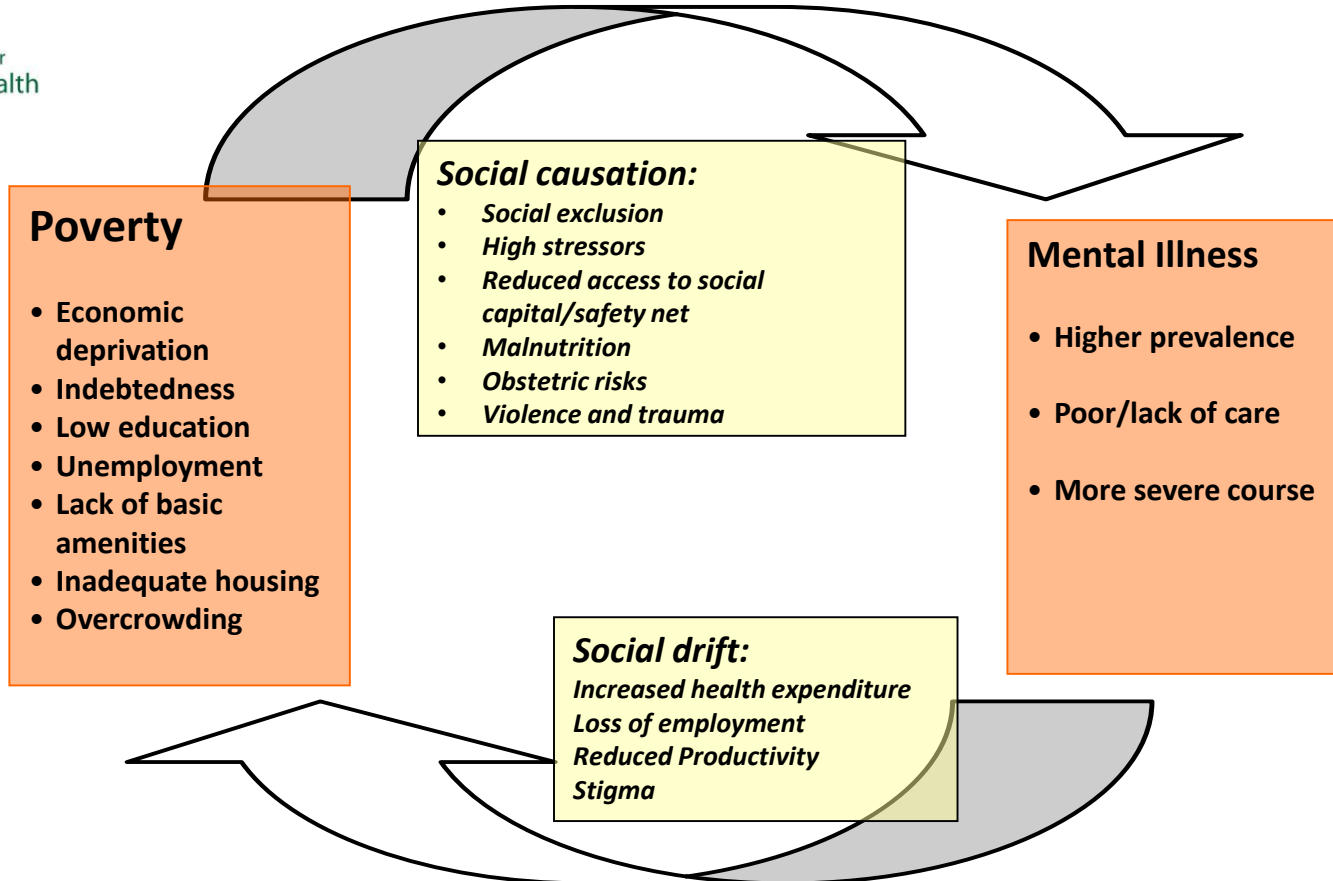 - Longer course and worse outcome

76 Community-based studies

* (p<.05; OR with 95%CI>1))

Lund et al 2010 Poverty and CMD in LMIC: A systematic review. *Social Science and Medicine* 71:517-528.

