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Editorial

The gap in treatment of serious mental disorder in the community: a public health problem

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In recent decades, according to the European Union (EU) Green Paper: *Improving the Mental Health of the Population: towards a strategy on mental health for the European Union*, a change of paradigm is happening all over the world.[1] This has resulted from the 'deinstitutionalisation' of mental health services and the establishment of services in primary care, community centres and general hospitals which respond to patient and family needs and can support social inclusion. This change recognises that large mental hospitals or asylums can easily contribute to stigma and, as a result of reform of psychiatric services, many countries are moving away from the provision of mental health services through large psychiatric institutions towards community-based services, although, in some new EU member states, large psychiatric institutions still account for a large share of the mental health services infrastructure. All international bodies and the majority of scientific-based recommendations have supported the policy of 'deinstitutionalisation'.[1]

Not all the data, however, support this ideal. At the end of the 20th century, Lamb and Weinberger reviewed on people with serious mental disorder (SMD) in US prisons and noted that reports of large numbers of mentally ill persons in American jails and prisons began appearing in the 1970s, a phenomenon that had not been reported since the 19th century.[2] Seven years later, Lamb and Weinberger suggested the possibility that this change could be accounted for as a result of a transfer of care of mentally ill patients from psychiatric beds to prisons,[3] a concern shared by some other commentators.

A European study by Priebe *et al* describes the transfer of mentally ill patients from psychiatric beds to social services residential care beds, where therapeutic continuity is not necessarily assured by health services.[4] The psychiatric morbidity rate in prison has also increased in several European countries, with France reporting that the prevalence of schizophrenia is 6.2% in its prisons.[5] Priebe *et al* name this phenomenon 're-institutionalisation'.[4]

However, this phenomenon of re-institutionalisation cannot solely be explained by transfers. A likely explanation is based on two emerging phenomena, a decrease in hospital bed numbers, and the development of alternative community services that have either failed, or have implemented changes in delivery that do not keep pace with the hospital bed closure programme. Together these may make a change of paradigm unsuccessful.

The *Lancet* series on global mental health, published data relevant to community care of the mentally ill that had been collated from previous reports disseminated by the World Health Organization (WHO).[6,7]

One of the articles in the *Lancet* series stated that, as a result of their chronically disabling nature, approximately 14% of the global burden of disease has been attributed to neuropsychiatric disorders including psychoses.[8]

Within this panorama, the care of those suffering from chronic serious mental disorder, and probably the care of depression and identifying and meeting the treatment gap in their needs, becomes the most central public mental health problem.

A WHO study that adopted a global perspective sought to discover not only the prevalence of the most frequently encountered SMDs but also the relative weight of unmet need.[9] This study compared seven European countries and assessed the prevalence of *severe* cases, regardless of the degree of severity. The mean prevalence of severe cases for EU member states in this study was 11.95%, whereas in Ukraine it reached 20.4%. Ukraine also had a much higher percentage of work days lost due to SMD than the other western European countries (42%). The most striking aspect of the study, however, was that

35.5–50.3% of SMDs go without treatment, at the global level – even in developed countries.

The European data showed that, within the EU, the Netherlands has the highest percentage of people with untreated SMD, half of the total (49.8%). Outside the EU, in Ukraine, only one in five of those with SMD are in treatment (19.7%). Moreover, the paper showed that, while many people with discomfort below the threshold of SMD receive treatment, others with SMD do not. This leads to the assumption that the lack of treatment for those with the most severe forms of mental disorder is due not to a lack of resources but to where those resources are targeted and the priority given to programmes for SMD.

A publication entitled *The Treatment Gap in Mental Health* reviewed a number of studies that gave very worrying data on countries in all continents and concluded that the mean rate of people with schizophrenia who do not receive treatment was 32%.[10] Another survey in six EU countries estimated that 3.1% of the adult population had an unmet need for mental health care, and that one in five of those who sought treatment did not receive it. This represents around 6.6 million adults in a population of 213 million. It was also shown that the groups that show a higher risk of unmet need included young people, retired people and homemakers, as well as those with long-term mental disorders, usually SMD.[11] Consequently, the WHO proposed a practical measure aimed at strengthening adherence to the treatment of people with SMD, which consisted of the provision of community-based multiprofessional specialised teams, available 24 hours per day, 7 days per week.[12]

Many psychiatric diagnoses lead to vulnerability, particularly a diagnosis of schizophrenia. Although statistics based on reliable studies state that 30–50% of those who suffer schizophrenia recover completely, the negative side is that 50–70% of those with the disorder develop a chronic illness. The terms psychoses, long-term mental disorders and SMD, and others, are used somewhat imprecisely to define a wide group of clinical conditions within the schizophrenia spectrum, which require continuing care for a long time or sometimes indefinitely. A significant proportion of this group remains uncared for, either because they fail to adhere to therapy or because of structural flaws in the services that should care for them.

