

Mental Illness and Disability

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Mental illness is common, with approximately **450 million people affected globally**¹. It is prevalent in all population groups however **those with psychosocial stressors such as poverty and unemployment are particularly at risk**². **Mental illness is associated with significant long-term disability** which manifests in both decreased physical and social functioning³.

Poor Mental Health significantly contributes to a cycle of poverty where people who experience **social hardship and poverty are of increased risk of mental illness**, and conversely **those with mental illness are at increased risk of poverty**². Despite potentially crippling cost of mental illness, **low-income and middle-income countries contribute less than 1% of their health expenditure to Mental Health**¹.

Global Burden of Mental Illness

Neuro-psychiatric conditions are the number one contributor to non-communicable disease burden worldwide. Including disorders such as schizophrenia, mood disorders, substance abuse and dementia, these conditions **contribute more to global disease burden than cancer or cardiovascular disease**³.

The WHO has projected that by the year 2030, unipolar depressive disorders will be the number one cause of disease burden in high-income countries⁴. Further, they project that depressive disorders will be one of the highest causes of disease burden in middle- and low-income countries, following HIV/AIDS and perinatal deaths only⁴. **Globally, unipolar depressive disorders will be responsible for a greater burden of disease than chronic lung disease, ischaemic heart disease, diabetes, vision or hearing loss, or stroke**⁴.

The relationship between mental health and physical health is complex and often multi-directional^{3,5}. For example, there is a **strong association between depression, anxiety and coronary heart disease**³. In an Australian study, death from ischaemic heart disease was linked to most mental disorders, especially schizophrenia and other psychoses³.

Having a mental illness can place an individual at higher risk for developing other illnesses^{3,5}. For example, depression is noted to be an independent risk factor for stroke³. Further, the prevalence of diabetes in patients with schizophrenia is at least five times that of the general population³. This may occur due to biological causes such as altered functioning of the immune system, or shared genetic or environmental causes³. Mental illness is also a risk factor for accidental and non-accidental injury³.

Conversely, **having a physical illness can place an individual at higher risk of developing a mental illness**^{3,5}. In fact, disability itself is a risk factor for developing depression³. This may occur due to a disease process directly affecting the brain, or commonly due to psychological strain³.

Mental illness may also contribute to disease burden through higher risk exposure³. For example, **mood disorders and schizophrenia are strongly associated with obesity and tobacco smoking, both of which are recognised as independent risk factors for heart disease³.**

Maternal mental illness also affects child health and may increase infant mortality³. For example, mothers who are experiencing psychoses during pregnancy are twice as likely to have babies that are stillborn³. Further, maternal mental illness such as depression may adversely affect bonding between mother and child, and may result in a child's failure to thrive³.

Importantly, mental illness may also increase communicable disease transmission such as HIV/AIDS, malaria and tuberculosis³, the leading causes of disease burden in low-income countries⁴. Mental illness may also result in poor physical health outcomes through delayed diagnosis, decreased access to care and decreased compliance with care³.

Gap in Care

One in four people will develop a mental or behavioural disorder during their lifetime¹, however only approximately one third of these people will receive treatment⁶. Further, in some communities as little as 10.4% of people with a mental illness who are being treated will receive adequate treatment⁶. This gap in care is most pronounced in low-income and middle-income countries, where fundamental resources are less accessible or unavailable⁷.

These resources include⁷:

1. Policy and infrastructure including legislation to protect human rights for people with mental illness
2. Training and retention of Mental Health workers
3. Funding by Government, including a designated budget for Mental Health Care
4. Equitable allocation of financial resources including prepayment mechanisms that increase availability of mental health care by decreasing out-of-pocket expenses
5. A Mental Health Service that balances both community-based and inpatient care and integrates this into the Primary-Care setting
6. Equitable access to affordable essential medications
7. Non-Governmental Organisation support in the form of direct service provision, advocacy, mental health promotion, prevention, and mental health care in emergencies
8. Indigenous, traditional and alternative health care
9. Community-base rehabilitation and social services

A gap in care is also created by inequitable distribution of the available resources both at a community and global level⁷. **High needs groups such as people of low socio-economic status, women, those with poor education levels, people living in a rural setting, young people, refugees, homeless and indigenous groups are often those who receive the lowest level of care^{5,7}.** In many cases, stigma acts as a barrier to those with mental illness such that they may not seek formal help, a phenomenon that is particularly evident in young people⁷.

The gap in care is widened by **an inefficient appropriation of resources⁷.** Much of the research linking allocation of resources and outcomes of care has taken place in high-income countries and may therefore be less applicable to low- and middle-income countries⁷. Thus the mechanisms of monitoring progress in these countries may also not be applicable⁶.

Inefficient appropriation of resources may also occur even in the presence of significant research evidence⁷. For example, **global research has recommended that the most effective and efficient care can be provided when there is appropriate balance between community-based and institution-based care⁷. However, some countries are reluctant to shift away from institution-based care due to prior expenditure, despite evidence for improved clinical and economical outcomes^{7,8}.**

Finding Solutions

Both psychological and pharmacological approaches to treatment mental illnesses such as depression and schizophrenia have been shown to be cost effective, even in developing nations⁶. In fact, the cost-effectiveness is comparable to that of anti-retroviral treatment for HIV/AIDS⁶. However, **despite better understanding of the burden and effective treatment of Mental Illnesses, the provision of mental health care in low- and middle-income countries has improved very little over previous decade⁹.**

The WHO identified several key factors in the barriers to improving Mental Health Care⁹:

1. Insufficient funding stemming from poor public interest, the stigma of mental illness, and insufficient patient advocacy
2. Resources focused on centralised urban and/or institutional care, such that there is little or no access to Mental Health care in the rural and/or community settings
3. Difficulty integrating Mental Health care into the primary health care system
4. Poor human resources, with only a small number of Mental Health workers and inadequate Mental Health training in other health care professionals
5. Insufficient Public Mental Health training in Mental Health leaders

Currently, **progress is occurring in a diversity of low- and middle-income countries¹⁰**. For example, Ghana has integrated local provisions with international human rights standards to create new mental health legislation, China and Sri Lanka are moving towards de-institutionalisation¹⁰. However, the resultant success of these changes relies not only on legislation, but on an integrated model that ensures adequate human, financial and mental health resources⁹.

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