Mental Health

CMED 311

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Disclaimer

- Minor modifications have been applied, and information added to Prof Randa's lecture, by Dr Rufaidah
- However, this did not change the overall objectives or content

Objectives

1. Define mental health (MH)
2. Discuss the global and national magnitude of mental illnesses
3. List and classify the factors contributing to the occurrence of mental illnesses
4. Define stigma and explain its consequences on mentally ill patients, their families and treatment outcome
5. Provide reasons for the integration of MH in PHC
6. Discuss the prevention and control strategies for MH in KSA

Definition of mental health

- State of successful performance of mental function,
- resulting in productive activities,
- fulfilling relationships with people, and
- the ability to adapt to change and
- to cope with adversity”

Surgeon General David Satcher, 1999

Definition of mental illness

- The suffering, disability or morbidity due to mental, neurological and substance use disorders, which can arise because of a variety of factors:
  - genetic
  - biological
  - psychological
  - adverse social conditions
  - environmental

Source: World Health Organization. Investing in mental health: evidence for action. Geneva: World Health Organization, 2013.

Achieving positive mental health

Structural factors:

- satisfactory living conditions,
- housing,
- employment,
- transport,
- education

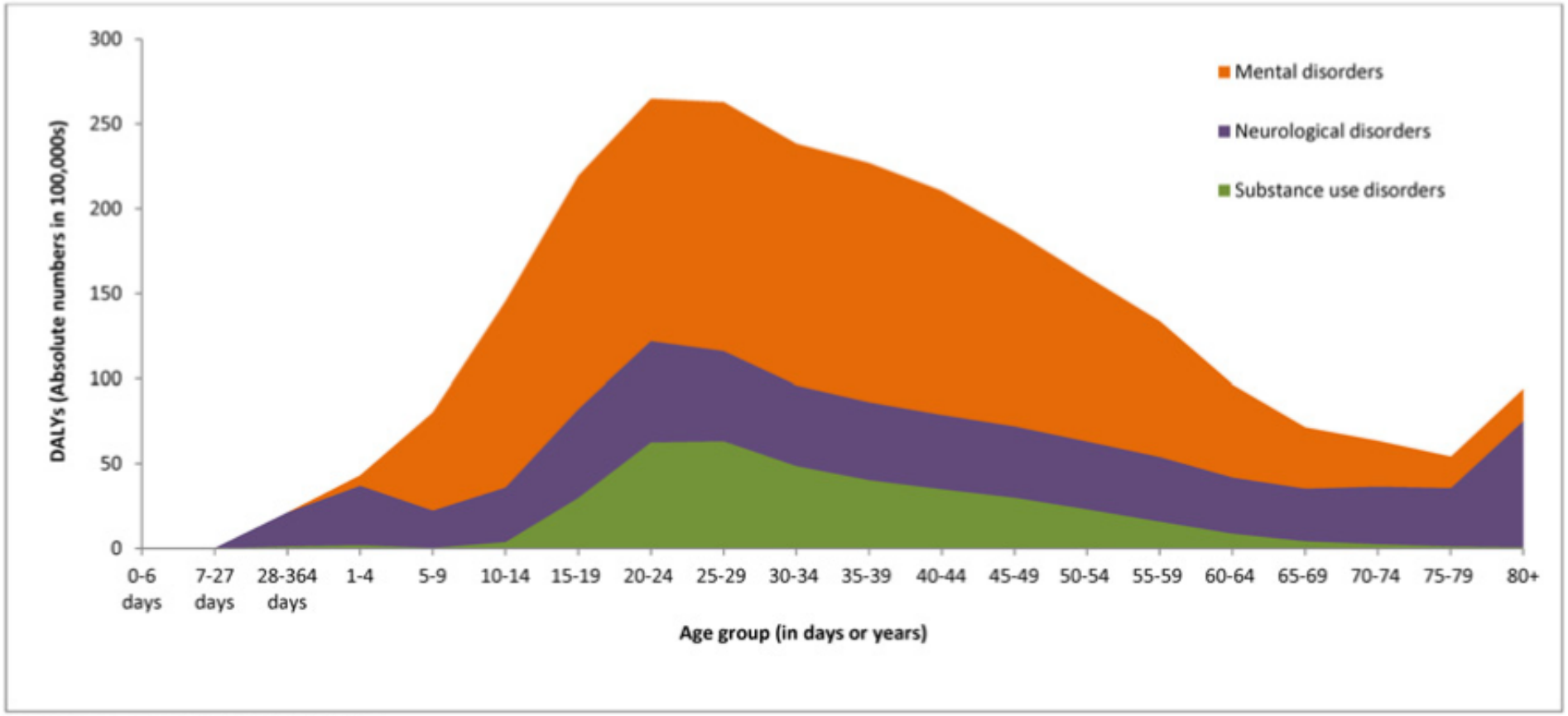
Individual factors:

- resiliency,
- ability to cope with demands and pressure of life

Community factors:

- sense of belonging,
- social support

Global Burden of Mental Illness

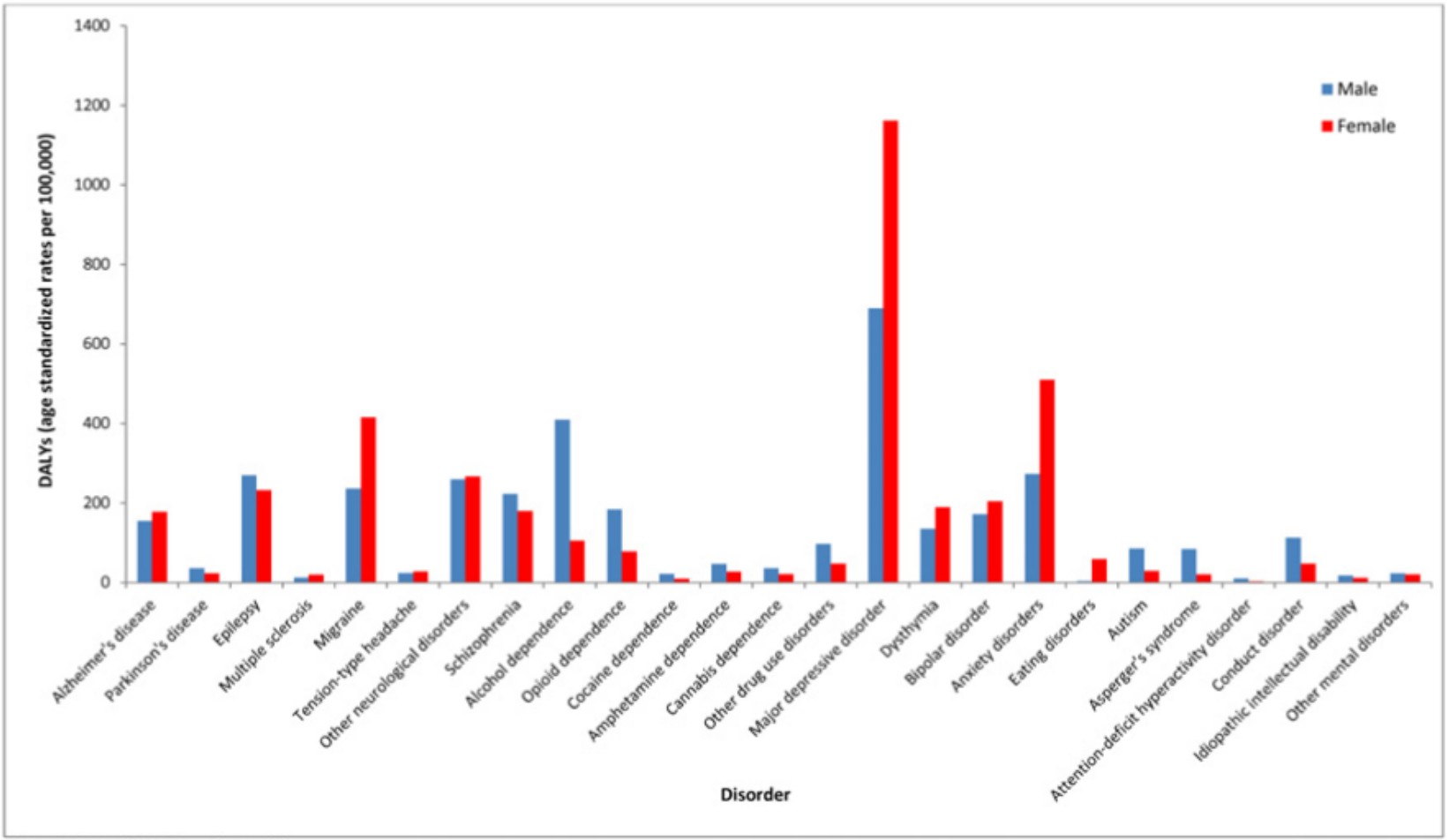


Note: DALYs = disability-adjusted life years.

