Upcoming PGC Worldwide Lab

- Date: Friday, January 10, 2014
- Presenter:
  - **Ronald C. Kessler, Ph.D.**
  - McNeil Family Professor of Health Care Policy; Harvard Medical School
- Title: **The Global Burden of Mental Illness**
- Duration: 1 hour
- Start Time: 10:00am (EST); 7:00am (PST); 3:00pm (GMT); 4:00pm (CET)
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Upcoming PGC Worldwide Lab

- Date: Friday, February 14, 2014
- Presenter:
  - **Kerry Ressler, MD, Ph.D.**
  - **Emory University**
- Title: **Genes and Environment in PTSD**
- Duration: 1 hour
- Start Time: 10:00am (EST); 7:00am (PST); 3:00pm (GMT); 4:00pm (CET)

The Global Burden of Mental Illness

Ronald C. Kessler, PhD
McNeil Family Professor of Health Care Policy
Department of Health Care Policy
Harvard Medical School
January 10, 2014

The generations of psychiatric epidemiology

• Pre-1945	Key informant and treatment record studies
• 1945	World War II screening studies
• 1948 – 60	Two-stage clinical surveys (e.g. The Midtown Manhattan Study)
• 1960 – 80	Screening surveys (e.g. Americans View Their Mental Health)
• 1980 – 2000	Structured diagnostic interview surveys (e.g. ECA/NCS surveys)
• 2000 -	Structured-clinical interview surveys (WMH)

The core descriptive goals of WMH

To estimate…

- Prevalence of mental disorders
- Societal burdens of mental disorders
- Comparative burdens of physical and mental disorders
- Rates of unmet need for treatment
- Rates of treatment adequacy

The core analytic goals of WMH

To examine…

- Modifiable risk factors for onset and course of mental disorders
- Barriers to seeking treatment
- Predictors of treatment dropout
- Predictors of treatment adequacy

Core nosological goals

To support changes in DSM-V and ICD-11 by…

- Searching for evidence of taxonicity
- Examining effects of threshold variation on external validators

The social policy audiences of WMH

- Government policy makers
- Employers
- Citizens

The social policy messages of WMH

- Mental disorders are top illness-related cost drivers of impairment
- Safe and effective treatments are available
- Substantial barriers exist to treatment that require structural solutions
- Enhanced outreach and treatment are investment opportunities

The WMH study design

- Nationally or regionally representative household surveys
- Adults 18 and older
- Subsamples of spouses of target respondents
- Standardized interviewer training and monitoring
- Standardized face-to-face interviews

The WMH study design

- Sample of at least 5000 interviews per country
- Both CAPI and PAPI versions
- Shared training, quality control, and data processing protocols

