

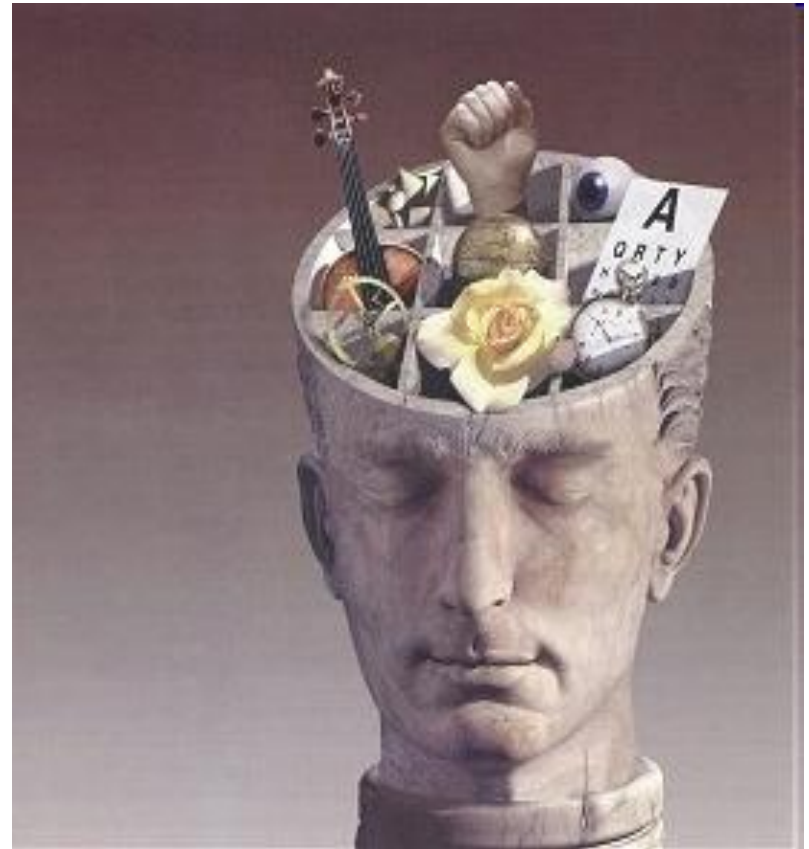
# ***The population impact of psychiatric disorder***

From agoraphobia to  
zoophilia

# What is a psychiatric disorder?

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- Diagnosed by doctors mostly GPs and psychiatrists.
- Different systems of diagnosis based on symptoms and signs no confirmatory tests
- ICD10 & DSM IV Approx. 150 disorders, many not used or different phases
- Examples – EDNOS, IED



# Which are the main disorders?

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- Common mental disorders
  - Depression.
  - Anxiety disorders eg. Generalised Anxiety Disorder, Panic disorder, Social anxiety disorder.
- 'Severe' Mental disorders
  - Bipolar disorder.
  - Schizophrenia.
- (Substance abuse disorders)

# Adult psychiatric morbidity in England, 2007

## *Results of a household survey*

Edited by Sally McManus, Howard Meltzer, Traolach Brugha, Paul Bebbington, Rachel Jenkins