Fig 1. Absolute DALYs Attributable to Mental, Neurological, and Substance Use Disorders, by Age, 2010.

Source: Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T. The global burden of mental, neurological and substance use disorders: an analysis of the Global Burden of Disease Study 2010. Plos One 2015; 10(2): e0116820

Global Burden of Mental Illness

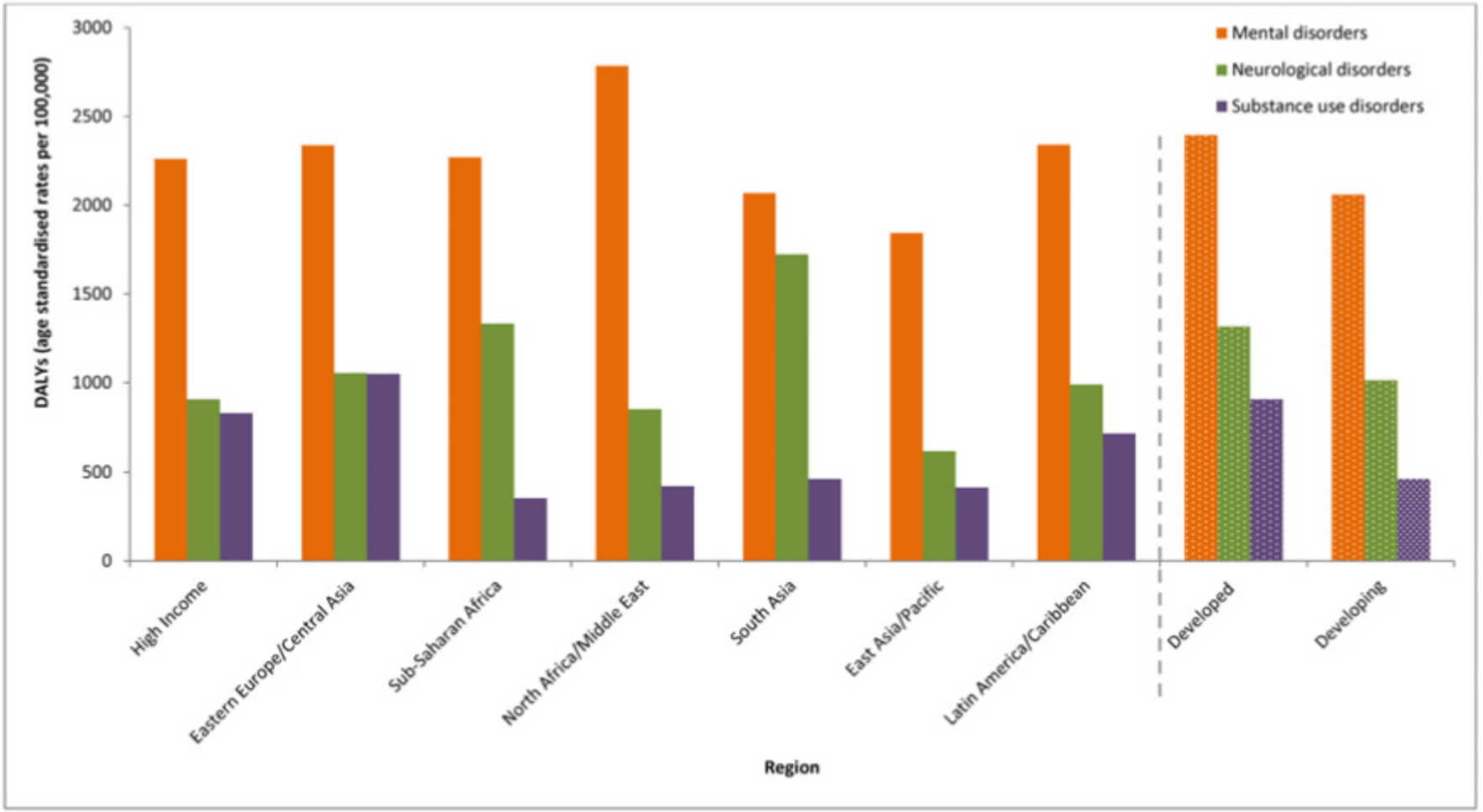


Note: DALYs = disability-adjusted life years.

Fig 2. Age-Standardized DALY Rates Attributable to Individual Mental, Neurological, and Substance Use Disorders, by Gender, 2010.

Source: Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T. The global burden of mental, neurological and substance use disorders: an analysis of the Global Burden of Disease Study 2010. Plos One 2015; 10(2): e0116820

Global Burden of Mental Illness

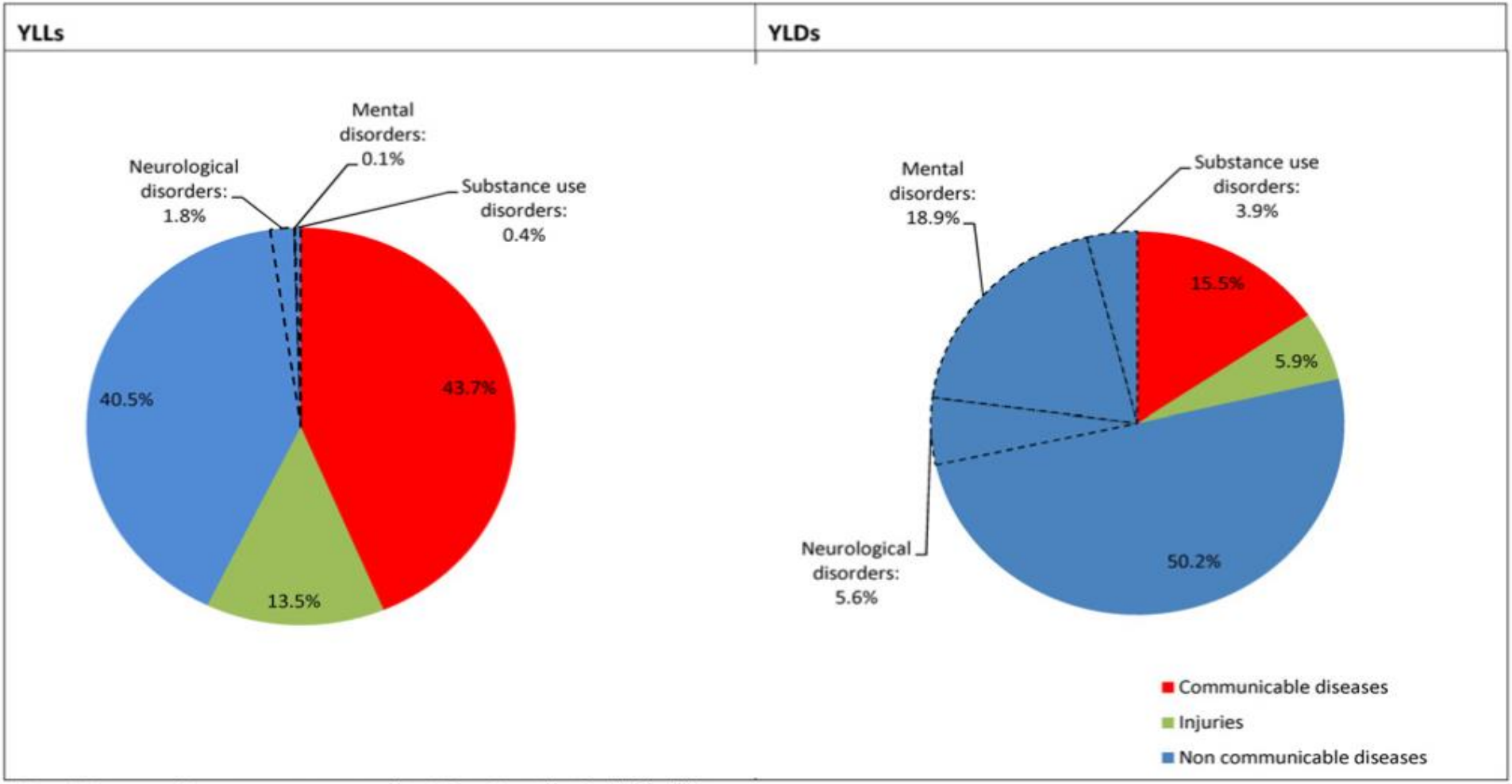


Note: DALYs = disability-adjusted life years.