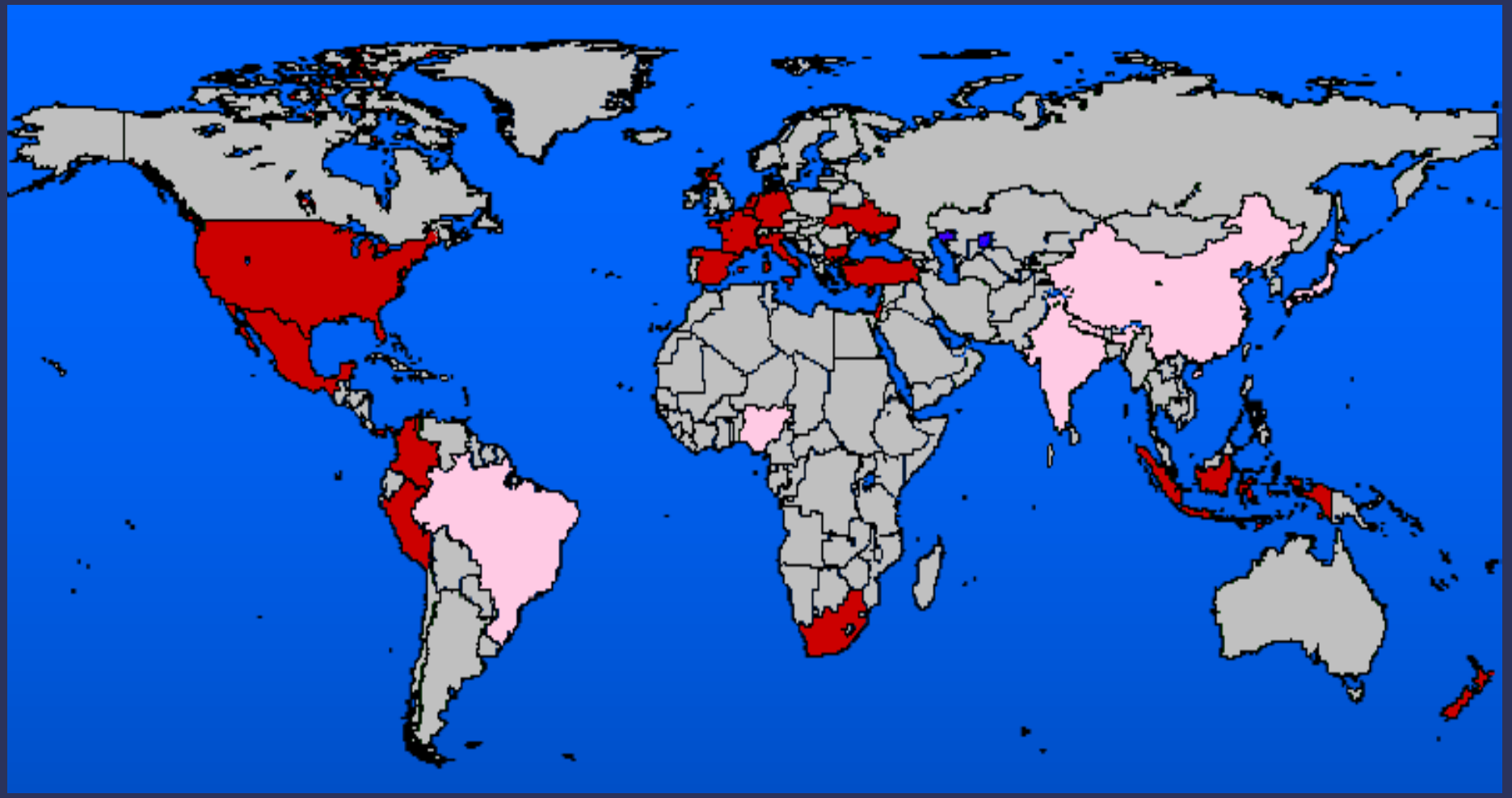
Unique aspects of WMH

- Large scale, worldwide
- Same design, translation methods, training, and quality control protocols
- CIDI enhancements
- Clinical follow-up

WHO World Mental Health (WMH) Survey Consortium

- 28 countries
- All regions of the world
- National household samples of at least 5,000 people
- A total of over 200,000 interviews

WMH countries



Initial WMH findings

- Mental disorders are highly prevalent.
- They are often seriously impairing.
- They affect not only the people with the disorders, but also their families, friends, and coworkers.

Lifetime prevalence in selected WMH countries

Country	Anxiety	Mood	Substance	Any
Brazil	17%	15%	16%	36%
Canada	21	10	20	37
Germany	10	17	21	38
Mexico	6	9	10	20
Netherlands	20	19	19	41
Turkey	7	7	0	12
USA	25	19	28	49

WMH definitions of severity

Severe	NAP, BPI, physiological substance dependence syndrome, serious suicide attempt, severe role impairment in multiple roles (GAF < 50)
Moderate	Any disorder with serious role impairment (GAF < 60)
Mild	Any other

