FREDRIK WIKSTROM: Welcome to this overview on global mental health. My name is Fredrik Wikstrom. I'm an M.D. I've recently received a Master's degree in Global Mental Health and I'm soon to be a Resident Psychiatrist.

Mental health can be defined in many ways. Basically, it's a state of well-being, which lets a person live a free and fruitful life and take part in society. We will start by looking at the global burden caused by mental illness. Here is a graph you now recognize showing the global burden of disease measured in DALYs, or disability adjusted life years.

The highlighted blue box shows the contribution of the most important mental disorders. Depression, the biggest contributor, anxiety disorders, drug use disorders, schizophrenia, alcohol use disorders, bipolar disorder, autism spectrum disorders, intellectual disability, and others.

The green group in the graph shows burden by injuries, and here we find suicide represented by self harm, the highlighted green box in the corner. And we'll come back to suicide later. Together, the two groups amount to about 8.5%. This is comparable with the burden from, for example, cancer, or HIV, TB, and malaria put together. These two groups represent about 8% and 9% of the burden respectively.

However, the 8.5% of the burden from mental disorders are probably underestimated. Why? Well, firstly, mental disorders may increase unhealthy lifestyles with, for example, more smoking and less exercise.

Important risk factors for other health conditions. For example, if you're depressed you may have less interest in energy for exercise, and you may consume more alcohol or tobacco because of increased anxiety. Secondly, medications used for mental disorders may have side effects and can increase the risk of, for example, weight gain and diabetes.

Thirdly, for a person with a mental health condition, it may be more difficult to follow treatment for other medical conditions. Again, if you suffer from depression and at the same time diabetes, you may feel less interested in and have more trouble with following a strict plan for your anti-diabetic medication or your insulin.

And lastly, but this is a very important point, because of discrimination and often a lower social

position, less treatment and support is offered by society in general. The stigma and discrimination associated with mental health has a tremendous negative impact on the lives of people with mental illness.

So this means that, if a person dies from, let's say a coronary heart infarction, any coexisting mental illness may have heavily influenced this. And studies show that people with mental disorders, on average, live 15 to 20 years shorter lives than the general population. This influence from mental disorders, however, is not represented in the graphs, leading to an underestimation.

What about the burden at different income levels? Let's look at the data. Here you can see the proportion of burden caused by mental disorders. The proportion is lower in low and lower middle income countries.

Does that mean the mental disorders are not common in low income countries? No. As you now know and see in the graph, infectious diseases-- the red and orange-- are more common in poorer countries, and this makes the percentage of the burden from mental disorders smaller. Not the actual amount.

Here, in the next graph, we'll instead look at the average burden only from mental disorders. The bars show us DALYs, or disability adjusted life years, per 100,000 people. And we see that mental disorders are important at all income levels.

Here is a more detailed version of the graph. Now the bars are divided into the different mental disorders I listed at the beginning of the lecture, and also between men and women. You see that most disorders are common everywhere. Between the disorders, there are some differences. I will not go into detail, but, for example, you can see that depression is more common among women and drugs and alcohol are more common among men.

To sum up, the burden and frequency of mental disorders are comparable at all income levels, even though the proportion of the total burden is lower at lower income levels.

What about treatments? Can mental disorders be treated? Yes is the short answer. Treatments and social interventions can dramatically improve the lives of people with mental illness. For example, psychotherapy to treat depression, anti-psychotic medications for psychosis, or higher taxation to decrease alcohol use.

However, there is a big so-called treatment gap, meaning that in many high income countries

only about a third of people with depression or bipolar disorder receive treatments. In low and middle income countries the situation is even worse, with less than one in 10 receiving treatment.

Why is there a difference between income levels? A major problem is a lack of resources. Take Ethiopia, for example. Africa's second most populous country with almost 100 million people. What are the main mental health resources? One mental hospital in the capital with 300 inpatient beds, a total of around 50 psychiatrists, and about 50 sites throughout the country where psychiatric nurses can provide basic mental health services.

Even though the mental health services in Ethiopia are improving, there is still a clear lack of resources. If you compare high-income Europe to low and middle-income Africa, you see a big difference.

HANS ROSLING: Psychiatric care in low-income countries has much less resources than in the other end of the income scale, in the richest countries or so-called high-income countries. This table compares Ethiopia to Sweden. Income in Ethiopia is $500 per year per person. In Sweden, it's $60,000. The ratio is 1:120.

The number of psychiatric inpatient beds per one million population is 3 in Ethiopia and 400 in Sweden. The ratio is 1:133, almost exactly the same as the ratio between the incomes. Psychiatric care is obviously about having money.

Number of psychiatrists per one million population is 0.5 in Ethiopia, whereas in Sweden it's 200. So the ratio is 1:400. That means a psychiatrist in Ethiopia more or less has to do the same job as 400 psychiatrists are doing in Sweden.

FREDRIK WIKSTROM: It is often assumed that mental disorders require specialized treatment. To tackle the lack of specialists in low and middle-income countries, research is now examining if non-specialists can be trained to deliver mental health treatment.

One example is from Zimbabwe. Here, in a project called The Friendship Bench, laypeople are trained in a form of talking therapy for depression. The project has promising results and is a way of delivering effective treatment at an affordable cost. This use of trained laypeople, which may be more available than scarce specialists, is referred to as task sharing. Another important goal is to increase the general awareness and to reduce the stigma associated with mental disorders.

Investing in mental health costs money. However, being sick and not being able to work also has a societal cost because of lost productivity. Investing in treatments for mental disorders could therefore result in a financial net gain. This can be important for countries with insufficient health budgets. The WHO 2013 report, Investing in Mental Health, Evidence for Action, has summarized the evidence of the economic reasons for investing in mental health.

People with mental disabilities are a vulnerable group, often subject to discrimination and abuse. The stigma of mental illness is global, and people with mental illness often have less access to treatment in people with physical disorders.

What's more, people are sometimes treated against their own will. A person with psychosis may need short-term forced treatments until he or she becomes better. However, there are many reports of patients being held against their will for long periods of time without receiving appropriate treatments, or being severely mistreated in overcrowded asylums under conditions that cannot be seen as humane.

Where no treatment is available, literal incarceration may be the only option for a family or community to prevent increased harm to the person suffering and to prevent harm to others. This, however, is not compatible with human rights. So the human rights perspective is central for mental health.

In 2006, the UN Convention on the Rights of Persons with Disability, or the CRPD, was adopted. For the first time, a universal and legally binding UN document now specifically protects the rights for people with mental disorders. However, there is a long way to go before the basic human rights of people with mental disorders are fully respected and protected.

Now, let's return to suicide. The WHO Suicide Report estimates that around 804,000 people died by suicide in 2012. There are more suicides among the young, and for those aged 16 to 29 it is the second leading cause of death after traffic accidents. Among women between 15 and 19 years old, suicide is actually the leading cause of death worldwide.

There are big variations in what causes suicide and in suicide rates within regions and within countries, so it's hard to generalize. But disorders that highly increase the risk of suicide are, for example, depression, schizophrenia, and drug abuse.

It must be stressed, however, that suicides are not always caused by mental illness. Many are

the results of nearly impossible life situations with, for example, poverty, unemployment, oppression, and the lack of liberty and control over one's life.

Ending with those words, I hope that the growing importance of global mental health has become clearer. Thank you and good luck with the course.