Fig 3. Age-Standardized DALY Rates Attributable to Mental, Neurological, and Substance Use Disorders, by Region, 2010.

Source: Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T. The global burden of mental, neurological and substance use disorders: an analysis of the Global Burden of Disease Study 2010. Plos One 2015; 10(2): e0116820

Global Burden of Mental Illness



Note: YLLs = years lost to premature mortality; YLDs = Years lived with disability

Fig 4. Proportion of Global YLDs and YLLs Attributable to Mental, Neurological, and Substance Use Disorders, 2010.

Source: Whiteford HA, Ferrari AJ, Degenhardt L, Feigin V, Vos T. The global burden of mental, neurological and substance use disorders: an analysis of the Global Burden of Disease Study 2010. Plos One 2015; 10(2): e0116820

Consequences of Mental Illnesses

- Likely to increase in the future (ageing, low mortality, technologies)
- Disabling
- Stigmatizing
- Family effects (changes to adapt)
- Costly
- Economic loss and drift to poverty
- Burden on healthcare system

Stigma

Stigma is defined as "a cluster of negative attitudes and beliefs that make the general public to fear, reject, avoid, and discriminate against people with mental illness."

Stigma is a gap between actual identity (who they are) and virtual identify (what people think they are)

Impact of stigma

- Limits access to quality healthcare
- leads to concealment or denial of symptoms
- Prevents adherence to treatment
- Inaccurately affects patients' beliefs about what is wrong with their health
- lowers patient's self-esteem and negatively affects self-perception and self-care

Impact of stigma

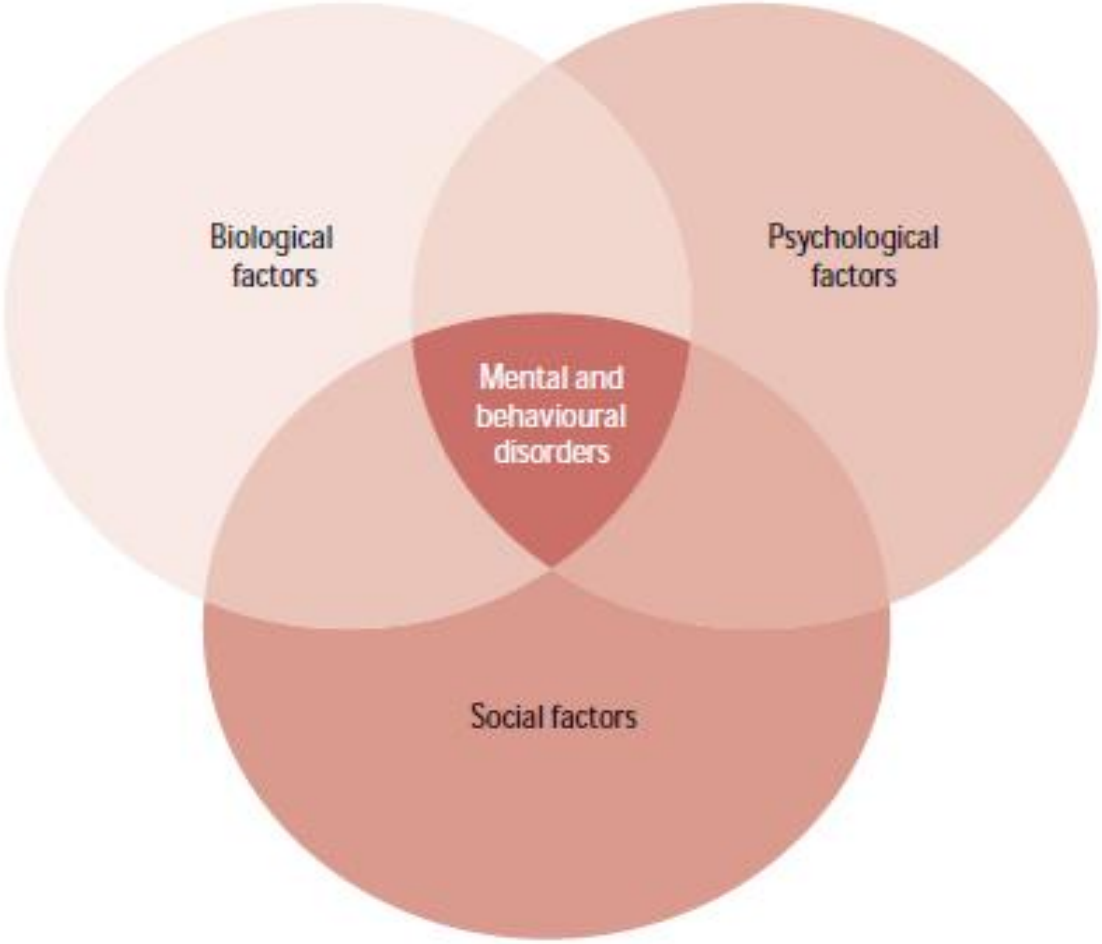
- It negatively affects the attitudes of health care providers
- Increases isolation of patients and their families
- Contributes to the economic conditions that influence poor outcomes
- Limits the community's response to illness
- Limits the formation of nonprofit groups for support

Stigma reduction

Stigma will lead to negative discrimination

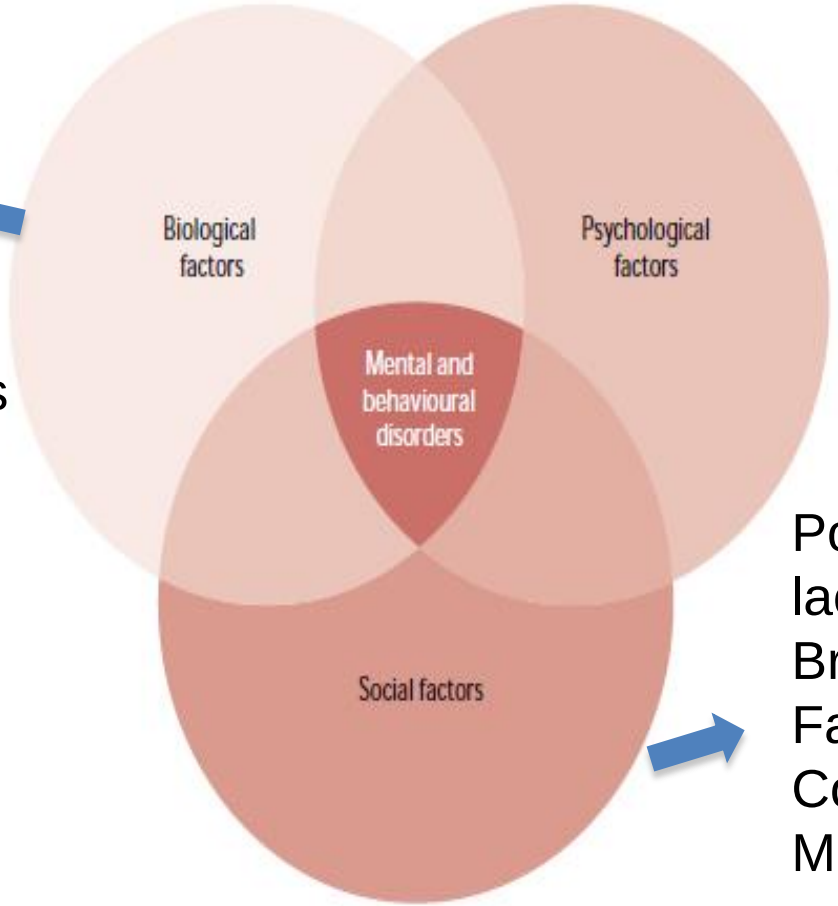
- An important aspect of mental health promotion involves
  - dispelling myths and stereotypes associated with vulnerable groups
  - providing knowledge of normal parameters
  - increasing sensitivity to psychosocial factors affecting health and illness
  - enhancing the ability to give sensitive, supportive, and humanistic health care.