Proportion of 12-month cases that are severe

I. Americas

Colombia, Mexico, United States	29-30%

II. Europe

Belgium, France, Germany, Italy, Netherlands, Spain, Ukraine	11-24%

III. Middle East and Africa

Lebanon, Nigeria	9-27%

IV. Asia

Japan, People's Republic of China (Beijing and Shanghai)	10-26%

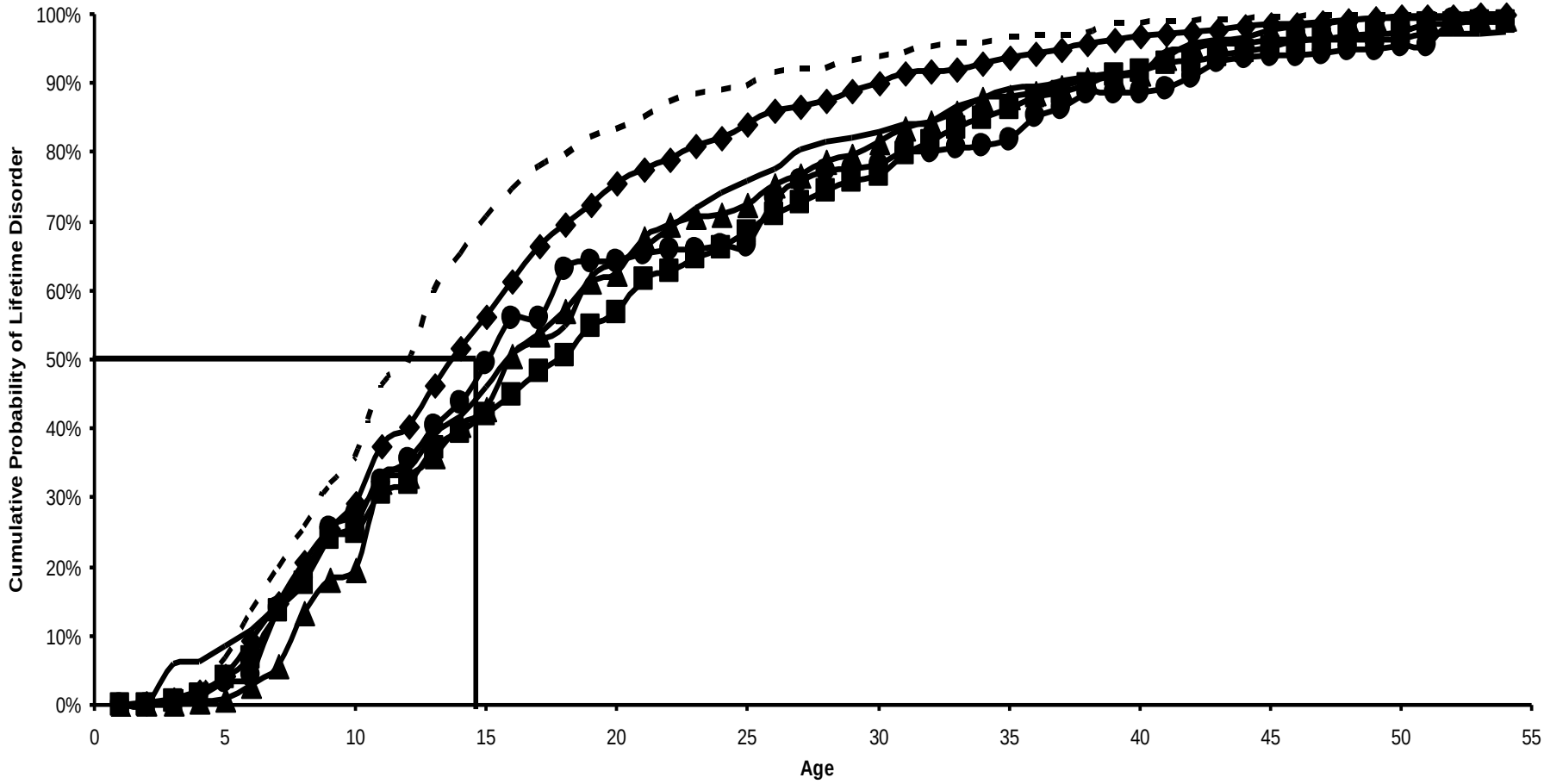
WMH severity and days out of role

Severe	32 - 81
Moderate	9 - 19
Mild	0 - 4

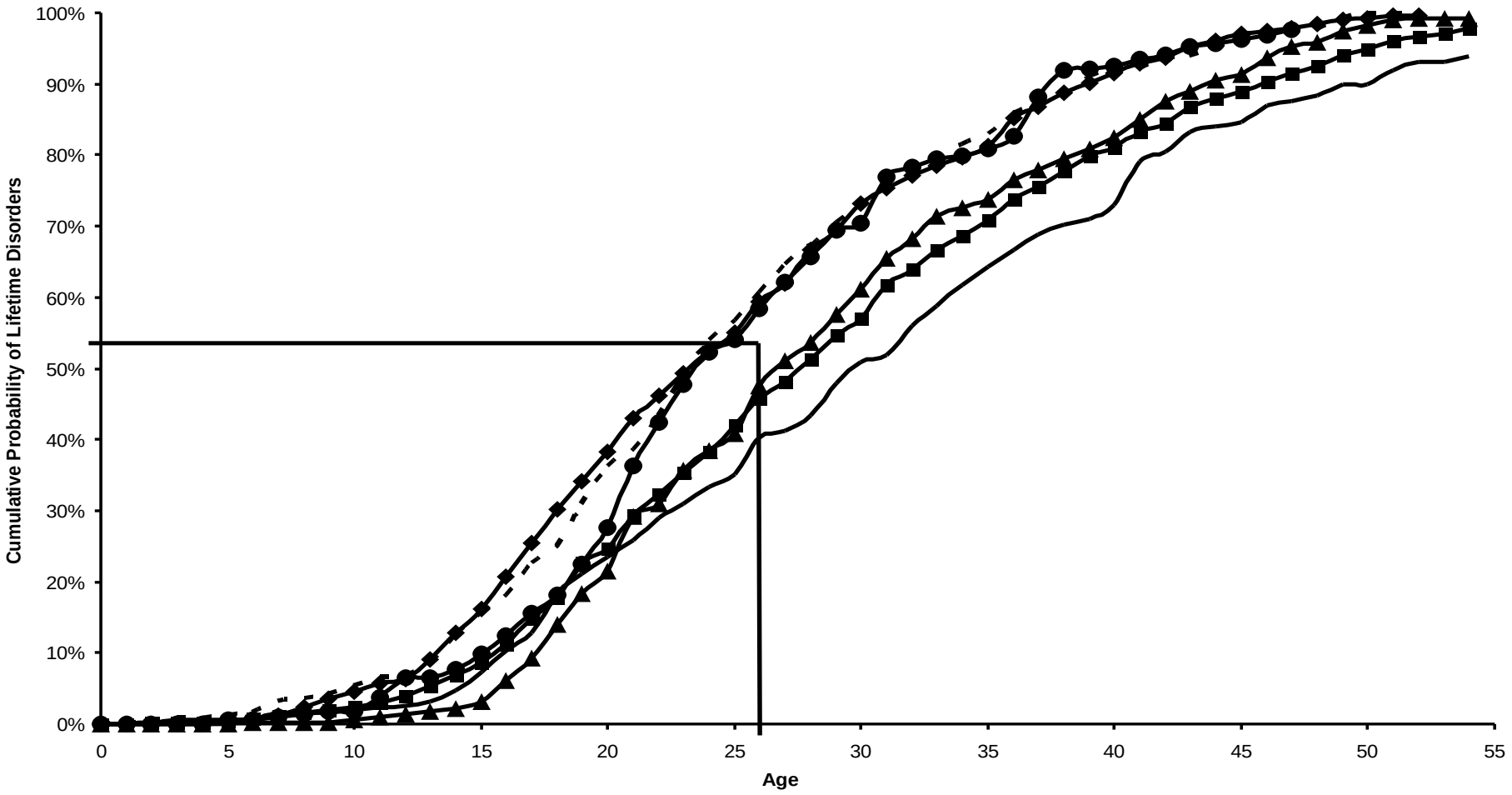
Initial WMH findings (cont.)

