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Mental health: a continuing history of neglect

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Physical and mental health are closely interwoven and deeply interdependent, the result of a complex interaction of biological, psychological and social factors. Medicine, however, continues to focus on the biological and neglect the psychosocial, despite the growing recognition of its importance to population health.

This artificial separation has been a formidable obstacle to understanding mental health; as a consequence, its importance to the wellbeing of individuals, communities and societies has been underestimated. Both developing and developed countries show this bias towards physical health, and especially mortality.

Developing countries tend to give priority in health to infectious disease and reproductive and child health; developed countries prioritise non-communicable diseases that cause early death (such as cancer and heart disease) over those that cause years lived with disability (such as mental disorders).

The relative neglect of mental health is seen in the growing efforts in disease prevention and health promotion, both internationally and nationally. These include: the WHO global strategy for the prevention and control of non-communicable diseases; the Oxford Health Alliance; the Trust for America's Health (in a report, 'Prevention for a healthier America'); and the Australian National Preventative Health Taskforce (in its strategy paper, 'Australia: the healthiest country by 2020').

All imply a wide health perspective, but focus on the physical diseases that contribute most to premature mortality, notably cardiovascular diseases, cancer, chronic respiratory diseases and diabetes. These diseases account for about 60% of all deaths globally.

The efforts will culminate in the United Nations' first high-level meeting of the General Assembly on chronic non-communicable diseases in September 2011, billed in *Lancet* as 'a once in a generation opportunity to put chronic diseases on the global and national agendas'. These diseases have been 'surprisingly neglected elements of the global-health agenda'. Mental illnesses, while also chronic, non-communicable diseases, are not part of this agenda, but are acknowledged to be 'similarly ignored'.

About 450 million people worldwide are suffering mental illness; only a small minority receives treatment. Worldwide, community-based studies have estimated the lifetime prevalence of mental disorders at 12%-49%, and 12-month prevalence at 8%-29%. In 2004, neuropsychiatric conditions as a group accounted globally for 13.1% of the total burden of disease, measured as both death and disability (disability-adjusted life years or DALYs), the second largest contributor after infectious and parasitic diseases. They account for about a third of the burden of disability, making them the most important source. Depressive disorders are the third largest specific cause of

death and disability (and the largest in high- and middle-income countries), and are projected to become the leading cause by 2030. Yet the median allocation of the total health budget of nations to mental health is only 3.8%.

The ‘global burden of disease’ study has played a seminal part in exposing the importance of mental health to overall population health. However, its estimates of the burden of mental illness may still understate its significance for several reasons:

- mental disorders might affect many more people than the burden of disease estimates suggest, especially in middle- and low-income countries.
- the estimates do not include the growing burden of suicide and self-inflicted injuries, which is counted under injuries.
- the burden of mental disorders (in sharp contrast to chronic, physical diseases) falls mostly on those under 60, so increasing the personal, social and economic costs.
- mental disorders increase the risk of physical diseases and injuries, with one estimate that depressive disorders raise the risk of all-cause mortality by about 70%, and affect adherence to treatment for other diseases.

Aspects of this picture of mental health have been contested. For example, it has been argued that the high prevalence of mental disorders reflects changed DSM diagnostic criteria and the medicalisation of normal human emotions. This is part of a wider concern about the medicalising of life itself, and ‘disease mongering’: the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments, including the medicalisation of health problems previously regarded as ‘troublesome inconveniences’.

While medicalisation is undoubtedly occurring in the sense that new treatments are being developed for new conditions, this does not negate the core argument here that mental illness has been neglected relative to physical illness. The charge of ‘disease mongering’ applies to both physical and mental health, and is directed particularly at treatment provision. Indeed, it has been specifically associated with a policy priority of market-based economic development at the expense of more equitable social policies, such as public-health strategies. (Ironically, the medicalisation of mental health has contributed to greater awareness of its importance.)

Questions of definition, diagnosis and treatment aside, the disability associated with mental health problems is generally higher than for other chronic conditions. Even mild cases cause levels of impairment equivalent to those associated with clinically significant, chronic physical disorders.

People attribute higher disability to mental disorders than to commonly occurring physical disorders, especially with respect to their ‘social and personal role functioning’ (with ‘productive role functioning’, the disability of mental and physical disorders is comparable). A comparison of the disability of 15 disease stages found severe depression ranked third behind quadriplegia and being in the final year of a terminal illness, and ahead of stroke and acute myocardial infarction.

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