Factors Contributing to Mental Illness (bio-psycho-social)



Factors contributing to mental illnesses

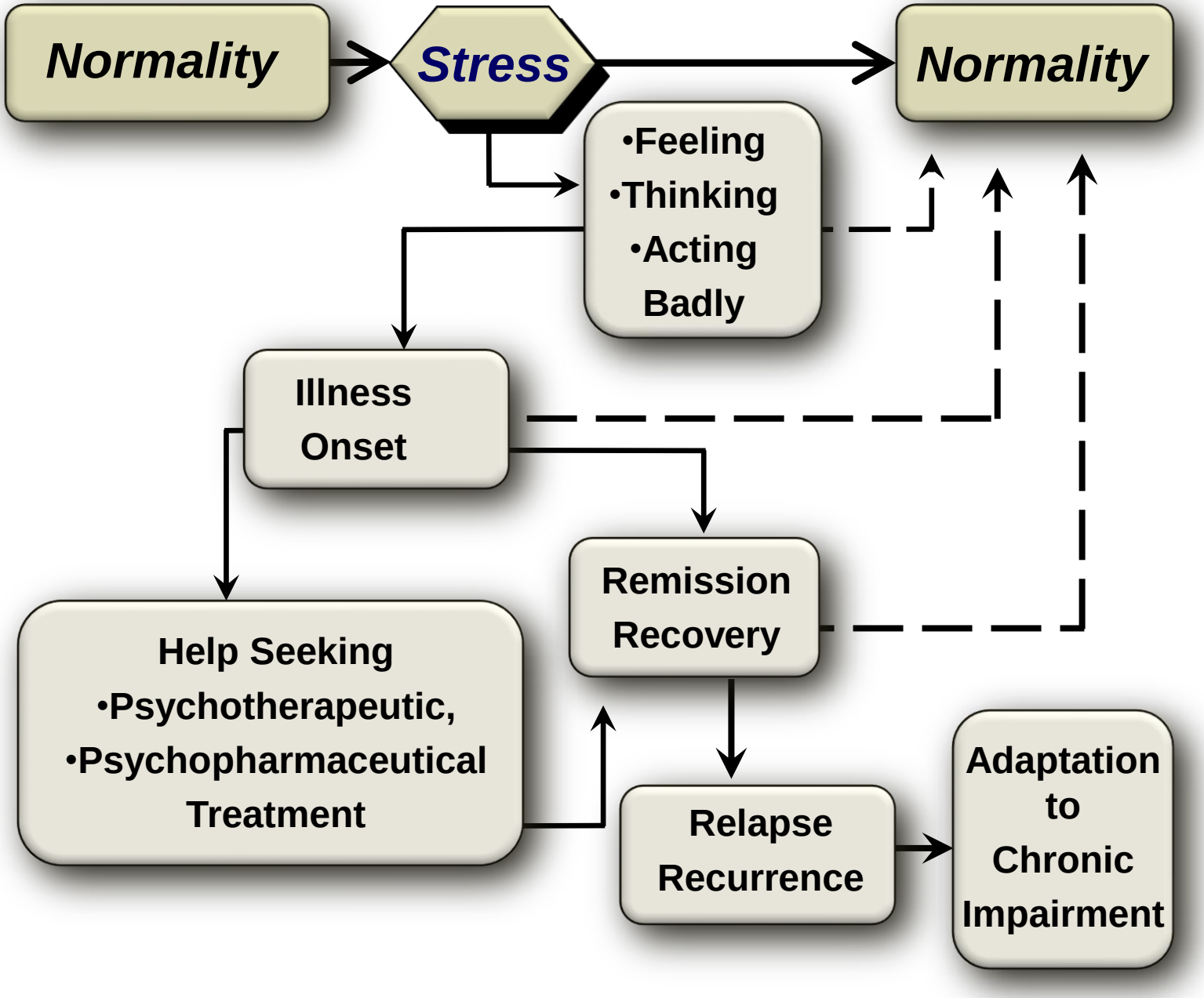
Age
Sex
Major physical diseases



Coping skills
Low self-concept and self-esteem

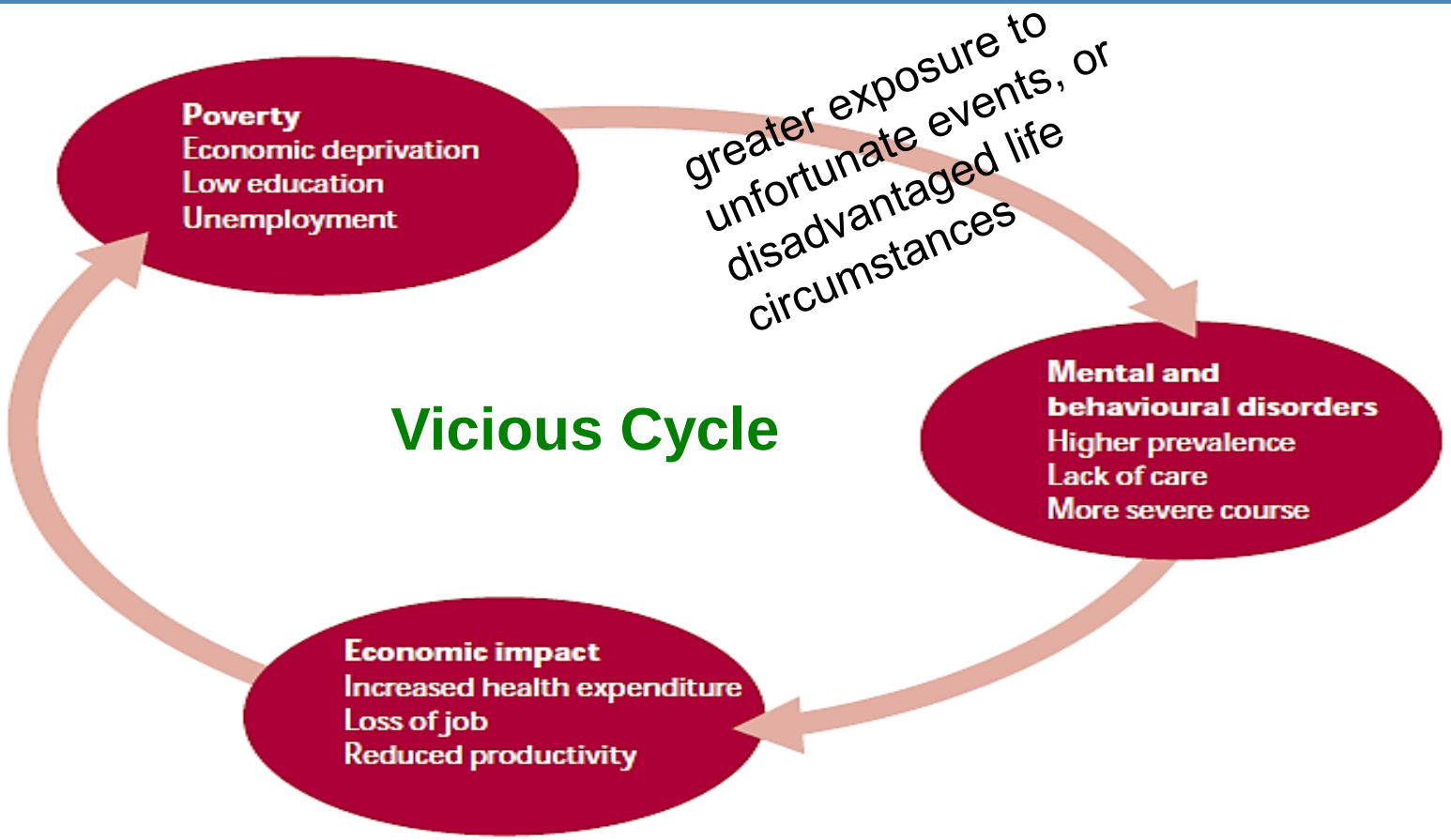
Poverty
lack of social support
Broken homes
Faulty parenting
Conflicts and disasters
Major life events

- Most of mental illnesses have their roots during the childhood period
- Interaction between biological, psychological and social factors in the development of mental disorders



Career model of mental illness *(Carol S. Aneshensel. Handbook of sociology of mental illnesses.)*

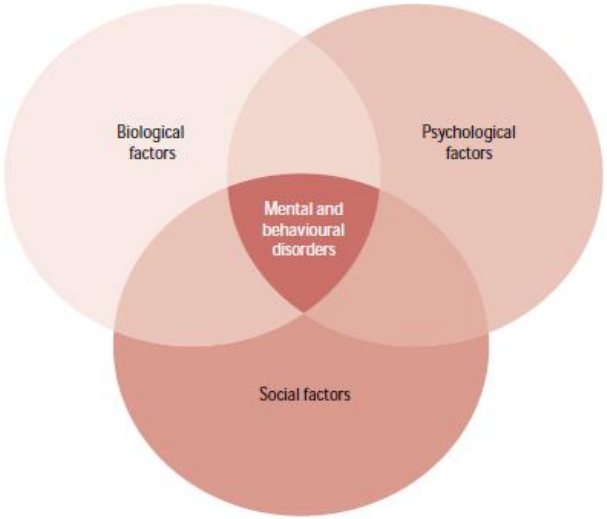
The link between poverty and mental illnesses



