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Editorial

Integrating mental health care with chronic diseases in low-resource settings

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The 'treatment gap' refers to the gap between the numbers of people with clinically significant health conditions and those amongst them who are not accessing evidence based services. The large treatment gap for people with mental disorders has been extensively documented[1–2]; though treatment gaps are evident in virtually all countries, they are the largest in low and middle income countries (LAMIC). It was precisely this large treatment gap which fuelled the publication of the Lancet series on global mental health which culminated in a call to action to 'scale up services for people with mental disorders' in all countries of the world[3]. Scaling up should be based on the principles of evidence of effectiveness and the human rights of people with mental disorders. About two years on from this publication, there are now promising signs of global action to address the treatment gap[4].Notably, the WHO has launched its new flagship program for mental health (mhGAP) on October 9th, 2008, with the explicit agenda of developing and scaling up packages of care for eight selected mental, substance abuse and neurological disorders[5]. The new Movement for Global Mental Health[6] launched the following day, seeks to build a global coalition of individuals and institutions committed to carrying out a series of coordinated actions to force change on the ground towards the goal of achieving the call to action.

A core strategy in scaling up is to integrate mental health care within other health care programs, building on epidemiological evidence pointing towards co-morbidity and interactions between mental disorders and other health conditions. This commentary specifically considers the evidence base on the relationship between chronic diseases (a term often used as synonymous with cardiovascular diseases and diabetes) and mental disorders to make the case that chronic disease programs offer an exciting opportunity for integration of mental health care. The evidence, much of it from the developed world and including several articles in this issue, offer compelling evidence of an intimate association between chronic diseases and mental disorders. If one considers only the evidence in this issue, data from nationally representative samples in the US show that, with respect to chronic diseases, there can be 'no health without mental health'. Li et al demonstrate[7] the much higher prevalence of serious psychological distress (SPD) in persons with diabetes. McGuire et al[8] report that people with SPD are more likely to report heart disease, diabetes, arthritis, asthma, or multiple chronic health conditions, and are more likely to be smokers. The prevalence of SPD is higher among respondents with a CVD history than those without, and among CVD survivors, those with SPD had worse disability status than those without SPD[9]. In another article, Fan et al[10] report on the close association between two major cardiovascular risk factors (HBP and HBC) and SPD and suggest that "persons with these conditions may improve these conditions and their mental health if they receive mental health interventions"[10]. McKnight-Eily et al[11] report that comorbid SPD is significantly associated with reported frequent activity limitation among persons with chronic diseases. Furthermore, adults with comorbid lifetime diagnosis of a selected chronic disease and SPD were significantly more likely to report days of activity limitation than those with only a lifetime diagnosis of a chronic condition. These authors conclude that "physicians should proactively screen and effectively treat co-occurring mental conditions in patients with chronic diseases".

These papers serve to strengthen the already robust evidence base on the extensive linkages between chronic diseases and

mental disorders, reviewed in the recent Lancet series[12]. There is also a growing, if small, evidence base arising from LAMIC which confirm these associations; for example, the World Health Surveys reported findings from 245,404 participants from 60 countries in all regions of the world[13]. The prevalence of depression was significantly higher in the presence of a chronic physical disease (arthritis, angina, diabetes, asthma). After adjustment for socio-economic factors and health conditions, depression had the largest effect on worsening mean health scores compared to the other chronic conditions alone. Consistently across countries and different demographic characteristics, respondents with depression co-morbid with one or more chronic diseases had the worst health scores of all the disease states.

Longitudinal evidence point to a number of pathways of association between chronic diseases and mental disorders (notably depressive disorders). First, both share common risk factors, for example, tobacco use and alcohol abuse. Second, mental disorders increase the risk for experiencing a chronic disease. Third, mental disorders are a consequence of a chronic disease, particularly one which is associated with disability. Fourth, mental disorders reduce the effectiveness of a chronic disease interventions, for example due to poorer adherence with long-term treatments. In this way, co-morbidity may lead to worse outcomes, including higher mortality. Finally, and here the evidence is still not compelling, treatment of either condition may have a beneficial impact on the outcomes of the other. Given these extensive linkages between mental disorders and chronic diseases, it would seem obvious that their integrated management should be an obvious recommendation. Indeed, there is an even more compelling reason for integration: most mental disorders are chronic in course (or at the very least, have a tendency to relapse) and require very similar approaches to management: complex packages of care typically involving combinations of pharmacological and psychosocial interventions delivered in a stepped care manner. Delivery systems which include a collaborative component are likely to have better results[14–15]. These are all common features of the management of both chronic diseases and mental disorders and provide the most compelling pragmatic reason for their integrated management[16].

The growing epidemic of chronic diseases in LAMIC has been highlighted by several authors and major reports[17–19]. In most parts of the world, chronic diseases are already the leading causes of death and, despite the evidence of extremely cost-effective public health and primary care interventions for many diseases, the majority of persons do not receive any care: another case of a large treatment gap. However, there are now major global initiatives and responses to the burden of chronic diseases afoot in LAMIC, both at the level of national health policies and on global resource flows for chronic diseases. The intimate epidemiological associations between chronic diseases and mental disorders and the pragmatic benefits for their integration in clinical care offer a tremendous new opportunity for scaling up services for people with mental disorders in LAMIC. Indeed, there is very little evidence from LAMIC on the effective methods for delivery of chronic disease care and much of what does exist pertains mainly to mental disorders (for example[20]). These lessons have great importance for chronic disease management and hold out the tantalising promise that the massive challenges posed by the unmet needs for care for people living with chronic disorders and mental disorders in LAMIC can be met simultaneously through integrated programs of care.

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