Disease Control Priorities related to Mental, Neurological, Developmental and Substance Abuse Disorders

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Department of Mental Health and Substance Abuse
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Contents

Contributors **v**

Acknowledgements **vii**

Introduction Benedetto Saraceno **ix**

Chapter 1 **Mental Disorders** **1**
Steven Hyman, Dan Chisholm, Ronald Kessler, Vikram Patel, Harvey Whiteford

Chapter 2 **Neurological Disorders** **21**
Vijay Chandra, Rajesh Pandav, Ramanan Laxminarayan, Caroline Tanner, Bala Manyam, Sadanand Rajkumar, Donald Silberberg, Carol Brayne, Jeffrey Chow, Susan Herman, Fleur Hourihan, Scott Kasner, Luis Morillo, Adesola Ogunniyi, William Theodore, and Zhen Xin Zhang

Chapter 3 **Learning and Developmental Disabilities** **39**
Maureen S. Durkin, Helen Schneider, Vikram S. Pathania, Karin B. Nelson, Geoffrey C. Solarsh, Nicole Bellows, Richard M. Scheffler, and Karen J. Hofman

Chapter 4 **Alcohol** **57**
Jürgen Rehm, Dan Chisholm, Robin Room, and Alan Lopez

Chapter 5 **Illicit Opiate Abuse** **77**
Wayne Hall, Chris Doran, Louisa Degenhardt, and Donald Shepard

Conclusion Shekhar Saxena **101**

Contributors

Nicole Bellows
University of California, Berkeley

Carol Brayne
University of Cambridge

Vijay Chandra
World Health Organization,
Regional Office for South-East Asia

Dan Chisholm
World Health Organization

Jeffrey Chow
Resources for the Future

Louisa Degenhardt
University of New South Wales

Chris Doran
University of Queensland

Maureen S. Durkin
University of Wisconsin Medical School
University of Wisconsin-Madison

Wayne Hall
University of Queensland

Susan Herman
University of Pennsylvania

Karen J. Hofman
Fogarty International Center, National Institutes of Health

Fleur Hourihan
University of Newcastle, Australia

Steven Hyman
Harvard University
Harvard Medical School

Scott Kasner
University of Pennsylvania

Ronald Kessler
Harvard Medical School

Ramanan Laxminarayan
Resources for the Future

Alan Lopez
University of Queensland
Harvard School of Public Health

Bala Manyam
Texas A&M University HSC School of Medicine

Luis Morillo
Javeriana University

Karin B. Nelson
National Institute for Neurological Disorders and Stroke,
National Institutes of Health

Adesola Ogunniyi
University of Ibadan
University College Hospital, Nigeria

Rajesh Pandav
World Health Organization,
Regional Office for South-East Asia

Vikram Patel
London School of Hygiene and Tropical Medicine

Vikram Pathania
University of California, Berkeley

Sadanand Rajkumar
University of Newcastle
Bloomfield Hospital

Jürgen Rehm
Centre for Addiction and Mental Health, Canada
ISGF/ARI, Switzerland

Robin Room
Stockholm University

Benedetto Saraceno
Department of Mental Health and Substance Abuse,
World Health Organization

Shekhar Saxena
Department of Mental Health and Substance Abuse,
World Health Organization

Richard M. Scheffler
University of California, Berkeley

Helen Schneider
University of the Witwatersrand, South Africa

Donald Shepard
Schneider Institute for Health Policy,
Heller School, Brandeis University

Donald Silberberg
University of Pennsylvania

Geoffrey C. Solarsh
Monash University, Australia

Caroline Tanner
Parkinson's Institute

William Theodore
National Institute for Neurological Disorders and Stroke,
National Institutes of Health

Harvey Whiteford
University of Queensland

Zhen-Xin Zhang
Peking Union Medical College Hospital
Chinese Academy of Medical Science

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Introduction

Benedetto Saraceno
Director
Department of Mental Health and Substance Abuse
World Health Organization
Geneva

This volume brings together five chapters from *Disease Control Priorities in Developing Countries,* 2nd edition (DCP2 Jamison and others 2006). These chapters cover mental disorders, neurological disorders, learning and developmental disabilities, and alcohol and illicit opiate abuse. The purpose of this special package is similar to the overall objective of the parent volume - to provide information on cost-effectiveness of interventions for these specific groups of disorders. This information should contribute to reformulation of policies and programmes and reallocation of resources, eventually leading to reduction of morbidity and mortality.

Why these five chapters together? The primary reasons are both a conceptual basis and a practical consideration. Not only do these five chapters tend to cover brain and behaviour, but also most departments and ministries of health in developing countries deal with these areas together. Since the target readership of this volume includes policy makers and advisers in government departments in developing countries, it seemed sensible to publish these chapters together. In addition, these areas have many other commonalities - they are responsible for a large and increasing burden, they are still low priorities in the public health agenda, the resource gap for their control is especially high and the evidence for cost-effectiveness interventions against these disorders has become available only relatively recently. The Department of Mental Health and Substance Abuse, World Health Organization (WHO), which is co-publishing this volume, is responsible for all these five areas.

WHO also commissioned additional background reviews to support the work of Disease Control Priority Project; these are available on the DCPP website: (http://www.dcp2.org/page/main/Research.html) and cover the following topics.

