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Care gap: a comprehensive measure to quantify unmet needs in mental health

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Aim. Treatment gap refers to the percentage of individuals who require treatment in a country or a defined community but do not receive it due to various reasons. There is widespread acceptance of 'treatment gap' as a measure of unmet needs in mental health. However, the term 'treatment' carries a medical connotation and implies biomedical treatment (or lack of it) of mental illness and is often interpreted by policymakers, planners and researchers, as well as by non-professional stakeholders as exclusively referring to curative clinical psychiatric interventions. This common interpretation results in the exclusion of a range of effective psychosocial interventions available today. Treatment gap also does not include physical health services for persons with mental illness, a major concern due to the relative frequent yet highly unattended physical comorbidity and early mortality of persons with severe mental illness.

Methods & Results. We, therefore, propose a more comprehensive measure of unmet needs.

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Introduction

Advocates and planners of mental health services are moving beyond traditional epidemiological measures of incidence and prevalence rates to include parameters such as treatment gap (Kohn *et al.* 2004) (Lora *et al.* 2012) to assess unmet needs in psychiatry (Andrews & Henderson, 2000). This measure refers to the percentage of individuals who require treatment in a country or in a defined community but do not receive it, either due to, e.g. non-availability of services, stigma or poor access. Indeed, mental health stakeholders have increasingly focused on *treatment gap* as a measure of the unfair supply of services and the presence of disparities in both the needs and demands for treatment of mental illness worldwide (Patel *et al.* 2010). Typically the measure refers to mental health treatment needs to be answered by specialised or primary care health services, while those addressed by related sectors (cf. the pyramid of levels of care (World Health Organization, 2009)) are usually not included. Despite this limitation, treatment gap has wide acceptance in advocacy and planning efforts of services as demonstrated by a large number of citations of the article proposing the concept and authored by World Health Organization (WHO) staff and associates (Kohn *et al.* 2004).

A critique of definition and method

Websters' dictionary states that *treatment* refers to 'the act or manner or an instance of treating someone' (while gap would indicate the absence of it). Often, the term 'treatment' carries a medical connotation and implies biomedical treatment (or lack of it) of mental illness. Given its relative restricted conceptual domain, we propose that this term be replaced by '*mental health care gap*'. *Care,* in our opinion, is a more comprehensive term, and again, according to Websters' dictionary, it represents, among other concepts: 'painstaking or watchful attention; concern and solicitude and supervision (e.g., under a doctors')'.

The second and more fundamental critique is that treatment gap seems to be frequently interpreted by policymakers, planners and researchers, as well as by non-professional stakeholders as exclusively referring to curative clinical psychiatric interventions. This common interpretation results in the exclusion of a range of effective psychosocial interventions available today (Mueser & McGurk, 2004). Importantly, these psychosocial interventions are almost always required by persons with severe mental illnesses as they affect social functioning (Jaracz *et al.* 2015) and their omission

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impedes or delays recovery (Lieberman *et al.* 2008). Moreover, it can also be argued that the association between psychopathology and functioning is not restricted to severe mental illness. It has been noted that 'history of – and current anxiety and/or depressive disorders were associated with increasing work disability and absenteeism…compared to healthy controls. Long-term work disability and absenteeism were most prominent in comorbid anxiety-depressive disorder, followed by depressive disorders, and lowest in anxiety disorders' (Hendriks *et al.* 2015). Analogous findings were made by Knudsen *et al.* (2013) among many others. We argue that this *psychosocial care gap*, as we propose to call it, is not captured in the current treatment gap measure.

The third gap we propose to include is *the physical health care gap*, a concern raised by the relative frequent yet highly unattended physical comorbidity (Saxena & Maj, 2017) and early mortality of persons with severe mental illness (Correll *et al.* 2017) (Haklai *et al.* 2011). The wealth of evidence of a physical health disadvantage for persons with mental illness led the WHO to include the following in the Mental Health Action Plan 2013–2020: '…health workers must not limit intervention to improving mental health but also attend to the *physical health care needs of children, adolescents and adults with mental disorder*' (italics is ours) (World Health Organization, 2013).