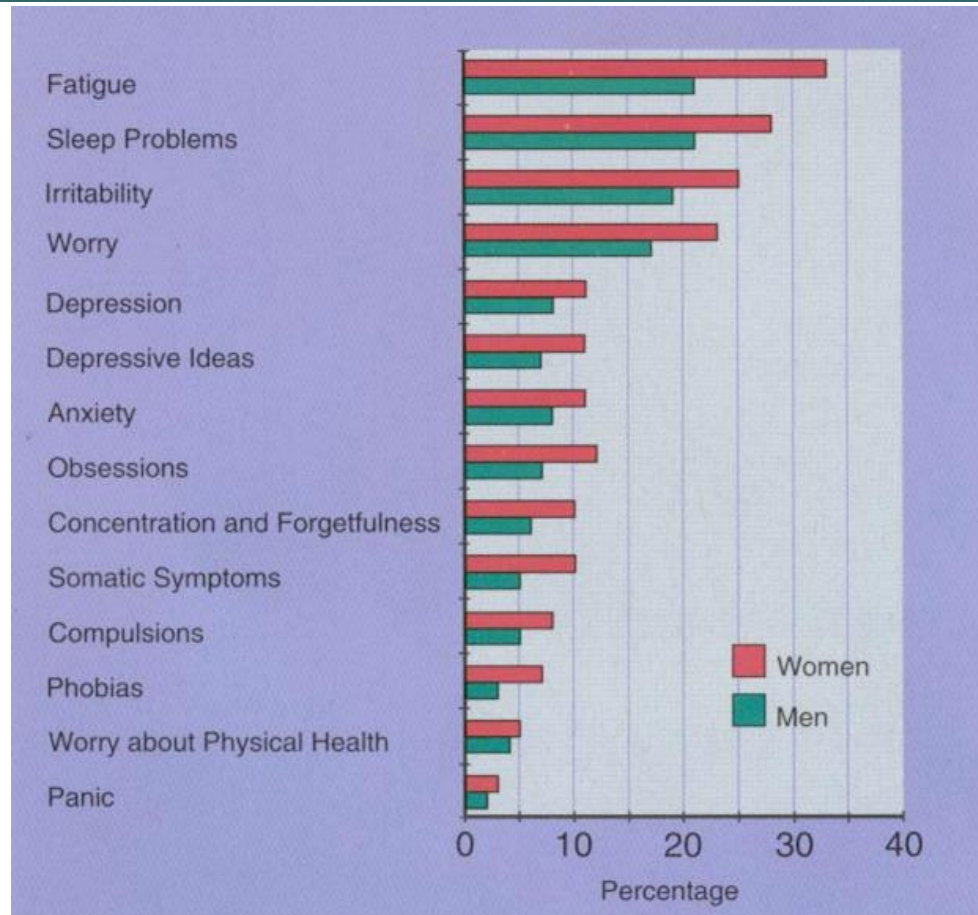
A survey carried out for The NHS Information Centre for health and social care