Mental disorders are disproportionately present among the poor

Primary prevention: Exerting control over contributing factors

Age
Sex
Major physical diseases



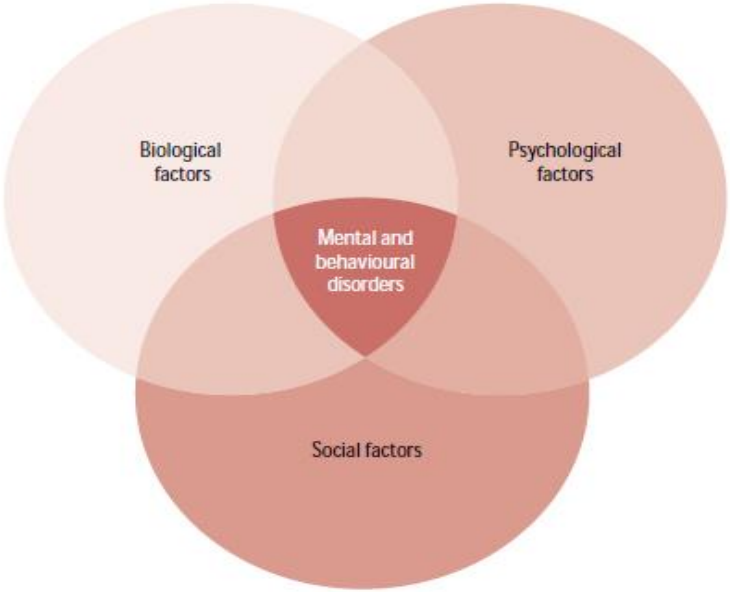
Coping skills
Low self-concept and self-esteem

Poverty
Social deprivation
Broken homes
Faulty parenting
Conflicts and disasters
Major life events

Question of practicality:
How many of the factors can be effectively addressed?
What conditions could be prevented at primary level?
How many conditions could be prevented at primary level?

Primary prevention: Exerting control over contributing factors

Age
Sex
Major physical diseases



Coping skills
Low self-concept and self-es

RESILIENCE

Poverty
Social deprivation
Broken homes
Faulty parenting
Conflicts and disasters
Major life events

- Little or no evidence about the primary prevention of depression, schizophrenia, cognitive impairment of idiopathic origin
- Possibility of primary prevention of a proportion of cases related to childhood behavior disorders and substance abuse

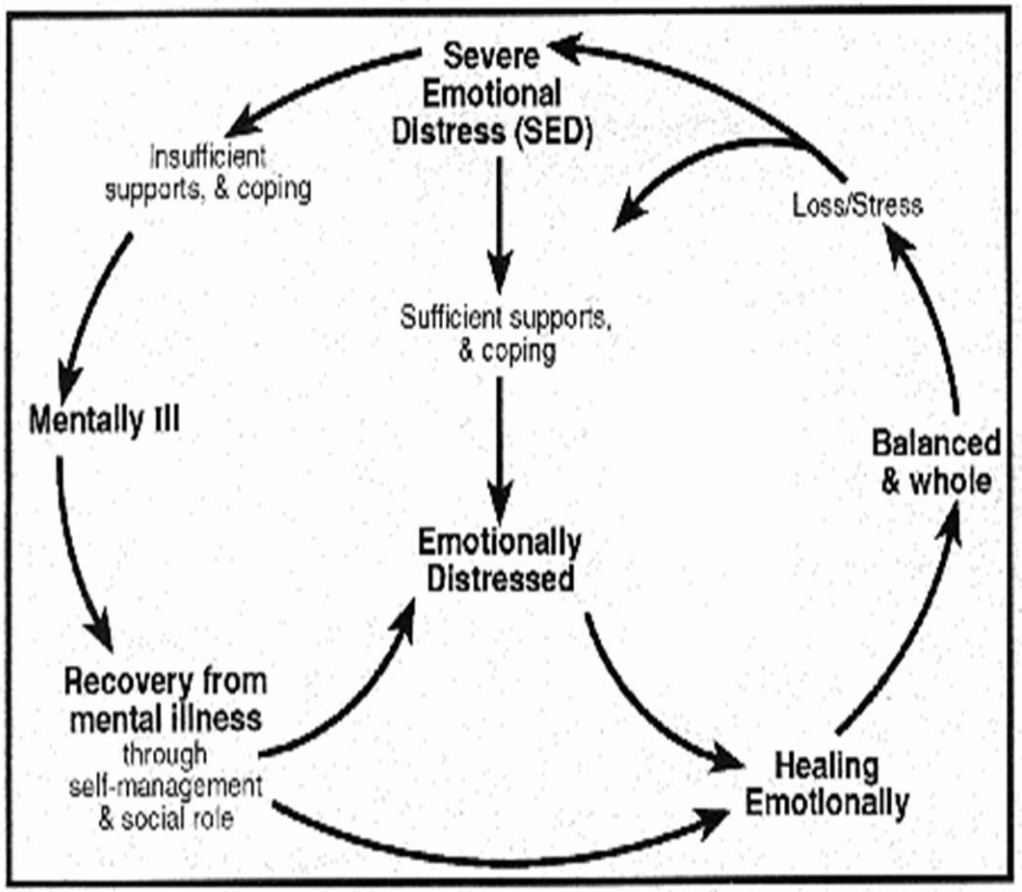
Challenge of primary prevention with respect to MH

- Controlling contributing factors for mental illness is difficult (many non-modifiable factors)
- A major contributing factor that MAY be controlled at the public level would be poverty and social disadvantage
- **Primary prevention at the government/community levels:**
  - Provide proper health and social services to the under-served
  - Spread education and awareness about mental illnesses in the community
- Most of the available measures are secondary prevention:
  - Early Rx; increase access; financial protection; social support

Secondary prevention

- Early detection
- Appropriate management
- Follow up
- Support component

PROMOTE RECOVERY
PREVENT RELAPSE



Empowerment Model of Recovery from Mental Illness
by Daniel B. Fisher, M.D., Ph.D. and Laurie Ahern
©1998 National Empowerment Center, Inc.

Principles of treatment

- Early identification of the disorder to ensure good prognosis
- Provide care at PC supported by referral (integrate MH into PC)
- Limit institutionalization and shorten its duration
- Collaboration with other sectors for support and integration:
  - **Education:** measures to complete at least primary education in friendly schools
  - **Employment:** gainful employment in a work environment free from discrimination
  - **Housing:** subsidiary cost, prevent discrimination in location of housing or geographic segregation
  - **Social development/affairs:** welfare coverage
  - **Criminal code:** no incarceration of mentally ill and providing mental services to prisoners

WHO suggested method for effective secondary prevention of mental illness

Integrating mental health services to primary care services

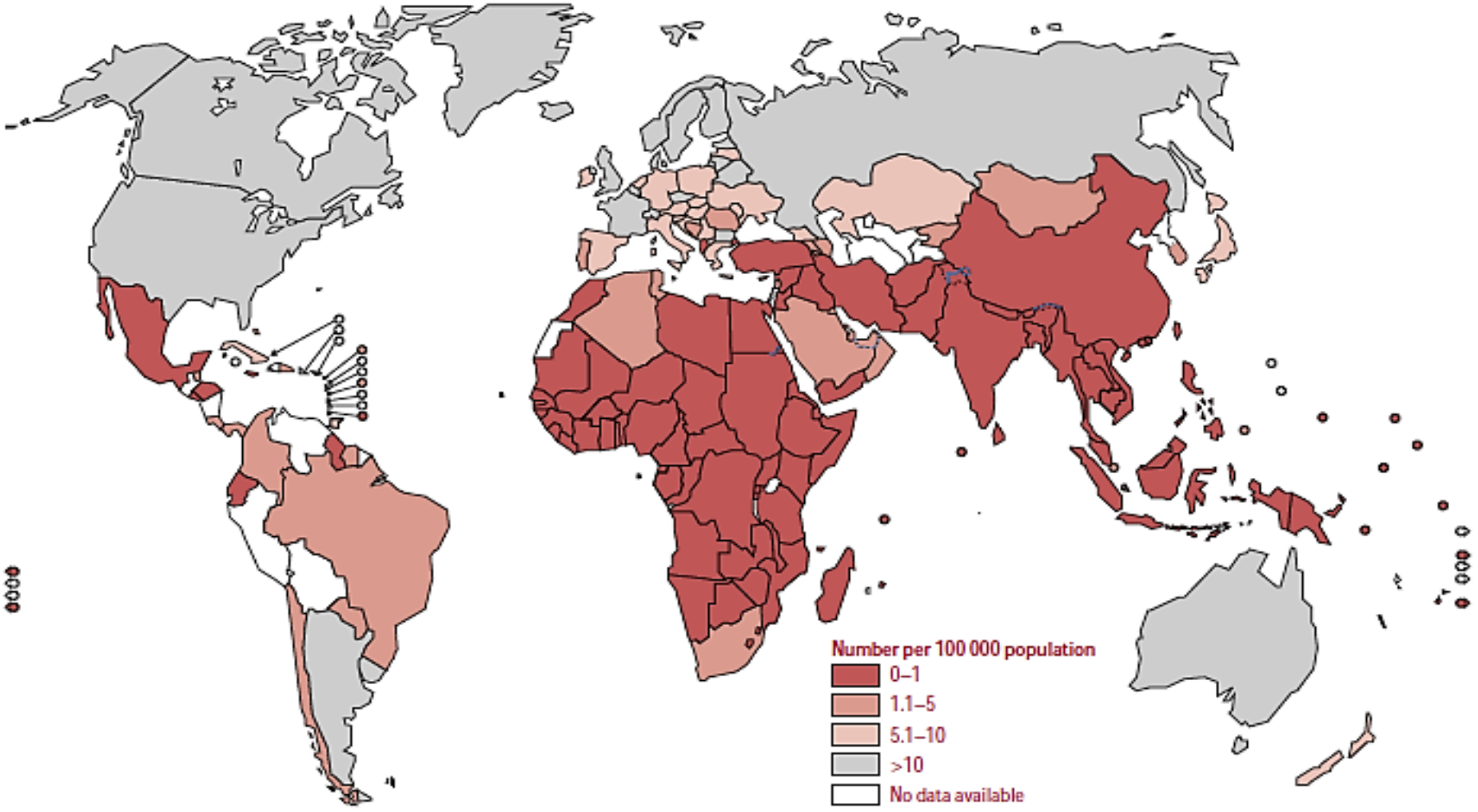
Integration of mental health into primary health care