We therefore propose a more comprehensive measure called the *Mental Health Care Gap* which encompasses the above three domains, as follows: '*treatment gap*', as currently understood and measured, implying the lack of conventionally understood biomedical and clinical treatments, plus a '*psychosocial care gap*', implying the lack of psychosocial interventions and a '*physical health care gap*', implying the lack of or substandard provision of physical health interventions (promotion, primary prevention, curative and rehabilitation care) for persons with mental illness. We summarise this as follows:

Mental Health Care Gap = Treatment Gap (as currently understood) + Psychosocial Care Gap + Physical Health Care Gap.

Mental illness, psychosocial impairments and physical comorbidity

The combined epidemiologic evidence on the above is increasingly growing. The psychosocial impact of mental illness is found in community surveys, such as the World Mental Health Survey. For example, in one of the studies from the World Mental Health Survey, respondents in 14 countries affected with serious mental illness reported that at least 30 days in the preceding year they were totally unable to carry on with their usual activities (IQR, 32.1–81.4 days), and for 4.1–33.7 days (Interquartile range (IQR), 9.2–18.8 days) and respondents with moderate disorders for 4.1-33.7 days (Demyttenaere *et al.* 2004).' A recent study from Portugal showed that for persons with mental illness in the preceding 12 months the mean days out of role (person was totally unable to work or carry their usual activities) for every cycle of 30 days amounted to 1.9 (SE 0.3). The authors concluded that mental illnesses accounted for a substantial proportion of all role disability in the studied country population (Cardoso *et al.* 2017).

Reciprocally, there is substantial evidence as well that psychosocial care can favourably impact outcomes for disadvantaged groups with severe mental illness. For example, Mueser & McGurk (2004) reviewed a set of psychosocial care interventions for persons with schizophrenia, e.g. family psychoeducation, supported employment, social skills training. These interventions were found to provide highly positive results not obtained by curative care exclusively targeted at symptom reduction.

Policy makers in countries are recognising the importance of psychosocial care. 'Closing the gap: priorities for essential change in mental health', a UK government document to upgrade mental health policy aptly stated: 'we know that not having a job is too often associated with the onset or recurrence of mental health problems and being out of or away from work can sustain the symptoms of mental ill health. Effective support requires a joined-up approach between health and employment services and supportive action by employers…' (Social Care, Local Government and Care Partnership Directorate, 2014).

There is also a relationship between psychosocial care gap and its contribution to social disparities. A follow-up study conducted in the UK comparing two disadvantaged and one relatively advantaged social group found:'… some evidence that adjusting for the clinical course (there were) attenuated associations with lower social function at follow-up, but not the percentage of time employed.' The authors suggested that …'addressing the social needs of those from these groups should be a priority for mental health services. If our tentative findings are right (the authors conclude), this may lead to improved clinical outcomes and engagement with services' (Morgan *et al.* 2017).

Lastly, with regard to evidence for the healthcare gap, we direct our readers to a recent set of articles that were part of an effort to draw attention to the excess mortality in persons with severe mental illness. The articles addressed the frequency, origin, characteristics and policies of comorbidity and premature mortality (Liu *et al.* 2017) along with an editorial calling for

'not to leave anyone behind' (Saxena & Maj, 2017). More recently, an article further highlighted the morbidity and mortality from cardiovascular disease ascertained in one of the largest populations ever studied (Correll *et al.* 2017).

Gaps and human rights

These psychosocial and health care gaps negatively impact the exercise of a number of human rights protected under international conventions, particularly the UN Convention on the Rights of Persons with Disabilities (CRPD). These include, among others: the right to education (Art. 24); the right to habilitation and rehabilitation (Art. 26); right to work and employment (Art. 27); and right to adequate standard of living and social protection (Art. 28). Countries that have ratified the UN CRPD have an obligation to take steps to enable persons with disabilities, including disability due to mental illness, to exercise all of these rights. Similar to the treatment and psychosocial care gaps, the healthcare gap also constitutes a human right violation. Indeed, the right to health was enshrined as early as 1948 in the Universal Declaration of Human Rights, and further reinforced in article 25 of the CRPD recently.

WHO recognises the need for psychosocial care and general healthcare

The importance of a combined strategy for tackling the mental health burden is recognised by WHO in the objectives and targets of the Comprehensive Mental Health Action Plan 2013–2020, 'To provide comprehensive, integrated and responsive mental health and *social care services* in community-based settings' (italics are ours) (World Health Organization, 2013).