- Suicide and Suicide Prevention in Developing Countries (Vijayakumar)
- An International Review of the Economic Costs of Mental Illness (Hu)
- An International Review of Cost-Effectiveness Studies for Mental Disorders (Knapp and others)
- Mental Health and Labor Markets Productivity Loss and Restoration (Frank and Koss)

The disorders and conditions covered in this volume are common and burdensome. Neuropsychiatry conditions together account for 10.96% of the global burden of disease as measured by DALYs (Mathers, Lopez, and Murray 2006). Alcohol as a risk factor is responsible for 3.6% DALYs and illicit drugs 0.6%. The burden associated with the full range of learning and developmental disabilities has not been estimated, but is likely to be substantial.

The proportion of the global burden of disease attributable to mental, neurological and substance use disorders together is expected to rise in future. The rise will be particularly sharp in developing countries, primarily because of the projected increase in the number of individuals entering the age of risk for the onset of disorders. These problems pose a greater burden on vulnerable groups such as people living in absolute and relative poverty, those coping with chronic diseases and those exposed to emergencies.

While these figures are large and impressive, there are many other varieties of burden that are not covered by the DALY methodology but are extremely important for these disorders. These include burden to family members (time, effort and resources spent or not availed in the care of a sick family member) and lost productivity at the level of individual, family or society in general. The DALY methodology also does not take into account externalities including harm to others (quite substantial for alcohol and illicit drug use). While the evidence for cost-effectiveness for interventions in this area using the DALY methodology is persuasive, it is likely that the case would be even stronger, if other kinds of burden are taken in account.

WHO has recognized the need for enhancing the priority given to mental and neurological disorders, learning and developmental disabilities, and alcohol and illicit opiate abuse in several of its recent publications (WHO 2000; WHO 2001; Room and others 2002; WHO 2004a; WHO 2004b). WHO has also recommended specific actions to be taken by countries to strengthen the services available to individuals suffering from these disorders (WHO 2001). However, the progress in achieving these objectives has been slow and insufficient.

The data showing the magnitude and the burden of mental, neurological and substance use disorders are repeatedly presented and discussed in international literature. Data showing the gap in resources and in treatment are also frequently discussed. Finally, the evidence about the availability of cost-effective interventions is becoming more available than in the past.

In spite of all these "arguments" (the burden, the gap and the availability of cost-effective interventions) still there is not enough clarity and understanding about the obstacles that actually prevent low and middle income countries to improve mental health care and increase their investment in mental health. The strong resistance to change and innovation in mental health care in most countries of the world have not been examined carefully. Some "reasons" to explain the fact that too little is happening in mental health in spite of the evidence that something effective can be done, have been provided: stigma about mental disorders prevent people to be treated, primary health care doctors are not properly equipped in recognizing and managing mild and moderate mental disorders, general practitioners and specialist do not recognize the important implications of comorbidity thus ignoring the mental health component of many physical diseases. These explanations are all true but probably many others are not considered and they may prove to have an equal or even bigger influence in preventing more and better investments in mental health.

However, better evidence on cost-effectiveness is likely to make the case for prioritization of these disorders stronger but there are other kinds of arguments that can help build the case (Patel, Saraceno, and Kleinman 2006). There is abundant evidence that mental health is closely linked with many global public health priorities. Mental health interventions or principles must be tied to many programmes dealing with physical health problems. The case is not that we need to prioritize depression because it is co-morbid with, for example, HIV/AIDS, but that planning a health initiative for HIV/AIDS without a depression intervention component would be denying individuals the best possible treatment for HIV/AIDS. It is unethical to deny effective, feasible and affordable treatment to millions of persons suffering from treatable disorders. Mental, neurological, developmental and substance use disorders are just as severe and disabling as various infectious diseases; those who suffer from these disorders need treatment, as without it they may be disabled for long periods. We should also be aware that those who suffer from these disorders are often unable to advocate for their rights of access to affordable, evidence-

Centuries of neglect need to be compensated by positive action. Economic arguments need to be buttressed by social and humanistic arguments. Scientific evidence and economic costs and benefits need to be understood within the larger context of social responsibility.

What is needed is a radical change of paradigms for care of individuals with mental and neurological disorders, learning and developmental disabilities, and alcohol and illicit opiate abuse:

- From Exclusion to Inclusion: The "exclusion approach" is not focused on the patient's needs but rather on the environment's perception and needs. This approach results in an emphasis on security issues, including an over-estimate of dangerousness and a perception that mental disability makes people unable to take responsibility for themselves and others. Shifting the paradigm from exclusion to inclusion facilitates care in the community.
- From biomedical to biopsychosocial approach: In 1977, George Engel coined the expression "biopsychosocial" to describe the need in medicine for a new paradigm that would go beyond the traditional biomedical and reductionist model. Today, the adjective 'biopsychosocial' is frequently used to define that which is supposed to be an integral approach to medicine. However, it has become progressively more meaningless and ritualistic. This schism between the ritualistic use of holistic notions and the practice of medicine, which is still strongly oriented towards the biological paradigm, is particularly evident in the field of mental health. Shifting from a biomedical approach to a biopsychosocial one would cause important changes in the formulation of mental health policies, in the creation and financing of mental health programmes, in the daily practice of services and in the status of care providers. Such changes imply the recognition of the role of users and families, the recognition of the role of the community, not just as an environment, but as a generator of resources that must go hand in hand with the resources provided by the health services and finally, the recognition of the role of sectors beyond health, such as social security, social assistance, welfare and the economy in general.