- Worldwide, only a handful of people who need mental health (MH) treatment can have access to services
- It is more useful to care for MH through primary care (PC) and community-based services; close large mental institutions
- in 2008, WHO in collaboration with World Organization of Family Doctors (WONCA) developed a report on integrating MH into PC
- PC services are easier to provide; train PC workers in MH services
- Integration into PC is a cost-effective way to narrow the gap in mental health treatment

Integration of mental health (MH) into primary health care: Justification

- **It is affordable and cost effective** (<$ than Psychiatrists; specialists)
- **Inter-relationship between physical and mental disorders;** *bio-psycho-social approach* => better outcome
- **High burden of mental disorders** (disproportionate to specialized care)
- **PC for MH increase access to care** (closer to home; long-term follow)
- **Treatment gap for mental disorders is big** (gap 32% - 78%)
- **Reduces stigma and discrimination;** reduce human rights violation
- **It generates desirable outcomes** (linked to secondary services)

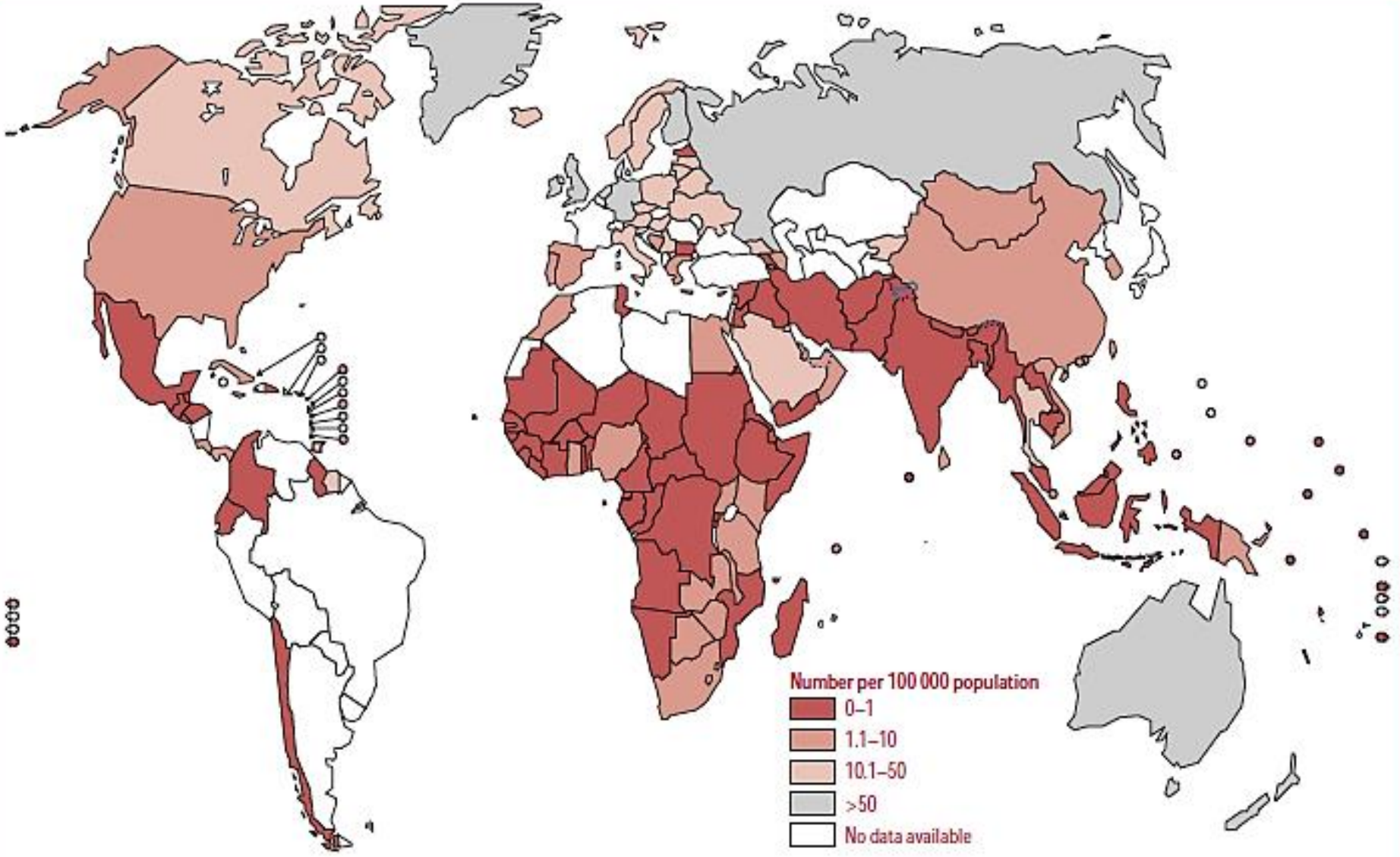
Figure 4.4 Number of psychiatrists per 100 000 population, 2000[a]



[a] Based on information from 177 Member States.

Source: *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization.

Figure 4.5 Number of psychiatric nurses per 100 000 population, 2000[a]



[a] Based on information from 157 Member States.

Source: *Mental health resources in the world. Initial results of Project Atlas* (2001). Geneva, World Health Organization.