If the reduction in numbers of psychiatric hospital beds is associated with this vulnerable group's migration from health services to social services, forensic mental health services or penitentiary institutions, there is an implication that this is because previously conventional psychiatric hospitals either took care of the problem or hid it. When the deinstitutionalisation policy was implemented and conventional psychiatric hospitals closed, they were not replaced by alternative community resources, contrary to policy recommendations. This combination of factors turned people with schizophrenic disorders into a very vulnerable and increasingly conspicuous group, and those with more severe signs of the illness became more likely to be admitted to social, forensic and prison settings.

International bodies have shown their concern by starting to develop policies to protect vulnerable groups. The Council of Europe offered a specific recommendation for vulnerable people with SMD.[13] Strategy 1 of the Appendix to this recommendation is particularly interesting and states:

> Strategies and guidelines aimed at the prevention of mental health problems and designed specifically to meet the needs of certain vulnerable groups should be formulated and promoted at national, regional and local levels with clear objectives linked to resources and should: offer continuity of care, be community oriented, be flexible, and ensure access to services and offer a wide range of professional skills. They should be linked to housing, provision of health and social services, accommodation and social security policies which are crucial to community care and to the implementation of mental health policy.[13]

In other words, it recommends positive discrimination by cutting across social and health policies oriented towards continuous care and the social integration of this vulnerable group, and the provision of emergency care 24 hours a day and 7 days a week in community-based treatment settings.

If the principles and recommendations of WHO and other international agencies to be applied to the vulnerable severely mentally ill group are accepted, could primary healthcare professionals ignore them in their daily practice?

A growing concern is being shown for vulnerable groups of mentally ill people who are not receiving appropriate care in the community, which constitutes a relevant public health problem. Primary care professionals need to engage in an urgent discussion to agree a way in which they could become effectively involved in reducing this public health problem in co-operation and co-ordination with other specialised levels of care.

Beyond any theoretical considerations, as expected, staffing and care resources are also related to the treatment gap. Patel points out that the dramatically low ratio of psychiatric resources to mental health patient need in low- and middle-income countries is one of the principal reasons to explain the large treatment gap for people with mental disorders in these settings.[14] He suggests that, in such countries, psy-

chiatrists should play a leadership role in addressing public health mental health needs by advocating and increasing the delivery of mental health care through non-psychiatric professionals.[14] In many countries, general practitioners would be the core professionals delivering day-to-day mental health care.

There is an urgent need for policy makers to afford public health priority to the treatment gap in SMD. Along these lines is the Spanish Government initiative launched in 2006 called Strategy in Mental Health of the National Health System.[15] It includes, among other specific objectives for care of the mentally ill, the following objectives specifically related to SMD:

1 the establishment of guidelines for the management of psychiatric emergencies and crisis situations, collaborating with the different sectors involved
2 an increase in the percentage of patients with SMD included in a rehabilitation programme
3 an increase in the percentage of families with SMD patients who receive a specific family intervention programme, to improve their capacity to face the crisis and prevent relapses.
4 the provision of adequate general health care to SMD patients
5 the Ministry of Health and Consumer Affairs to develop with the Autonomic Communities a collaborative model with the Justice Bodies and Penitentiary Institutions to improve the care of mentally disordered people subjected to the Penal Code and the Under Age Law, assuring continuity and equity of care with the rest of the population
6 establishment in each of the territorial health organisations, access to all relevant therapeutic and rehabilitation interventions or programmes, to address the needs of the population, assuring continuity of assistance through an integrated network of services, where the general hospitals will be included, and in co-ordination with primary care
7 establishment of an individualised care plan for mentally disordered people in treatment
8 the availability, in the mental health teams in the community and in relation to serious prolonged mental disorders, of an organised system to avoid abandonment and facilitate engagement, which includes home care, as well as multisectorial management and co-ordination of the care process.

In conclusion there is still a lot to be learned in understanding the problem of the treatment gap. Even in the most wealthy countries in Europe with a high level of human resources and beds in psychiatric and general hospitals, the treatment gap for those with SMD is almost 50%. Where are the failures?

The need for research in this field has been summarised by researchers in Washington University in the USA:

> One of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to consumers in routine care. Concerted efforts are required to advance implementation science and produce skilled implementation researchers.[16]

Co-ordinating efforts between secondary and tertiary care mental health services and primary care is a must, and 24 hours a day, 7 days a week community-based treatment for SMD should be guaranteed.

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