- The most serious mental disorders usually begin in childhood or adolescence.
- They are usually not severe when they begin.
- More typically, they become severe over time.

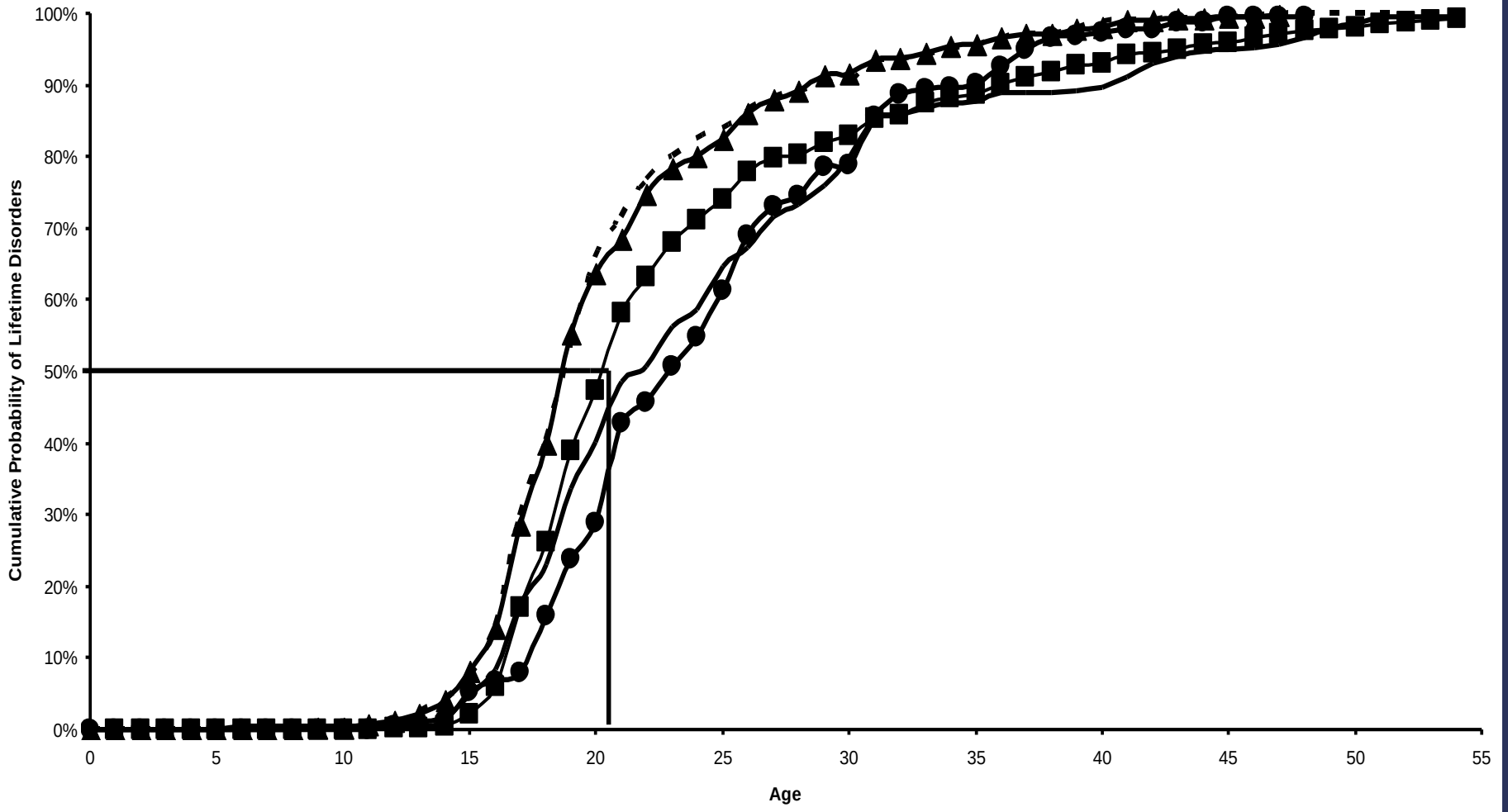
AOO distributions – anxiety disorders



AOO distributions – mood disorders



AOO distributions – substance disorders