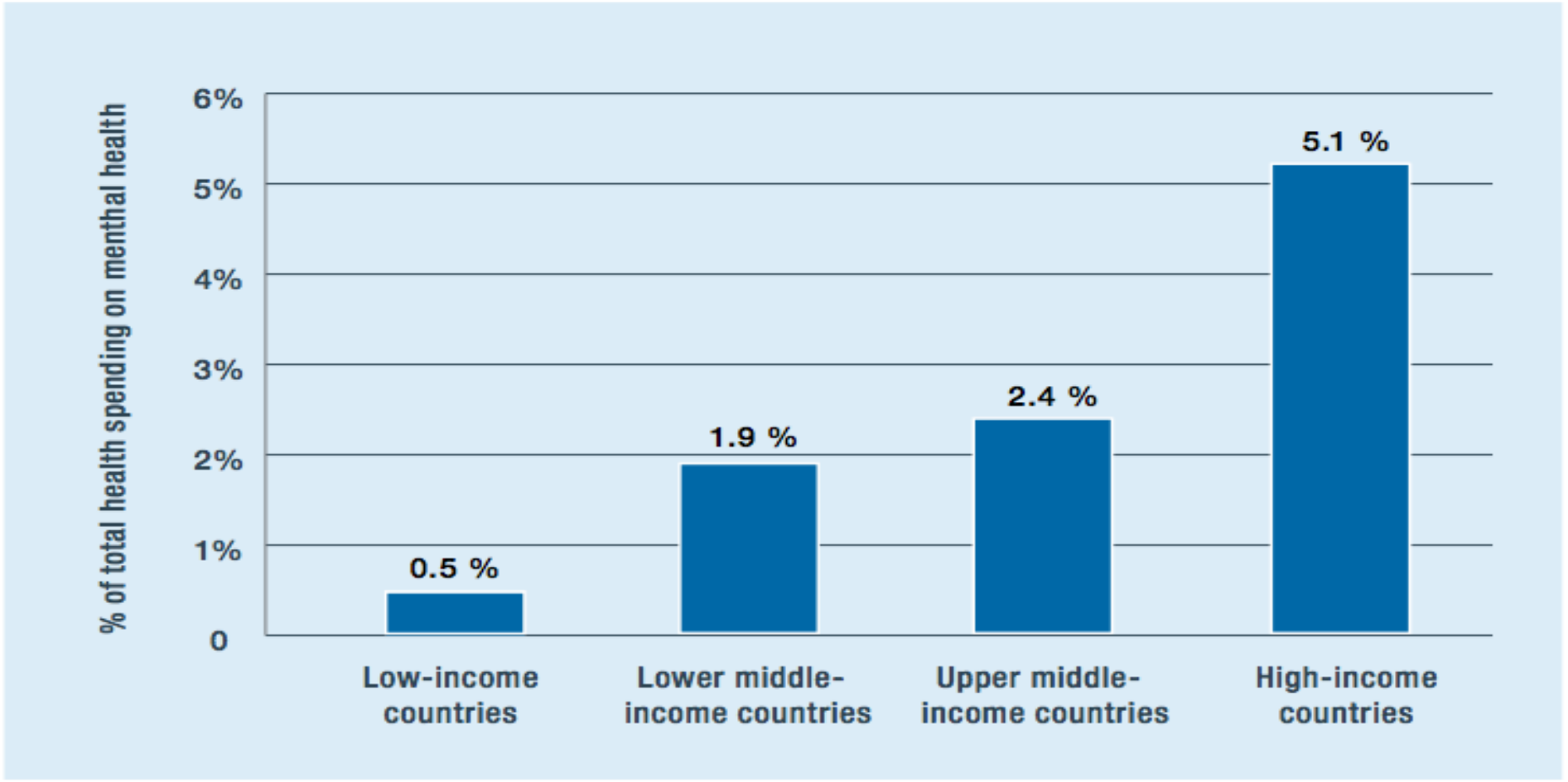
WHO's Optimal Mix of Services for MH

Source: Integrating mental health in PHC, WHO - 2008

Integration of mental health into primary health care: Main strategies

- Developing policy to incorporate mental health care into PC
- Advocacy to improve attitudes and behavior regarding mental health care
- Training of PC workers in screening for mental disorders
- Make use of resources: specialists and facilities readily available to support PC physicians
- Access of PC physicians to essential psychotropic medications
- Presence of a mental health-service coordinator in PC clinics
- Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers (**informal services**)
- Adequate funding for necessary staff and mental health specialists

Worldwide spending on MH Services, 2013



Source: World Health Organization. Investing in mental health: evidence for action. Geneva: World Health Organization, 2013.

Mental Health and its Services in Saudi Arabia

Mental Health In Saudi Arabia

- Attitudes towards MH are driven by culture and religion
- Up through early 1980's involved folk healing: exorcism; cautery; topical herbs
- Problems with substance abuse were hidden and did not receive attention until the late 1990's

Mental disorders contributing to YLD & DALYS – KSA, 2010

YLD (n=8 out of top30)

1. Major depressive disorders (78%)
5. Anxiety disorders (165%)
8. Drug use disorders (101%)
11. Migraine (107%)
15. Bipolar disorders (108%)
16. Schizophrenia (136%)
20. Dysthmyia (103%)
21. Epilepsy (65%)
23. Conduct disorders (46%)
25. Eating disorders (114%)

DALYs (n=5 out of top 30)

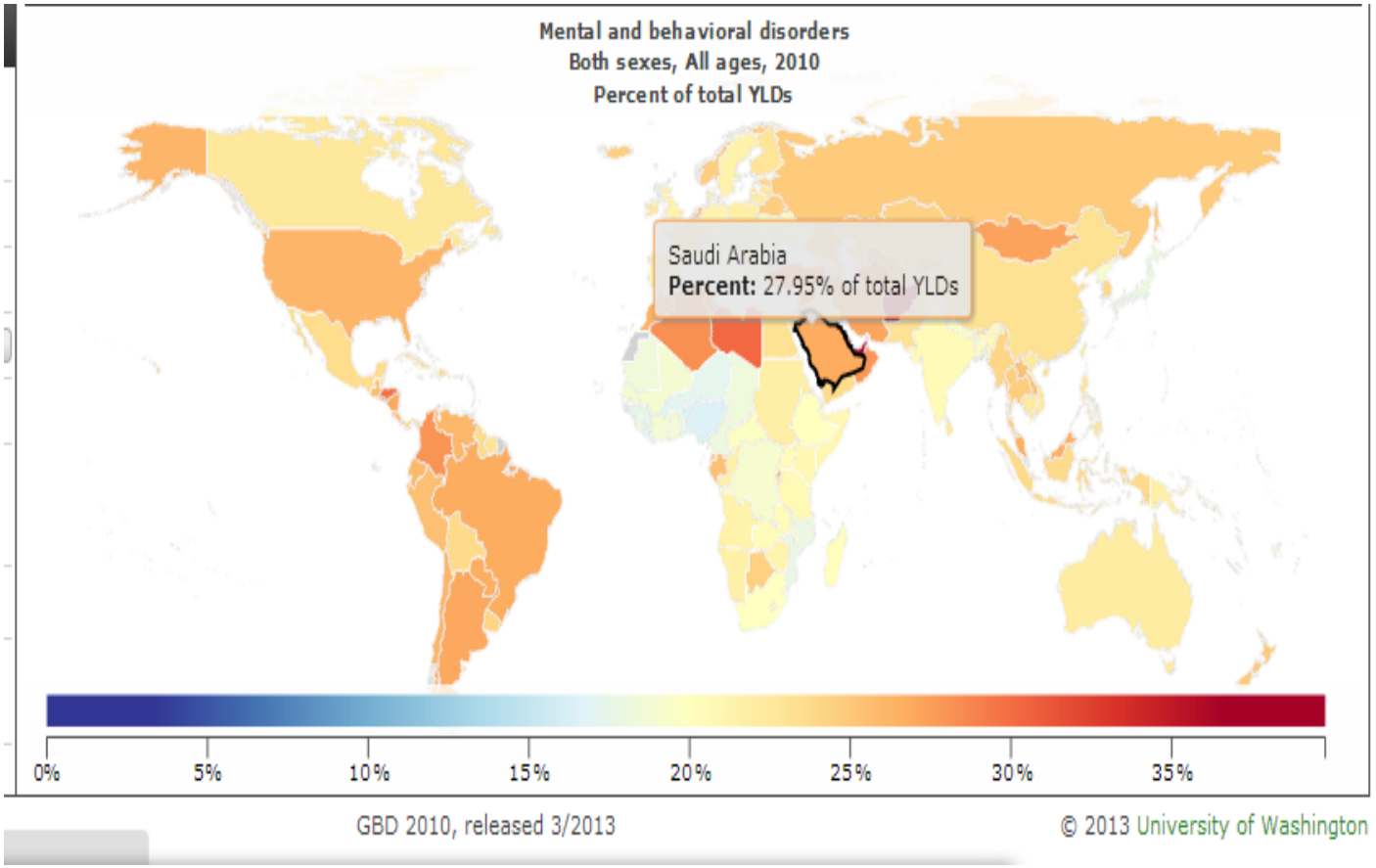
3. Major depressive disorders (78%)
10. Anxiety disorders (165%)
11. Drug use disorders (122%)
21. Migraine (107%)
24. Bipolar disorders (108%)
27. Epilepsy (55%)
28. Schizophrenia (138%)

Percentage increase between 1990 and 2010 and rank out of the top 30 conditions

Contribution of mental illness to YLDs – KSA, 2010

Mental and behavioral disorders:

Schizophrenia
Depression
Anxiety
Drug/alcohol
Eating disorders
Pervasive developmental disorders
Childhood behavior disorders

