ORIGINAL ARTICLE

Global mental health

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ABSTRACT

Mental disorders controbute significantly to the Global Burden of Disease, as four out of the ten diseases with the highest burden are psychiatric. About 25% of all develop one or more psychiatric and behavioural disorders during their lifetime. Unipolar depression ranges as the leading mental disorder wiht respect to disability adjusted life years. The major psychiatric disorders like schizophrenia and depression are found in all cultures and result in significant disability. The cost of mental disorders worldwide needs receiving increasing recognition.

There are about 450 million people who suffer at a certain point of a neurological, psychiatric or behaviour related disease [1], and about 25% of all the inhabitants in the world get a psychiatric or behavioural disorder at a certain moment in their life [1]. About 20% of all patients who consult the primary health sector have a psychiatric disorder, but a considerable part of them are never diagnosed or treated properly [1]. Four out of the ten most important diseases measured by YLD (Years of Life lived with Disability) are psychiatric conditions, namely uni-polar depression, alcohol abuse, schizophrenia and bipolar disorder [1]. In the European Union, psychiatric conditions constitute 25% of the total burden of disease [2].

The psychiatric diseases have a considerable geographical variation in both occurrence and in prognosis, but they are found in every culture. Amongst younger persons only the HIV/AIDS complex has a bigger impact on leave of sickness and disability than depression. At the same time, the psychiatric disorders are known for their earlier onset in a patient's life in comparison with other severe diseases, and their course lasts longer [1]. There are therefore reasonable arguments to be occupied with the world's mental health.

In this article, the authors review the global aspects of the epidemiology of the most important psychiatric disorders. Moreover, the most important health economics consequences in these disorders are described.

EPIDEMIOLOGY

SCHIZOPHRENIA

In the 1960's the World Health Organization performed an investigation comparing the incidence and course of schizophrenia in 10 different countries (the IPSS project and DOSMED) [3]. This research demonstrated similarities in the presentation form and incidences, whereas the differences of these variables increased significantly when using a wider delineation from 4.2 per 100,000 in Chandigarh, India to 1.6 per 100,000 in Århus [3]. Schizophrenia comprises 1.1% of the global burden of disease and 2.8% of YLD.

There is little gender difference in the prevalence of the disorder, but it manifests earlier in males.

The course of the disorder was quite different with a relatively more favourable course in developing countries, which is attributed to an interaction between genetic variations and specific conditions in the environment [3]. 63% of the schizophrenics in the non-industrialised world compared to 37% in the developed countries showed remission after two years. Also in countries as Singapore and Japan we see a more favourable prognosis, where these differences can probably be explained by the tendency to maintain an attachment to elements of their respective traditional cultural patterns more than their technological development [4].

AFFECTIVE DISORDERS

Depression is the fourth most important contributor to the global burden of disease and comprises in year 2000 4.4% of the total Disability Adjusted Life Years (DALY) (i.e. the sum of years lost due to early death and years lost due to disability (YLD)) and 12% of YLD [5]. The point prevalence for uni-polar depression is 1.9% for males and 3.2% for females. 5.8% of males and 9.5% of females will develop a depressive episode within a 12-month period. Every year 5-8% of the adult population gets a depression [2]. Lifetime risk for a severe depression amounts to 12-16%. In Europe the number of persons with depression is estimated to 20.8 millions. Bipolar disorders are estimated to have a global prevalence of 1-5%.

Epidemiological investigations show that women have a 1.5-2 times as high risk for getting a depression compared to men [1]. The burden of depression is ranked number four in the global disease burden in women and number seven in men.

The burden of depression depends upon region having a relatively smaller burden in poorer regions. E.g. depression amounts to 1.2% of the total burden in Africa to 8.9% in high-income countries.

WHO has shown a homogeneous symptomatology in the affective disorders, but there has been shown significant difference in its prevalence. Culture has been considered to have a pathoplastic effect on how the depressive behaviour manifests itself, and often it is indicated that in patients who are from non -industrialised nations the somatic symptoms dominate in relationship to psychological aspects [6].

ANXIETY DISORDERS

It is estimated that Europe has up to 41,4 million people with anxiety [2], and the one-year prevalence constitutes 12% of the adult population in the European Union [2].

Epidemiological prevalence studies in China have showed anxious disorders in 4 out of 1,000 men and 39 out of 1,000 women [6], and the greater frequency in women is found in other studies.. In the USA, the Epidemiological Catchment Area (ECA) investigation [6] showed that general anxiety was more frequent among Afro-Americans with a 1-year prevalence of 2,7% while the same figure was 1,6% amongst Anglosaxon-Americans.

