Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

Report by the Secretariat

1.   Mental disorders include common conditions such as depression and anxiety, those due to abuse of alcohol and other substances, and also severe and disabling disorders such as schizophrenia and bipolar disorder. Mental health problems in children and adolescents are of concern because of their high prevalence and the accompanying disabilities. Suicide is an extreme but not uncommon outcome for people with untreated mental disorders. In addition to these mental health problems, WHO has also identified as a priority epilepsy and dementia, which are neurological conditions that share common aspects with mental disorders in terms of provision of services.

2.   Untreated mental disorders exact a high toll, accounting for 13% of the total global burden of disease. Unipolar depressive disorder is the third leading cause of disease burden, accounting for 4.3% of the global burden of disease. The estimates for low- and middle-income countries are 3.2% and 5.1%, respectively. Current predictions indicate that by 2030 depression will be the leading cause of disease burden globally. When only the disability component is taken into consideration in the calculation of the burden of disease, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively.

3.   Exposure to a humanitarian emergency is a potent risk factor for mental health problems. Social structures and existing formal and informal provisions for the care of persons with severe, pre-existing, mental disorders are disrupted. Surveys among people affected by conflicts have found prevalence rates of 17% and 15% for depression and post-traumatic stress disorder, respectively, figures that are substantially higher than average prevalence rates in general populations.

4.   The gap between the need for treatment for mental disorders and its provision is wide all over the world. For example, between 76% and 85% of people with severe mental disorders receive no treatment for their mental health problem in low- and middle-income countries; the corresponding range for high-income countries is also high: between 35% and 50%.

5.   People with mental disorders have high mortality rates. For example, people with schizophrenia and major depression have an *overall* increased risk of mortality 1.6 and 1.4 times, respectively, greater than that of the general population because of physical health problems (such as cancer, diabetes, and HIV infection as well as the serious consequences such as suicide) associated with mental disorders.

6.   The social and economic impact of mental disability is diverse and far-reaching.

- Homelessness and incarceration in prisons are common occurrences for people with mental health conditions, which exacerbate their marginalization and precariousness. Rates of mental illness among the homeless can be greater than 50% and studies reveal that more than one third of the prison population have mental health conditions.

- People with mental health conditions often lack educational and income-generation opportunities, limiting their chances of economic development and depriving them of social networks and status within a community. For example, of all disabilities, severe mental illness is associated with the highest rates of unemployment: up to 90%.

- People with mental health conditions often have their human rights violated. In addition to restrictions on the right to work and to education they may also be subject to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, and harmful and degrading treatment practices in health facilities. They are often denied civil and political rights (such as the right to marry and found a family), rights of citizenship, and the right to vote and to participate effectively and fully in the conduct of public life.

- Mental health conditions frequently lead individuals and families into poverty and hinder economic development at the national level. A recent analysis estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 000 billion over the next 20 years.[1]

7.   WHO's *Mental health atlas 2011*[2] provides data that demonstrate the scarcity within countries of resources, particularly financial and human resources, to meet mental health needs. It also underlines the inequitable distribution and inefficient uses of such resources. For instance, globally, 67% of financial resources allocated for mental health are still directed towards mental hospitals despite their being associated with poor health outcomes and human rights violations. Directing this funding towards community-based services would allow access to better and more cost-effective care for many more people.

8.   Financing for the treatment and prevention of mental disorders remains insufficient in Member States. Globally, annual spending on mental health is less than US$ 2 per person and less than US$ 0.25 in low-income countries. Median annual mental health expenditures per capita range from US$ 0.20 in low-income countries to US$ 44.84 in high-income countries.

9.   Human resources for mental health in low- and middle-income countries are insufficient. For instance, almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people, and mental health-care providers who are trained in the use of psychosocial interventions, such as psychologists, social workers and occupational therapists, are even scarcer.

---

[1] *The global economic burden of non-communicable diseases*. World Economic Forum, Geneva, 2011.

[2] *Mental health atlas 2011*. Geneva, World Health Organization, 2011.

10.   Globally, nurses make up the largest professional group working in the mental health sector, yet a recent analysis for 58 low- and middle-income countries has identified a shortfall of 128 000 nurses between the number available now and the number needed to provide care for patients with priority conditions.

11.   A much higher proportion of high-income countries report having a policy, plan, and legislation on mental health than low-income countries. For example, only 36% of people living in low-income countries are covered by dedicated mental health legislation compared with 92% in high-income countries.

12.   Civil society movements for mental health in low- and middle-income countries are not well developed. Organizations of people with mental disabilities are present in only 49% of low-income countries compared with 83% of high-income countries; for family associations the respective figures are 39% and 80%.

EFFECTIVE STRATEGIES WITHIN HEALTH AND SOCIAL SECTORS

13.   WHO recommends the following strategies:

(a)   improve the provision of good-quality treatment and care for mental health conditions by:

(i)   including mental health into broader health policies and strategies such as those related to general health care, noncommunicable diseases, disability, maternal health and HIV/AIDS;

(ii)   expanding evidence-based mental health interventions in general health services and including them in packages of care, on the basis of cost–effectiveness, affordability and feasibility. For example, treatment of epilepsy with first-line antiepileptic medicines is one of the most cost-effective interventions for noncommunicable diseases; treatment for depression with (generically produced) antidepressant medicines and brief psychotherapy in primary care (altogether less than US$ 1) is very cost-effective; treating people with psychosis with older antipsychotic medicines plus provision of psychosocial support is a cost-effective and feasible public-health intervention; and taxation of alcoholic beverages and restriction of their availability and marketing are among the identified "best buys" for reducing the harmful use of alcohol;

(b)   improve access for people with or at risk of mental disorders to social welfare services and opportunities for education and employment, by:

(i)   actively supporting children and adolescents to receive an education, particularly primary and secondary level;

(ii)   promoting preschool education for vulnerable children, including those whose parents have mental health conditions, and for children in economically and socially disadvantaged groups; not only is this an effective strategy to improve mental health outcomes, but it reduces rates of crime and improves employment in adulthood;

(iii)   including people with mental health conditions in employment and income-generating programmes (for example, small business operations), introducing supported employment programmes, and providing social protection grants;

(iv)   creating strong links between mental health services, housing and other social services;

(c)   introduce human rights protection for people with mental health conditions, by:

(i)   developing policies and laws that protect and promote human rights and establishing independent monitoring mechanisms so as to improve conditions in health facilities, in line with international human rights standards such as the United Nations Convention on the Rights of Persons with Disabilities;

(ii)   supporting the development of a strong civil society and promoting the full inclusion and participation of people with mental disabilities in public affairs, including policy-making.

ACTIVITIES OF THE SECRETARIAT

14.   WHO's Mental Health Gap Action Programme,[1] launched in 2008, uses a multipronged approach to improving the mental health situation in countries. The Secretariat's most salient activities are summarized below.

Advocacy

15.   WHO has established the Mental Health Gap Action Programme Forum, an informal and evolving group, whose members include Member States, United Nations bodies and other intergovernmental organizations, international development agencies, foundations, academic institutions, nongovernmental organizations and WHO collaborating centres. The Forum, which meets annually, raises the priority given to mental health by Member States and other stakeholders with the aim of providing care for all people with mental, neurological and substance use disorders, with specific attention to low- and middle-income countries.

16.   WHO's recent report on mental health and development[2] is also useful for advocacy of the inclusion of mental health in national and international development agendas.

---

[1] *mhGAP: Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders*. Geneva, World Health Organization, 2008.

[2] Funk M et al. *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

Information and surveillance

17.   The Secretariat also has a central role in broadening the evidence base on mental health interventions in order to strengthen mental health-care systems in Member States. This function relies on several projects, as exemplified below.

- Through Project Atlas (see also paragraph 7) the Secretariat maps resources available in Member States. Data collected include information on policies, programmes, financing, services, professionals, treatment and medicines, information systems and relevant organizations. These data are needed at the country level for assessment of the domestic situation, and at the regional and global levels in order to compose an aggregate picture of the available resources and overall needs.

- The WHO Assessment Instrument for Mental Health Systems[1] enables countries to collect essential information on the mental health system of a country or region therein. The instrument has been applied in more than 80 countries to date. The Secretariat reviews and analyses the data, providing a detailed picture of mental health systems in low- and middle-income countries in order to facilitate the improvement of mental health systems and to provide a baseline for monitoring change.

- The Secretariat collects and analyses data on mental health in the context of general health care and development, and issues the findings as part of its country profile series. Each profile describes the national demographic and socioeconomic situation and provides an analysis of the consequences for mental health services in the country, with detail about the relationship between those services and the general health system. The profiles also describe countries' efforts to improve the mental health situation and document the milestones and achievements in this reform.

Policy, law and human rights

18.   The Secretariat also provides support to Member States in the development of comprehensive and realistic mental health policies, strategic plans and laws that promote improved quality and availability of mental health care and the rights of persons with mental disorders, in line with international best practice and human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities.

19.   Through its project "QualityRights: act unite and empower for better mental health" the Secretariat provides support to Member States for assessing and improving quality and human rights conditions in outpatient and inpatient mental health services. The project builds the capacity of national actors to assess thoroughly the mental health facilities in the country, using an assessment tool designed for the project, and to promote the creation or strengthening of organizations of people with mental disabilities and families. The results of the assessment and improved participation of civil society feed into the drafting of human rights-oriented policies and laws.

---

[1] Document WHO/MSD/MER/05.2.

Service development

20.   The Secretariat also works with Member States in developing mental health services, specifically, in deinstitutionalizing their mental health care, integrating mental health into general health care, and developing community-based mental health services.

21.   The objective of the Mental Health Gap Action Programme is to expand services in countries for people with mental, neurological and substance use disorders, especially those with lower incomes. The conditions it prioritizes are: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol and of illicit drugs, and mental disorders in children. An intervention guide, consisting of evidence-based interventions for prevention and management for each of these priority conditions, has been published.[1] Training, based on the guide, is provided to health-care providers working in non-specialized health-care settings in low- and middle-income countries, with the aim of moving from stand-alone mental health programmes to an integrated approach that promotes mental health at all levels of care. Many high-income countries are also finding the guide useful in their resource-poor settings.

Mental health and psychosocial support in humanitarian emergencies

22.   WHO takes a leading role in addressing mental health problems associated with humanitarian emergencies. It has initiated and cooperated in the preparation of both the Inter-Agency Standing Committee's Guidelines on mental health and psychosocial support in emergencies settings[2] and a standard on mental health in the revised edition of the *Sphere Handbook*[3]. During the past decade, WHO has provided substantial emergency and post-emergency support to health ministries for improving people's mental health in Haiti, Indonesia, Iraq, Jordan, Lebanon, Somalia, Sri Lanka and Syrian Arab Republic among other countries and territories.

ACTION BY THE EXECUTIVE BOARD

23.   The Board is invited to take note of the report and provide further strategic guidance.

=   =   =

---

[1] *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Programme (mhGAP).* Geneva, World Health Organization, 2010.

[2] Inter-Agency Standing Committee. *IASC Guidelines on mental health and psychosocial support in emergency settings*. Geneva, Inter-Agency Standing Committee, 2007.

[3] *The Sphere Project: humanitarian charter and minimum standards in humanitarian response.* Bourton on Dunsmore, Rugby, United Kingdom: Practical Action Publishing, Schumacher Centre for Technology and Development, 2011.