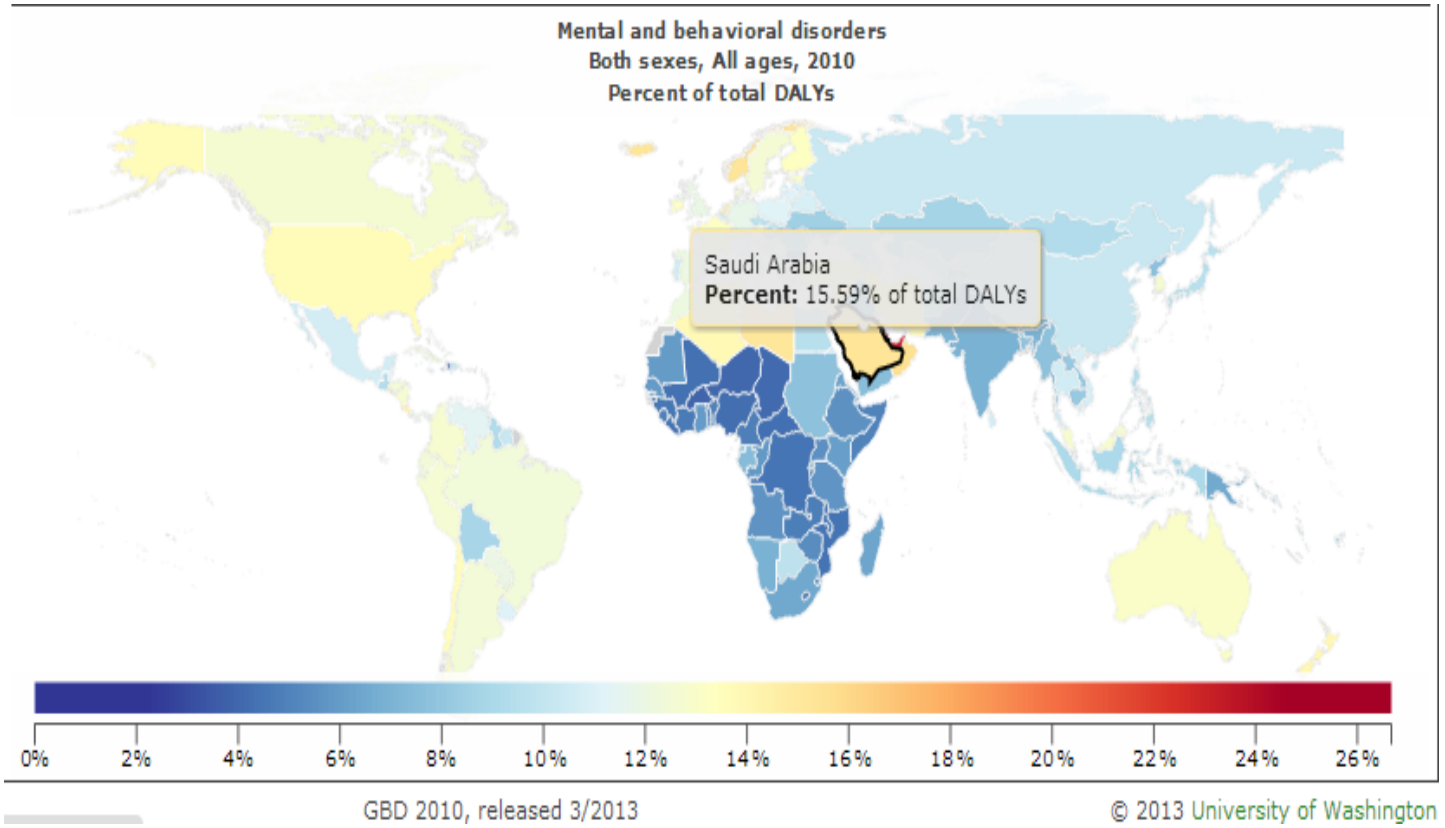


Rate: 3,061.19 per 100,00

Contribution of mental illness to DALYs – KSA, 2010

Mental and behavioral disorders:

Schizophrenia
Depression
Anxiety
Drug/alcohol
Eating disorders
Pervasive developmental disorders
Childhood behavior disorders



Rate: 3,204.65 per 100,00

Mental Illness In Saudi Arabia

- Scarce population-based data
- Mostly assess depressive symptoms
- Depressive symptoms ranges from 33% - 39% (studies only conducted on elderly or school populations)
- Anxiety symptoms 14% - 49% (in school populations)
- **PC setting:** 19% somatization, 20% depression, 14% GAD, 10% panic disorder

Mental disorders seen in general clinics in KSA

- Al-Khobar, 22% of health clinic patients had mental disorders such as depression and anxiety, however only 8% were diagnosed.
- In Riyadh, 30% to 40% of those seen in primary care clinics had mental disorders and again, most were not diagnosed.
- In central Saudi Arabia, 18% of adults were found to have minor mental morbidities

Low detection rate

Source: Integrating mental health in PHC, WHO - 2008

More Recent Studies In Saudi Arabia

The Saudi National Mental Health Survey

- This is the first population-based survey to collect data on mental health
- Conducted on all regions in KSA
- Used the WHO Composite International Diagnostic Interview (CIDI)
- Pilot was conducted in 2011; Actual study in 2013
- As of now (2018) no results published yet

Shahab M, Al-Tuwaijri F, Bilal L, Hyder S, Al-Habeeb AA, Al-Subaie A, Mneimneh Z, Pennell BE, Sampson N, Kessler RC, Altwaijri Y. The Saudi National Mental Health Survey: Methodological and logistical challenges from the pilot study. Int J Methods Psychiatr Res 2017; 26(3): Epub 2017 May 12.

Mental Health Services Approach in KSA

- Encourage PC services is the first line

=> If cannot handle, referral to **secondary services** (specialized psychiatric clinics in general hospital)

=> If cannot handle, referral **tertiary services** (specialty psychiatric hospital or teaching hospital)

- Directly to secondary or tertiary through ER services (without referral)
- Private clinics (out of pocket services)

Saudi Arabia integrated MH into PC

Saudi Arabia: integrated primary care for mental health in the Eastern Province. Primary care physicians provide basic mental health services through primary care, and selected

primary care physicians, who have received additional training, serve as referral sources for complex cases. A community mental health clinic provides complementary services, such as psychosocial rehabilitation. As a result of training and ongoing support by mental health specialists based at the community mental health clinic, physicians' knowledge and management of mental disorders have improved. Many people with mental disorders, who otherwise would have been undetected or hospitalized, are now treated within the community.

Source: Integrating mental health in PHC, WHO - 2008

Integration of mental health into PHC: experience of Eastern Province (2003 – 2006)

Training of PHC physicians at two levels of skills

- First level (one month – 17 PHC physician): basic training in mental health issues, diagnosis of common mental disorders, appropriate use of psychotropic medications, and provision of brief psychotherapeutic interventions.
- Second level (2 PHC physicians): training is more intensive and advanced, enabling graduates to manage more complicated mental health problems.

Source: Integrating mental health in PHC, WHO - 2008

Integration of mental health into PHC: experience of Eastern Province (2003 – 2006)

- **PHC (17-physicians):**
  - Provide mental health services,
  - Engage families in consultation
  - Provide families with information for patient support
  - Referral of complex cases

- **Community Mental Health Centres**
  - Two at province level
  - Referral source for complex cases
  - Diagnosis and treatment
  - Supervise PHC practitioners in the area

KSA allocates 4% of healthcare budget to mental illnesses; 78% is directed to mental hospitals (Mental health system in KSA. Neuropsychiatric Disease and Treatment 2013:9 1121–1135)

Source: Integrating mental health in PHC, WHO - 2008

Tertiary prevention

- Long term treatment
- Social and welfare support
- Care for in a community setting, day care centers
- Immediate care for crisis and relapse
- Long term stay in specialized hospital is the last option

Summary

1. Mental health is not being free of mental disorders
2. Mental illnesses are of considerable magnitude, likely to increase in the future and result in serious consequences to individuals and family
3. Mental illnesses in KSA contribute to 27.9% of YLD and 15.5% of DALYs
4. Mental illnesses adversely affect the life of people affected, place a significant burden on the country's economy and healthcare system
5. Stigma is associated with mental illnesses results in:
   - refusal of seeking care and delay recovery
   - limited access to quality care; increased isolation of patients and families, delayed recovery

Summary cont.

6. Mental illnesses result from the interaction of several factors and have its roots during the childhood period
7. KSA allocate 4% of healthcare budget to mental illnesses; 78% is directed to mental hospitals
8. Mental illnesses that form the main burden are not preventable at the primary level based on evidence
9. Most of childhood behavioral disorders are preventable at the primary level by good parenting, interactive schools and supporting social network
10. Mental health services are provided at PC, community hospitals, general hospitals and mental hospitals
11. Detection, treatment and follow up of mental illness is cost-effective in view of their presence in PC, shortage and cost of specialized care

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