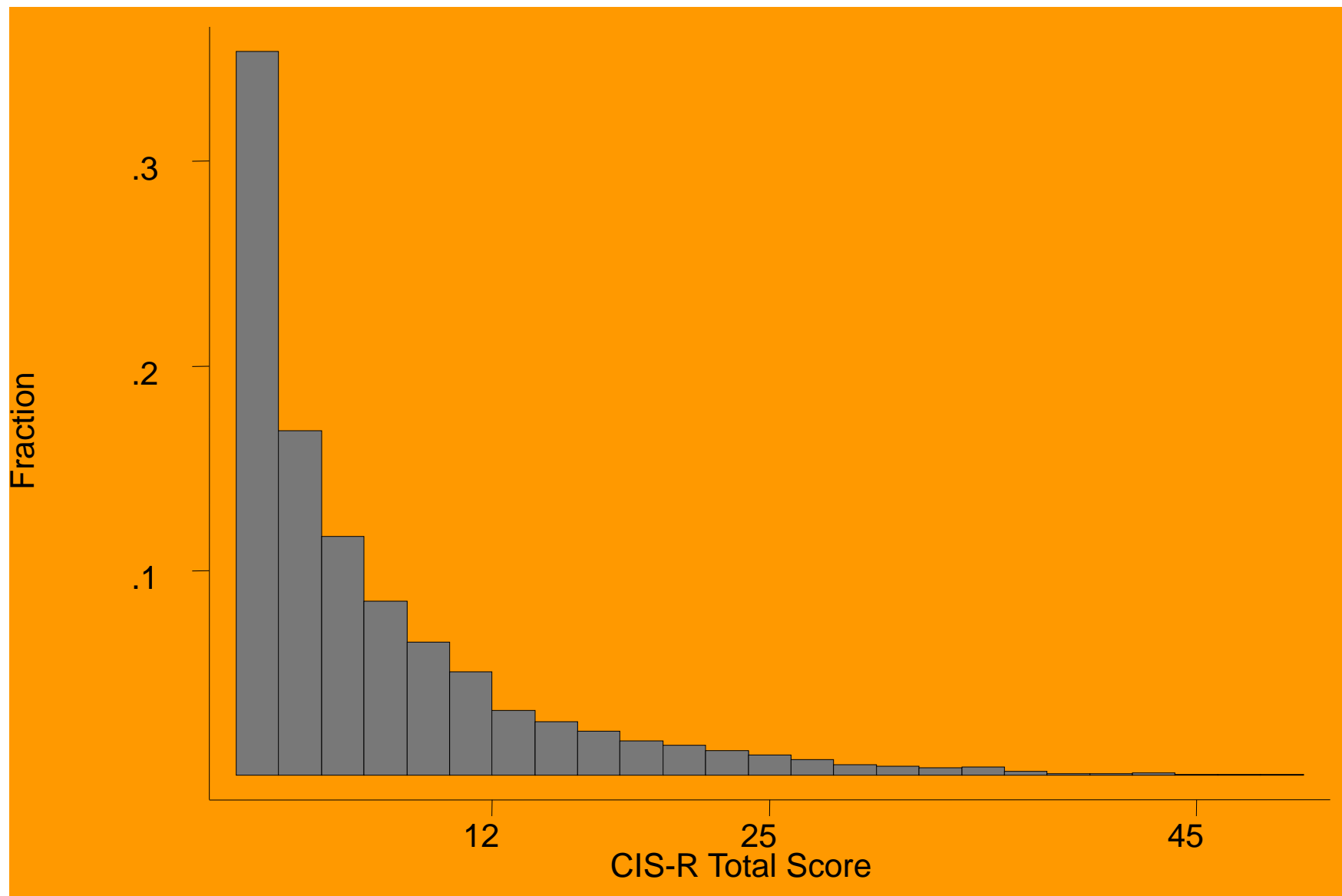
# Method

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- Sample of 14 000
  - Multistage stratified probability sampling design
- Stratified by region, SES and car ownership
- 90 minute interview including CIS-R
  - Follow up interview by clinician for +ve screens for psychosis and other disorders

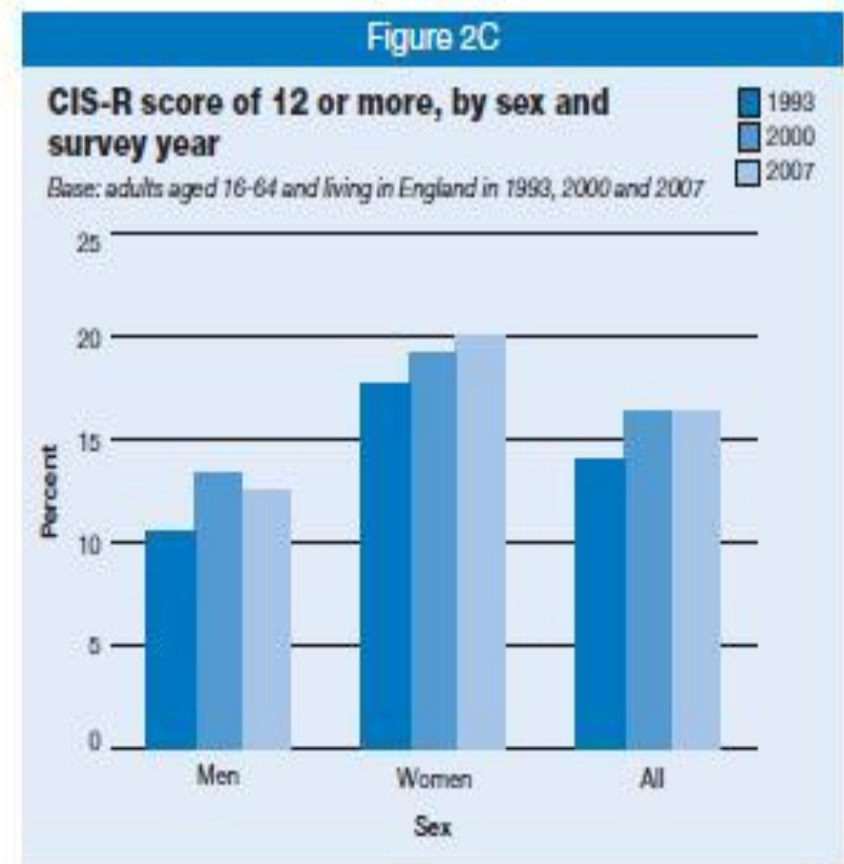
# Neurotic symptoms





# Common mental disorders

- 15.1% of adults significant symptoms
- 7.5% above 17 a level indicating need for treatment.
- F>M
- Overall increase between 1993 and 2000, but did not change between 2000 and 2007 (15.5% in 1993, 17.5% in 2000, 17.6% in 2007).





# Common mental disorders

- Rates of CMD varied by age: those aged 75 and over were the least likely to have a CMD
- In women, the rate peaked in 45-54 year olds, with a quarter meeting the criteria for at least one CMD.
- Among men the rate was highest in 25-54 year olds.
- The largest increase in rate of CMD between 1993 and 2007 was observed in women aged 45-64, among whom the rate rose by about a fifth.
- A quarter (24%) of people with a CMD were receiving treatment mostly medication.