Comparative studies of patients in general practice frequently report general anxiety disorders, from 22% in patients from Rio de Janeiro to 2% in Shanghai and 1% in Ankara [6]. Approximately a third of sickness absenteeism because of mental disorders is attributed to anxiety disorders.

DISORDERS PROVOKED BY TRAUMA

The point prevalence for posttraumatic stress disorder (PTSD) in the general population is estimated to be 0.4% of the global burden of disease, and the life-time prevalence for PTSD is calculated to be 10.4% in women and 5% in men [7]. Some epidemiological studies show that the prevalence of PTSD after traumatic experiences varies amply, among others because of methodological difficulties, but it is estimated to vary between 9% and 37% [7]. PTSD accounts as a significant public health problem at the global level and its symptoms are comparable across cultures, however, the applicability of the diagnosis in other cultures than the Western culture has been a matter for extensive criticism [7].

ALCOHOL ABUSE

Alcohol abuse is estimated to include about 76 million people

globally and there are significant regional differences in the accepted behaviour and attitudes to the abuse of ethanol. According to the global burden of disease project it is estimated that alcohol abuse is the cause of about 1,5% of all deaths. The point prevalence is deemed to be 1,7% globally, 2,8% in men and 0,5 in women. Alcohol ranks high in the burden of disease with 3,5% of all DALY's [1]. The life-time prevalence for problems related to alcohol in men in relation to women is found to be 31% and 7% in Canada, 25% and 2% in Puerto Rico, and 43% and 3% in South Korea. Similar and significant gender differences are documented in all the studies, both in relation to alcohol consumption as in physical and social consequences.

In comparative studies from general practice alcohol related problems have been found in about 10% of patients from Seattle, Manchester, Berlin and Paris, compared to around 2% in Ankara, Shanghai and Bangalore. These differences in combination with the biological and psychological vulnerability, as well as the sociocultural conditions determine the mental health consequences of substance abuse [6]. Moreover, there seems to be a relationship between abuse of alcohol and societal conditions such as destabilization and disintegration.

SUICIDE

A study in 53 countries demonstrated an age-standardized rate of suicide of 15,1 per 100,000 people with 24,0 per 100,000 men and 6,8 per 100,000 women [1]. In the age group 15-44 years suicide is the second most frequent cause of death in the European region.

The occurrence of suicide is closely related to family structures, religion, psychosocial stress, and substance abuse, and the relationship between mental disease and suicide is well documented not least on the background of Danish register studies [8]. Traditionally, a high suicide frequency is reported in certain countries as Hungary, while other countries as Mexico have a 30-40 fold lower occurrence of suicides, but with recent increases in suicide rate in countries as Mexico and India [1] This is in contrast to the development in Denmark where the rate has declined almost steadily since 1980 [8]. Suicidal behaviour is characterized by psychological, biological and sociocultural factors, and for the individual the experience of sense of coherence with his/her sociocultural group is essential.

HEALTH ECONOMICS

Since the World Bank and the World Health Organisation conducted their analysis of the Global Burden of Disease in the 1990's, the attention paid to the social and economical consequences of the mental illnesses has increased. The European Brain Council has just published a report on the ranking of the mental disorders in a European health-economical perspective.

Projections towards the year 2020 show that the neuropsychiatric illnesses will increase their share from about 10.5% of the total burden of disease in 1990 to 15% in 2020. In Europe neuropsychiatric disorders comprise more than 40% of all chronic disorders and ranks highest as regards contribution to DALY [9].

Unfortunately, the increased focus in this area has not been a guarantee for a better fate for people with mental disorders in the developing world, and there is still a significant distance between the diseases' extent and hence the possibilities for an adequate treatment (treatment gap), not least in non-industrialised countries, in which the availability of personnel with psychiatric training is extreme limited.

In Western Europe the treatment gap is estimated to 17.8% for schizophrenia, 45.4% for severe depression, and 62.3% for generalised anxiety [8]. Among 24 European countries 5.8% of the BNP is allocated to mental health, but the disorders comprise 20% of the burden of disease [9].

PREVENTION

In order to minimize the distance between the consequences of mental diseases and the possibilities of treatment, research has to be implemented in areas such as treatments which are practical, which focus on interventions, and which allow for the needs of the population in question [10].

As examples of this form for research the authors can name: 1) As maternal depression is predictor for low weight and diarrhoea in the pre and postnatal periods of the offspring, an early intervention can promote an improvement in the health of the general population in the long term. 2) With the combination of medication and psychoeducation and support to the family the relapse rate of psychotic manifestations can be reduced from about 50% to less than 10% after a year [1].

With the implementation of cost-effective measures, where the focus is directed towards the prevention and treatment of mental conditions, a decrease of the current burden of disease in psychiatric disorders is possible.

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