Cycle of poverty and mental illness

Poverty

- Economic deprivation
- Indebtedness
- Low education
- Unemployment
- Lack of basic amenities
- Inadequate housing
- Overcrowding

Social causation:
- *Social exclusion*
- *High stressors*
- *Reduced access to social capital/safety net*
- *Malnutrition*
- *Obstetric risks*
- *Violence and trauma*

Mental Illness

- Higher prevalence
- Poor/lack of care
- More severe course

Social drift:
Increased health expenditure
Loss of employment
Reduced Productivity
Stigma

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Breaking the cycle of poverty and mental illness: the evidence so far…
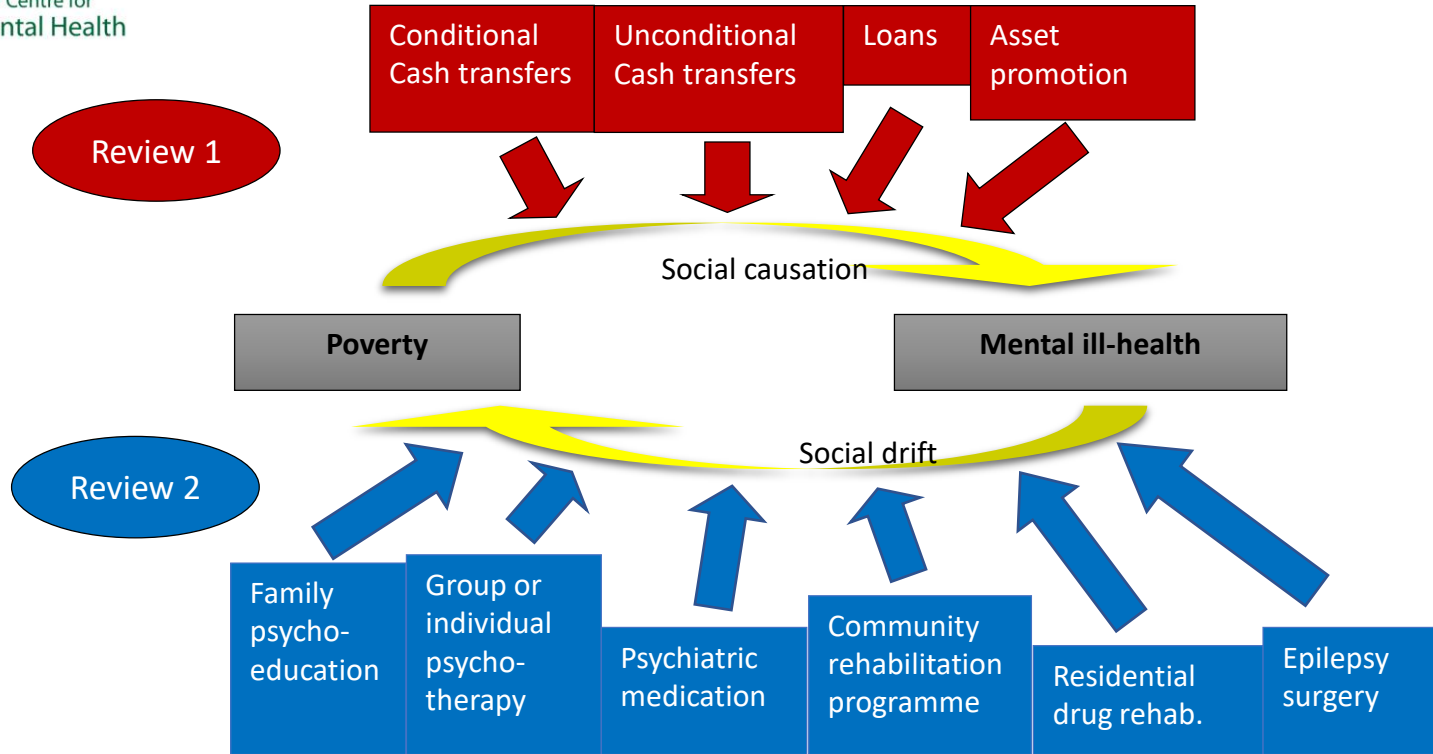
Lund, C. et al (2011). Poverty and mental disorders: Breaking the cycle in low and middle-income countries. *Lancet, 378*, 1502-1514.