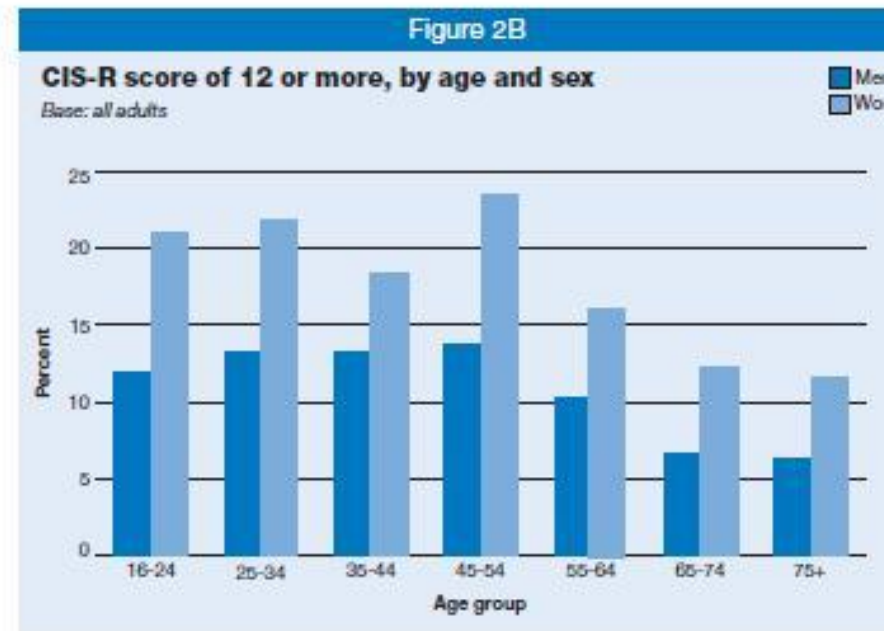
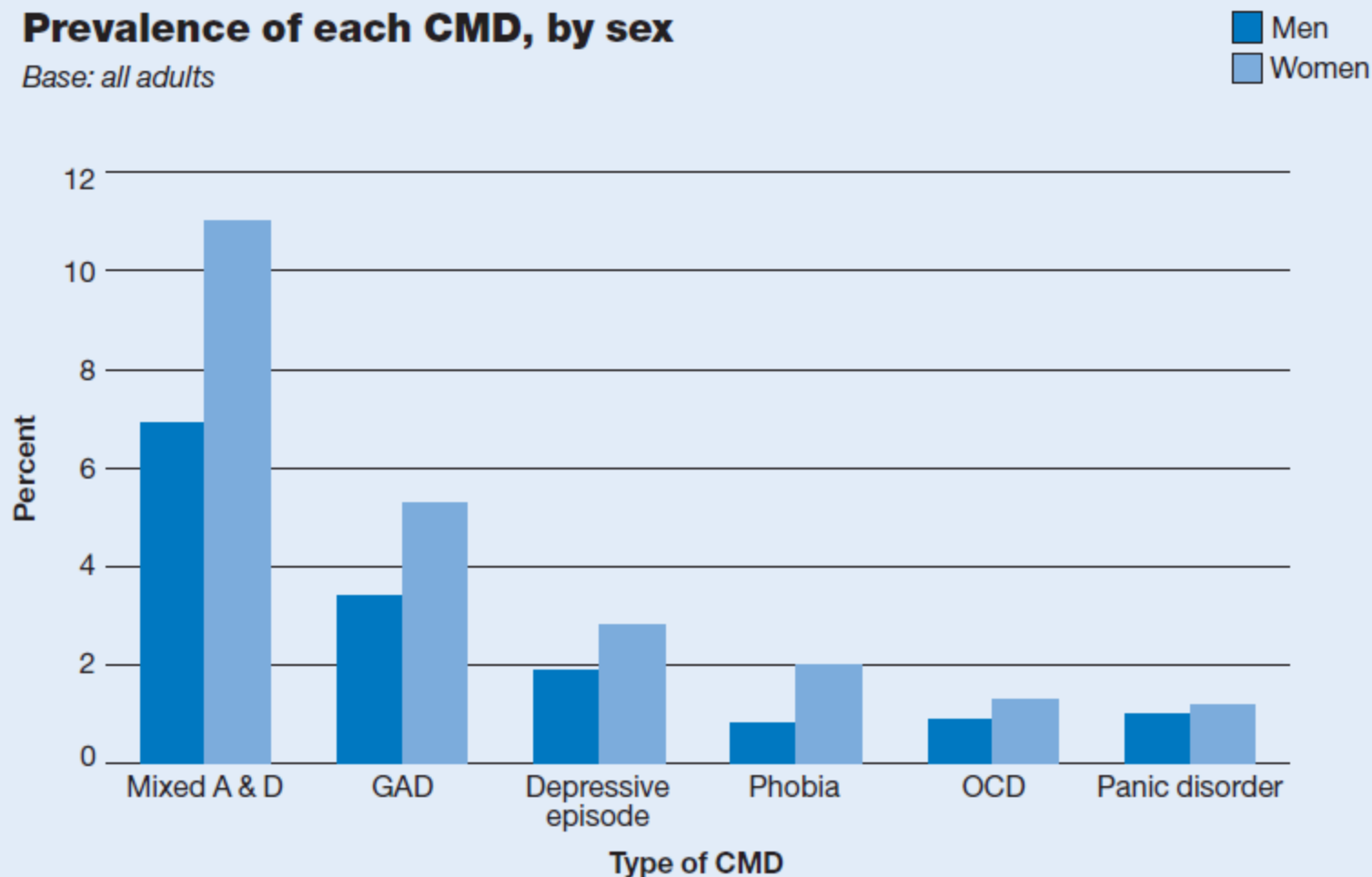