However, it appears that countries give insufficient attention to addressing the psychosocial care needs of persons with mental illness. The Atlas 2014 issued by WHO highlights that 'the rate of persons with severe mental disorder who receive disability payments, income support or other forms of non-monetary support (e.g. housing support, access to employment) is …(at a) far higher rate …in high income countries (520 persons per 100,000 population) compared to lower-income countries (12–14 in low and lower-middle income countries, and 73 per 100,000 population in upper-middle income countries)' (World Health Organization, 2015). Atlas 2014 also noted this 'item information (by the countries) suffered from a low response rate'. This underreporting is an indirect but significant evidence that countries are either ignoring or giving insufficient attention to addressing the psychosocial needs of persons with mental illness.

WHO has also called upon member-states in the Comprehensive Mental Health Action Plan 2013–2020 to focus programs and services on the often neglected area of the general status of health of persons with mental illness. In the item related to *Integrated and Responsive Care*, WHO requests countries to: 'integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health…' (World Health Organization, 2013).

The mental health sector needs partners to close the gaps

In some countries community mental health services, and early intervention services, in particular, do assess and seek to address social needs. However, these tasks often fall on already stretched community mental health staff who may lack relevant specialist knowledge. There is potential value, alongside clinical care, of enhanced packages of social interventions, particularly for minority service users (Howgego *et al.* 2003). WHO has rightly proposed to translate the psychosocial needs into a multisectoral reply. The *Comprehensive Mental Health Plan 2013–2020* states: 'A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.' (World Health Organization, 2013).

Gaps and measures for their ascertainment

Lastly, we outline some strategies to measure the two new proposed gaps which countries could adopt based on their needs and available resources.

For measuring the psychosocial gap, one option is to obtain information from the national social insurance records or similar records of individuals receiving disability pensions (e.g., army veterans, police force) and link those records with medical records of individuals receiving treatment from public mental health services. Psychosocial care gap represents the group of subjects with mental health problems but deprived of psychosocial care. The strategy requires databases with the capacity to establish linkages, which may not be present in many low-income countries. Even in countries where such databases are present, they often only record details of financial allowances or pensions and

not the entire range of psychosocial interventions. In some countries, there may be separate databases recording use of social care services such as personal assistance, use of social day care centres and it may be possible to link these to health care records to get a more comprehensive picture of psychosocial care coverage. A relative easier option for many countries is to review clinical records of a sample of users from both outpatient and inpatient mental health facilities stratified by diagnoses, gender, age and SES groups, and examine the records for references to psychosocial interventions. Another source of information for some countries is to refer to data from World Mental Health Surveys which includes data on psychological services used by participants. All these methods have their disadvantages and depending on their particular situation, countries will have to choose a combination of strategies to estimate the psychosocial care gap.

For the healthcare gap, the availability of single medical record in some countries facilitates the identification of mental health service users who are not engaged in promotive, preventive and/or curative health programmes. In the absence of this option, a strategy similar to one described above of examining clinic records of a stratified sample of users of mental health services will allow identification of health interventions that have been recommended and availed for major medical conditions, e.g. diabetes, cardiovascular disorders, to give just two examples.

Conclusion

We acknowledge that this article carries no innovation with respect to the need for psychosocial interventions for persons with mental illness as well as for interventions aimed at promoting health, preventing physical comorbidities and reducing the risk for premature death.

Where innovation is needed, and for which this article advocates, is in developing systems of recording and effective evidence-based models for psychosocial and physical health care, as well as scaling up effective interventions at the population level through legislation, policy, programs and services. We believe that our call to transform our language (from treatment to care), as well as our proposal (to extend the measure of the gaps), will help this process.

Furthermore, focusing on a comprehensive mental health care gap will significantly promote much needed intersectoral partnership by giving appropriate recognition to health and other social sectors in addressing the full spectrum of needs of persons with mental illness.

We thus argue that our call holds the potential of refocusing the attention of policymakers, service planners, practitioners and researchers on addressing the totality of health and social care needs of persons with mental illness, and thus meet the challenges of a full response to the human rights UN conventions.

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