Associations (odds-ratios) between 1992 illness severity and 2002 outcomes

	Hospitalization	Suicide Attempt	Any[1]
	OR	OR	OR
Severe	29.7*	11.7*	15.1*
Moderate	3.0*	2.9*	3.8*
Mild	2.7*	2.0	2.4*
Non-Cases	1.0	1.0	1.0

[1] Hospitalization, work disability, suicide attempt, or serious mental illness.

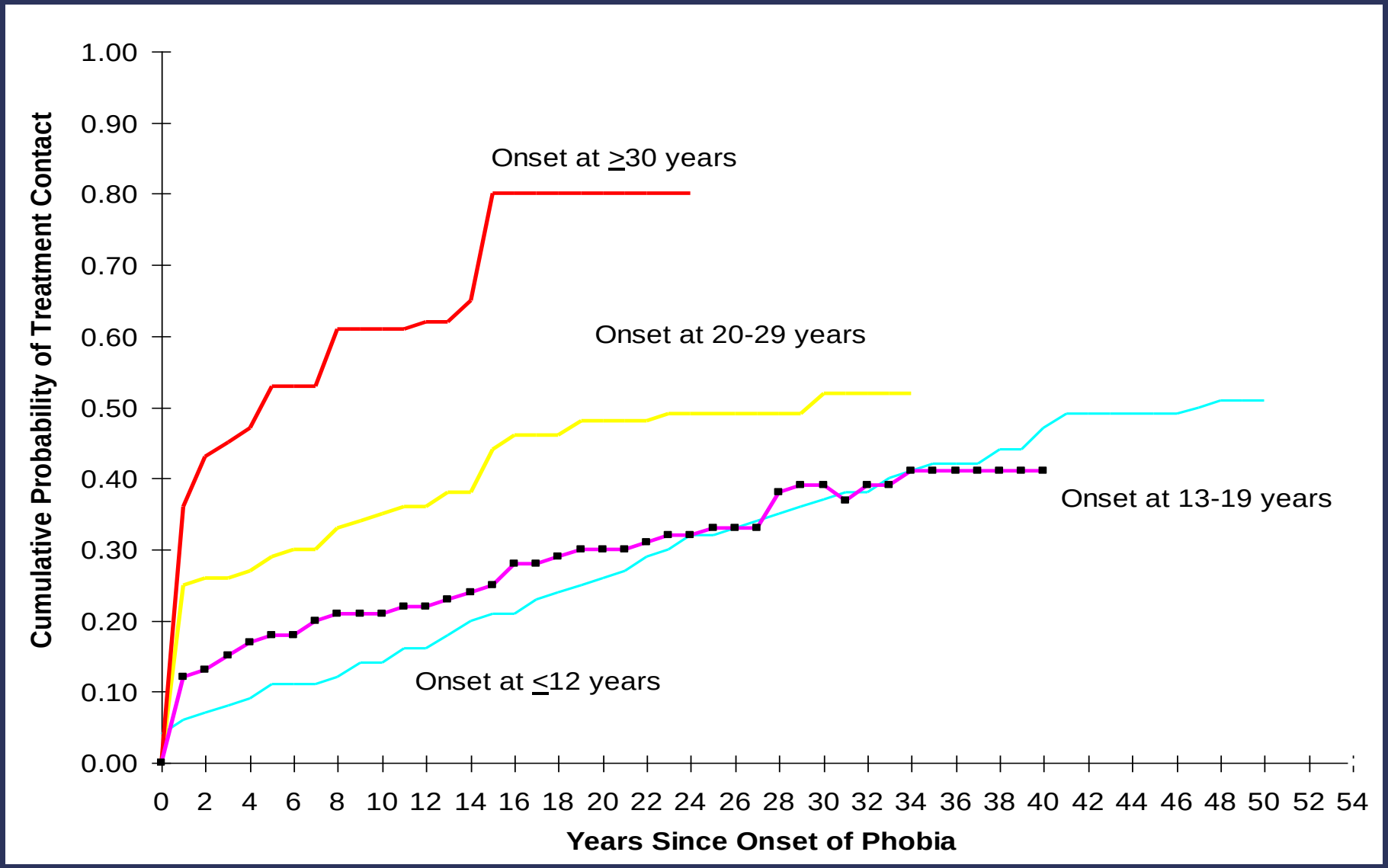
Initial WMH findings (cont.)