Links between mental health and the Sustainable Development Goals

Social determinants of mental health and the SDGs: a conceptual framework

Lund et al (2018) Social determinants of mental disorders and the sustainable development goals: a systematic review of reviews. *Lancet Psychiatry*. 5: 357-369.

The SDG Challenge

- How do we demonstrate the link between attaining "upstream" SDGs and mental health benefits?

- Can we also show that providing mental health care yields social, economic and environmental benefits?

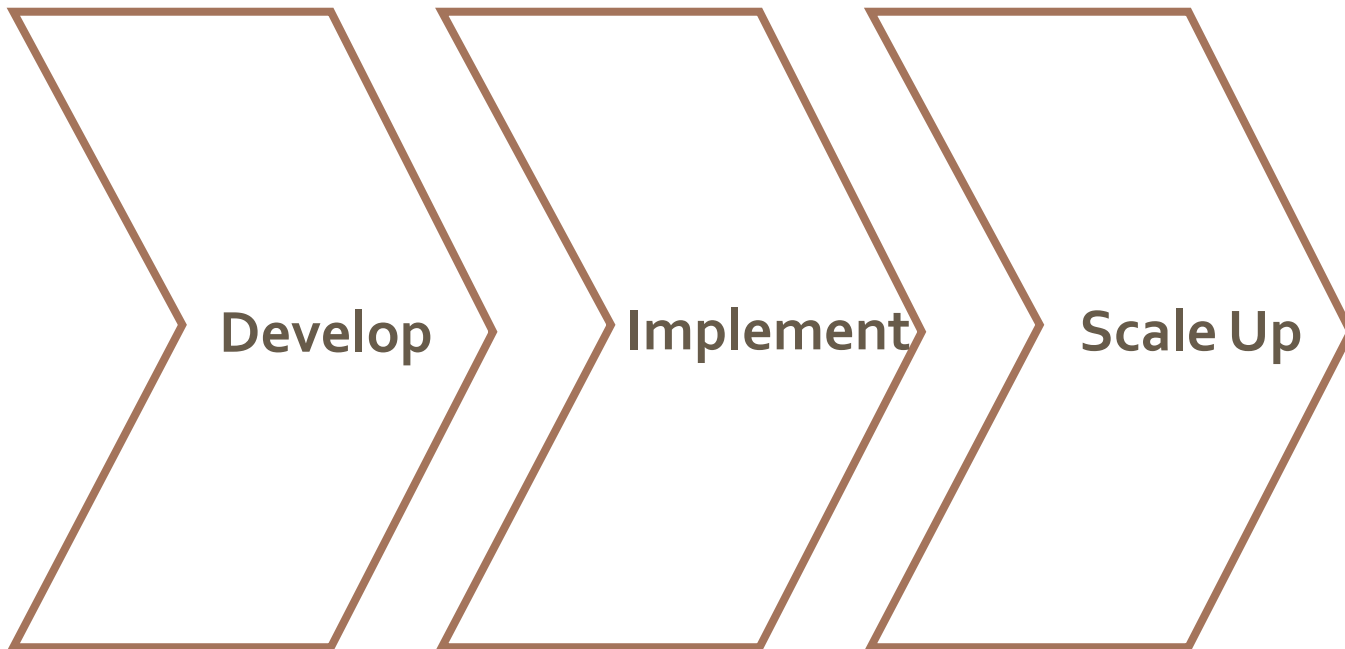- Is mental health both a means and an end of development?

Recent innovations: PRIME

PRIME Consortium

Lund et al (2012). PRIME: A programme to reduce the treatment gap for mental disorders in five low and middle-income countries. PLoS Med 9(12): e1001359.

www.prime.uct.ac.za

Mental Healthcare Plans

|	Awareness	Detection	Treatment	Recovery	Enabling
Healthcare Organisation	Engage and mobilise district stakeholders				Programme management, HMIS & capacity building
Specialist mental healthcare services			Provide specialist care to complex cases	Provide case reviews for complex cases	Ensure specialist MH care interfaces with PHC
Healthcare facilities	Increase awareness of service users and providers	Detect, screen and assess for priority disorders	Provide psychosocial interventions and psychotropic medication	Ensure continuing care	Build capacity of facility staff to deliver facility level packages
Community	Improve awareness and decrease stigma	Improve case detection in the community	Provide basic psychosocial interventions and peer support	Promote rehabilitation & recovery	Build capacity of community to support mental health care