Figure 2D

**Prevalence of each CMD, by sex**

*Base: all adults*



of men, 19.7% of women). Prevalence rates were significantly higher among women than men across all categories of CMD, with the exception of panic disorder and obsessive

# ***Depression***



# Course of depression

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- Generally thought that depression is time-limited disorder lasting up to six months with complete recovery but...
- WHO study 14 centres across the world, 66% of those suffering from depression were still found to satisfy criteria for a mental disorder a year later, and for 50% the diagnosis was depression
- At least 50% of people following their first episode of major depression will go on to have at least one more episode (Kupfer, 1991), with early onset depression (at or before 20 years of age) particularly associated with a significantly increased vulnerability to relapse (Giles *et al.*, 1989)

# Impact

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*'The impact on physical health puts depression on a par with all the major chronic and disabling physical illnesses such as diabetes, arthritis and hypertension (Cassano & Fava, 2002). Depressive illnesses substantially reduce a person's ability to work effectively, with losses in personal and family income (and, therefore, tax revenues), and unemployment (with loss of skills from the workplace). Wider social effects include: greater dependence upon welfare and benefits with the inevitable impact upon self-esteem and self-confidence; social impairments, including reduced ability to communicate during the illness; disturbed relationships during and subsequent to an episode; and longer term changes in social functioning, especially for those who have a recurrent disorder. The stigma associated with mental health problems generally (Sartorius, 2002), and the public view that depression suggests a person is unbalanced, neurotic and irritating (Priest et al., 1996), may account for the reluctance of depressed people to seek help (Bridges & Goldberg, 1987).'*

NICE 2004

# Population effect of depression of different severity

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	Major Depression	Minor Depression (with mood disorder)	Minor Depression (without mood disorder)	No Symptoms
Sample Size	49	178	696	1997
Mean disability days (SD)	11.0 (29.0)	6.1 (21.4)	4.0 (16.3)	2.0 (10.7)
Excess disability days	474	712	1356	Baseline

# **Depression and physical health**

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- Death rates following Myocardial infarction (MI) are significantly greater for those who are depressed following an MI, not only in the immediate post-MI period, but for the subsequent year (Lesperance & Frasure-Smith, 2000).
- Depressed people without cardiac disease also have a significantly increased risk of cardiac mortality (Pennix et al., 2001).





# **Elevated Risk of Fatal CHD and Phobic Anxiety Index in Men: Health Professionals Follow-up Study**

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**Always feeling panicky in crowds      RR 10.8 (95% CI: 2.2 - 52.5)**

**Worrying unduly when relatives  
are late coming home      RR 2.3 (95% CI: 1.2 - 4.2)**

**Definitely feeling more relaxed  
indoors      RR 3.7 (95% CI: 2.1 - 6.4)**

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**RR: Relative risk**

**Kawachi et al (1994)**

# THE GLOBAL BURDEN OF DISEASE

2004 UPDATE



World Health  
Organization

# Global Burden of Disease - DALY

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- The disability-adjusted life year (DALY) , combines years of life lost due to premature mortality and years of life lost due to time lived in poor health
- Was developed to assess the burden of disease.
- One DALY can be thought of as one lost year of “healthy” life, and the burden of disease can be thought of as a measurement of the gap between current health status and an ideal situation where everyone lives into old age, free of disease and disability