- Most chronic cases eventually get treatment.
- Treatment delays are pervasive.
- Treatment quality is often poor.
- Demonstration projects show that treatment quality can be improved.

Lifetime treatment percent and median years between onset and treatment

	Treatment %	Median Delay
Panic Disorder	70-90	1-4
GAD	60-82	4-6
Major Depression	63-92	5-8
Addictive Disorder	35-51	10-14

Speed of initial treatment contact by age at onset (phobias)



Adequacy of 12-month treatment by severity, US 2002

	Total Sample	Treatment Sample
	%	%
Severe	32.7	47.4
Moderate	14.5	35.0
Mild	10.3	28.8

Trends in US annual treatment 1992-2002

	1992	2002
	Total	Total
Specialty	3.9 %	6.2 %*
General medical	3.3	9.2 *
Human service	5.4	7.1 *

Trends in US annual treatment 1992-2002

	1992			2002		
	Total	Severe	Other	Total	Severe	Other
Specialty	3.9 %	18.1 %	2.6 %	6.2 %	20.7 %	4.8 %*
General medical	3.3			9.2 *		
Human service	5.4			7.1 *		

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General medical	3.3	14.6	2.6	9.2 *	31.9 *	6.7 *
Human service	5.4	21.7	4.2	7.1 *	20.9 *	5.7 *

What are the implications of these results?

- Barriers to seeking treatment are falling.
- But delays in initial help seeking are still pervasive.
- This is especially true for early-onset disorders.
- We need to develop school-based early screening, outreach, and treatment programs.

What are the implications of these results? (cont.)

- Does early intervention work?
- We don’t know.
- New efforts to develop effective early treatments.
- Long-term evaluations of developmental effects.

What are the implications of these results? (cont.)

- Quality of care has to improve.
- Quality assurance initiatives need to be evaluated.
- Quality assurance programs need to be embraced by payers.

Disorders in the comparative analysis of impairments in physical and mental disorders

Physical	Mental
Arthritis	ADHD
Asthma	Bipolar
Back/neck	Depression
Cancer	GAD
Chronic pain	IED
Diabetes	ODD
Headaches	Panic disorder
Heart disease	PTSD
High blood pressure	Social phobia
Ulcer	Specific phobia