ETHIOPIA   SOUTH AFRICA   INDIA   NEPAL   UGANDA

Implemented

- In 37 facilities across 5 countries

- >20340 mental health visits during the implementation phase

Country	District	Population	Number of facilities	Number of visits in PRIME facilities
Ethiopia	Sodo	165 000	8	4667
India	Sehore, Madhya Pradesh	1 311 008	3	3794
Nepal	Chitwan	575 058	10	4533
South Africa	Dr Kenneth Kuanda	632 790	3	572
Uganda	Kamuli	740 700	13	6774
Total	-	-	37	20340

ETHIOPIA   SOUTH AFRICA   INDIA   NEPAL   UGANDA
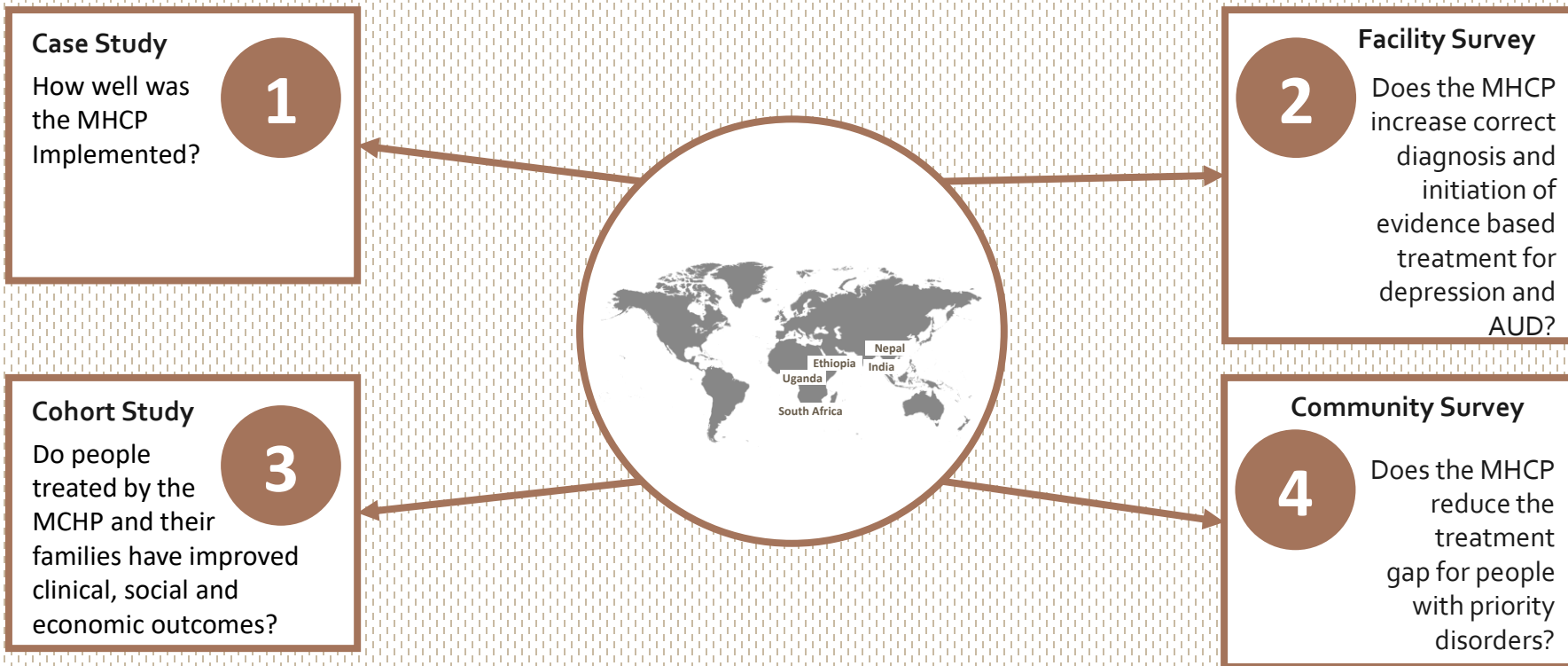
Funding acknowledgements

Thank you!