Disease or injury	DALYs (millions)	Per cent of total DALYs
Lower respiratory infections	94.5	6.2
Diarrhoeal diseases	72.8	4.8
Unipolar depressive disorders	65.5	4.3
Ischaemic heart disease	62.6	4.1
HIV/AIDS	58.5	3.8
Cerebrovascular disease	46.6	3.1
Prematurity and low birth weight	44.3	2.9
Birth asphyxia and birth trauma	41.7	2.7
Road traffic accidents	41.2	2.7
Neonatal infections and other <sup>a</sup>	40.4	2.7
Tuberculosis	34.2	2.2
Malaria	34.0	2.2
COPD	30.2	2.0
Refractive errors	27.7	1.8
Hearing loss, adult onset	27.4	1.8
Congenital anomalies	25.3	1.7
Alcohol use disorders	23.7	1.6
Violence	21.7	1.4
Diabetes mellitus	19.7	1.3
Self-inflicted injuries	19.6	1.3

which direct mortality is low.

Unipolar depression makes a large contribution to the burden of disease, being at third place world-wide and eighth place in low-income countries, but at first place in middle- and high-income countries. Effective treatments for depression are available, suggesting that this burden could be reduced.

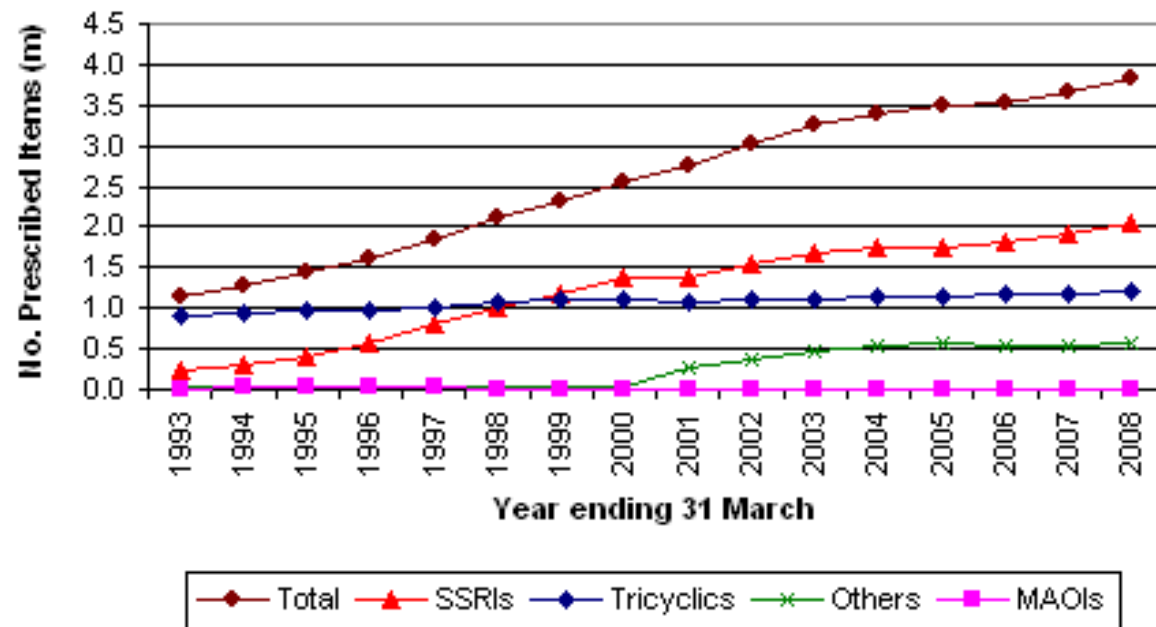
Cigarette smoking is a major and entirely preventable cause of burden of disease in middle- and high-income countries. Chronic obstructive pulmonary disease is in fifth place in middle-income countries and seventh place in high-income countries, and lung cancer is in ninth place in high-income countries. Cigarette smoking also contributes to the burden of disease from ischaemic heart disease and cerebrovascular disease, and affects communities in low-income countries as well. Alcohol use disorders are another important preventable contributor to burden of disease in middle- and high-income countries.