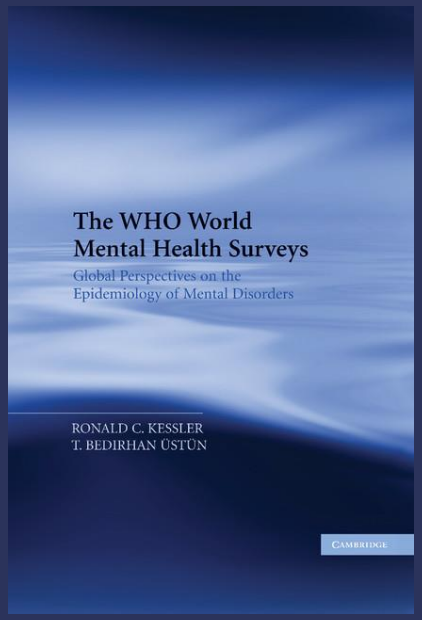
Overview of design

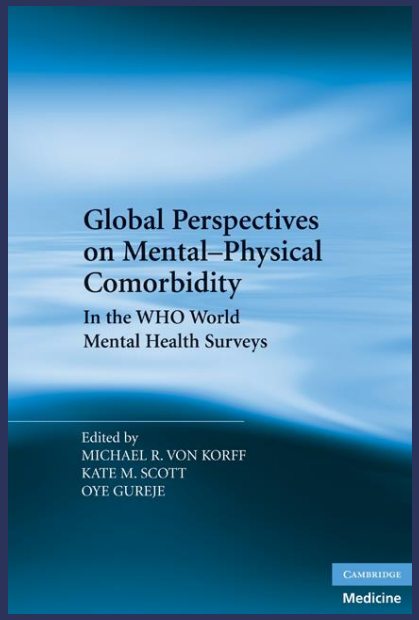
- One randomly selected physical condition was selected for each respondent who reported one or more such conditions.
- Respondents were asked to assess the impairment caused by the selected condition using the Sheehan Disability Scales and a question about days out of role due to the condition.
- Data were weighted to adjust for differential probability of selection of conditions as a function of extent of comorbidity.
- Parallel information was collected about each of the 10 mental disorders.
- Physical-mental comparisons were made both in the aggregate and in within-person paired analyses.

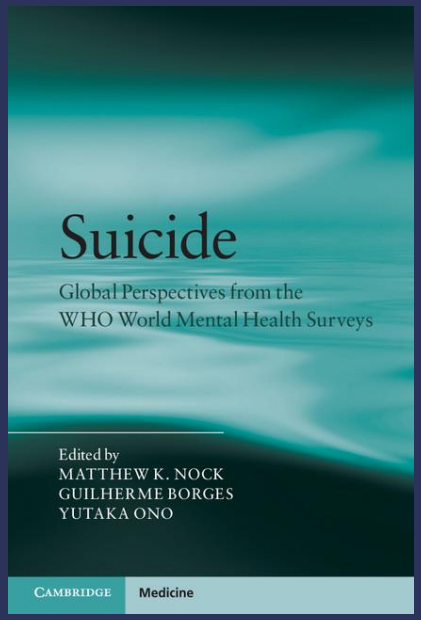
Overview of findings

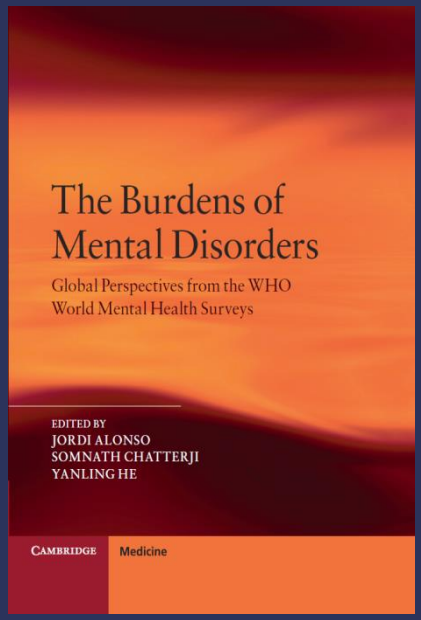
- Respondents in both developed and developing countries attributed highest impairment to mental than physical disorders.
- This pattern held whether we examined all disorders, those in treatment, or physical disorders in treatment compared to all mental disorders.
- The higher impairment of mental than physical disorders was more pronounced for social and personal relationships than for productive role functioning.
- Despite the higher impairments, only 11.9% of the seriously impairment mental disorders were treated in the developing countries vs. 64,.0% of comparably impairing physical disorders. In the developed world, the comparable proportions were 35.3% mental disorders vs. 77.6% physical disorders.

Volumes published so far in the Cambridge University Press WMH book series









www.hcp.med.harvard.edu/wmh