## Considerable variation between regions in the burden of disease

The WHO regions fall into two groups – those in which the burden of disease is dominated by infectious disease, and those in which the burden of dis-

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What about treatment of  
common mental disorders?







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## Health policy

### The case for psychological treatment centres

Richard Layard

The government is committed to improved access to psychological therapy. How big an expansion is necessary to meet the NICE guidelines on depression and anxiety, and how should it be organised?

Editorial by Scott  
and p 1027

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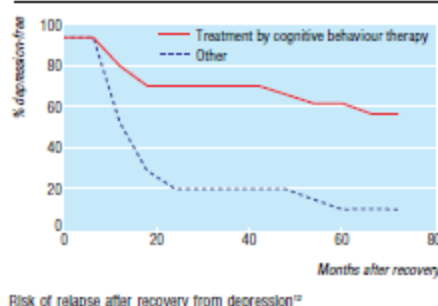
BMJ 2006;332:1050-2

If you have schizophrenia or bipolar depression in Britain, you will generally get specialist help from the NHS.<sup>1</sup> But only about 1% of the British population have these terrible conditions. Many more (some 15% of us) have unipolar depression or anxiety disorders, yet if you have one of these, often crippling, conditions you are unlikely to get any specialist help at all. You can see your general practitioner, but he or she is unlikely to prescribe any treatment other than drugs.

This pattern of prescribing is completely at variance with the guidelines from the National Institute for Health and Clinical Excellence (NICE) on treating depression and anxiety disorders.<sup>2-4</sup> These guidelines recommend that cognitive behaviour therapy should be available as an option for all but the mildest or most recent forms of depression and anxiety. The guidelines also recommend other forms of psychological therapy for selected conditions. The guidelines are, of course, based on hundreds of randomised clinical trials. These show clearly that cognitive behaviour therapy is as effective as drugs for treating depression and anxiety in the short term, and tends to have more durable effects.<sup>5-6</sup> Moreover, psychological help is what thousands or even millions of patients want.<sup>7</sup>

At present it is simply impossible for general practitioners to implement the NICE guidelines because the therapists are not available. Thus mentally ill people are denied specialist help, whereas it would automatically be supplied for equally disabling cases of physical illness. If the NICE guidelines were implemented many more people would receive help, and massive suffering would be avoided. And the cost of implementing the guidelines would be matched by savings to the government in reduced claims for incapacity benefits.

In what follows I shall discuss the scale of need, and show that the overall benefits of meeting it exceed the



should be provided through psychological treatment centres.

### The cost of depression and anxiety

According to the World Health Organization, half of all people with ill health in Western Europe have mental illness.<sup>8-10</sup> It accounts for as much suffering as all physical illnesses put together. And the bulk of these mental illnesses are depression and anxiety.

There is also a huge economic cost, because depression and anxiety make it much more difficult, or impossible, to do a job. And those capable of working are likely to have high rates of sickness absence.<sup>1</sup> The resulting loss of output can be calculated as £17bn (€24bn, \$30bn), or 1.5% of UK gross domestic product.<sup>11</sup> Much of this cost falls on the Exchequer, which loses in consequence roughly £9bn in benefit payments to mentally ill people and in reduced tax receipts. There are now more than one million mentally ill people receiving incapacity benefits—more



# Economic impact

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- 17 billion
- 1.5% of GDP
- 9 billion exchequer in benefit payments and lost taxes

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*‘Should the Treasury support psychological therapy? The cost of therapy would be about £750 for each patient who embarked on treatment. In the next two years the likely effect, compared with no treatment, would be about 12 extra months free of illness and at least one extra month in work, after allowing for natural recovery that could otherwise occur. In terms of extra output, the extra time in work is equivalent to more than £1880, which more than repays the £750 cost of treatment, without including the benefits of reduced suffering.’*

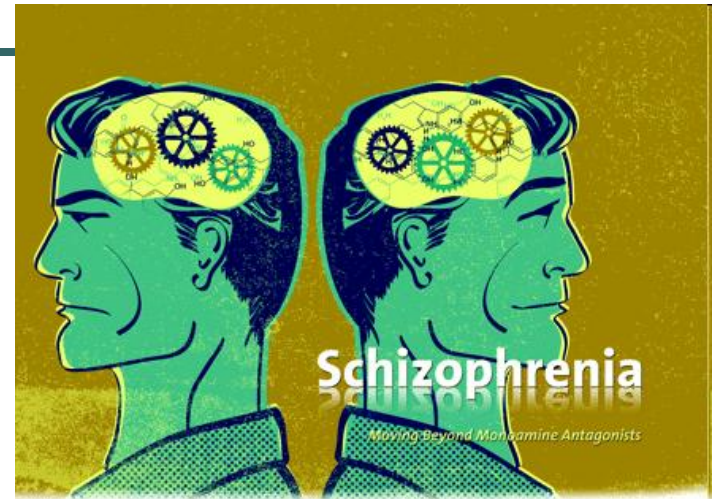
*Lord Layard 2006*

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What about severe mental illness?

# Schizophrenia

- Lifetime risk 1%
- Positive symptoms
  - Third person hallucinations
  - Bizarre delusions
  - Disorganised speech
  - Passivity phenomena (thoughts and actions)
- Negative symptoms
  - Social withdrawal
  - Poverty of speech/thought
  - Blunted affect
  - Loss/drive and motivation
  - Anhedonia
- Course
  - 20% have single episode and good recover
  - 20% do not recover after first episode and have severe chronic course
  - 60% relapsing course. Positive symptoms remit with varying levels of residual negative symptoms



# Bipolar disorder

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- Lifetime risk 1%
- Episodes of mania - elevated mood, thought disorder, overactivity, sleeplessness, impaired judgement
- Episodes of depression
- Symptom recovery in between
- It is estimated that someone developing BPD in mid twenties will lose 9 years of life, 12 years of normal health and 14 years of work activity

Disabling condition <sup>c</sup>	0–59 years	60 years and over	0–59 years	60 years and over	All ages
Hearing loss <sup>d</sup>	7.4	18.5	54.3	43.9	124.2
Refractive errors <sup>e</sup>	7.7	6.4	68.1	39.8	121.9
Depression	15.8	0.5	77.6	4.8	98.7
Cataracts	0.5	1.1	20.8	31.4	53.8
Unintentional injuries	2.8	1.1	35.4	5.7	45.0
Osteoarthritis	1.9	8.1	14.1	19.4	43.4
Alcohol dependence and problem use	7.3	0.4	31.0	1.8	40.5
Infertility due to unsafe abortion and maternal sepsis	0.8	0.0	32.5	0.0	33.4
Macular degeneration <sup>f</sup>	1.8	6.0	9.0	15.1	31.9
COPD	3.2	4.5	10.9	8.0	26.6
Ischaemic heart disease	1.0	2.2	8.1	11.9	23.2
Bipolar disorder	3.3	0.4	17.6	0.8	22.2
Asthma	2.9	0.5	15.1	0.9	19.4
Schizophrenia	2.2	0.4	13.1	1.0	16.7
Glaucoma	0.4	1.5	5.7	7.9	15.5
Alzheimer and other dementias	0.4	6.2	1.3	7.0	14.9
Panic disorder	1.9	0.1	11.4	0.3	13.8
Cerebrovascular disease	1.4	2.2	4.0	4.0	13.6

**Table 9:  
Estimated prevalence of moderate and severe disability (millions) for leading disabling conditions by age, for high-income and low- and middle-income countries, 2004**

only face lower life expectancies (higher risk of poor health.  
 mature death) than those in developed countries

YLD – years lived with disability

Figure 10: Leading global causes of YLD by sex, 2004

Males			Females		
Cause	YLD (millions)	Per cent of total YLD	Cause	YLD (millions)	Per cent of total YLD
Unipolar depressive disorders	24.3	8.3	1 Unipolar depressive disorders	41.0	13.4
Alcohol use disorders	19.9	6.8	2 Refractive errors	14.0	4.6
Hearing loss, adult onset	14.1	4.8	3 Hearing loss, adult onset	13.3	4.3
Refractive errors	13.8	4.7	4 Cataracts	9.9	3.2
Schizophrenia	8.3	2.8	5 Osteoarthritis	9.5	3.1
Cataracts	7.9	2.7	6 Schizophrenia	8.0	2.6
Bipolar disorder	7.3	2.5	7 Anaemia	7.4	2.4
COPD	6.9	2.4	8 Bipolar disorder	7.1	2.3
Asthma	6.6	2.2	9 Birth asphyxia and birth trauma	6.9	2.3
Falls	6.3	2.2	10 Alzheimer and other dementias	5.8	1.9

D, chronic obstructive pulmonary disease.

## Conclusions

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- Both common mental health problems and rarer psychiatric disorders such as schizophrenia and bipolar disorder are amongst the leading causes of poor health of populations worldwide.