Editorial: Treatment Gap In Mental Health Care

In Israel, as in other parts of the world (1), not every person in need of mental health care receives it (2). Although not all individuals with a diagnosable disorder require care (3), many do and yet remain untreated. The obstacles to care reside in a triad of factors: attitudes of the potential user, family and community; availability, accessibility and cultural adequacy of the services; and openness to psychiatry and belief system of the enveloping culture (1, 3). Recognition of this treatment gap by all stakeholders is an essential first step to diminish the burden of disease of the mental disorders (4).

How large is the treatment gap in Israel? The Israel National Health Survey (INHS) showed a considerable treatment gap in the care of common psychiatric disorders among adults (2). Among the findings: there was a 9.7% one-year prevalence rate of combined anxiety and mood disorders among Israeli residents aged 21 and over, of whom 64% were untreated. Projected, this would result in approximately 281,000 individuals untreated nationwide.

The treatment gap is even wider in selected population groups, such as residents of what is commonly referred to as the "periphery" (northern and southern Israel, in contrast to the cities of the central region) where mental health services are less available. Levinson reported that while 6.0% and 6.6% of the population in Jerusalem and Tel Aviv, respectively, consulted services for a mental health problem during a 12-month period, the corresponding figures in the northern and southern districts were 3.9% and 4.1%, respectively (5). With regard to the young, "39.1% of mothers whose child had any mental disorder consulted a professional source in the preceding year concerning the emotional or behavioral problems of their child, while only one-third of their children who had any mental disorder consulted someone in school in the past year" (6). In the Arab-Israeli minority, the treatment gap with regard to anxiety and depressive disorders is twice as high as in the Jewish-Israeli population (7). This may result from a combination of the three sets of potential obstacles to care referred to earlier. Members of other minority groups (i.e., ultra-Orthodox Jews) may be under-users of services even when available, perhaps because of the limited fit between the respective "assumptive worlds" (8) of users and providers as discussed by Rosen et al. in a study of ultra-Orthodox referrals to a North Jerusalem community mental health center (9).

As a consequence of the treatment gap, many people may remain without proper care, facing continued suffering and disability. Often, the impact of the psychiatric disorder extends to family members and caregivers (1). Additionally, the instrumental burden is considerable, measured in terms of the direct costs (for example, needless laboratory tests in the primary care context when the psychiatric disorder is not recognized) and of indirect costs (e.g., days lost from work). The INHS found that the treatment gap was narrower when the disorder had the highest level of severity (2). This burden is compounded further by the higher prevalence rates of the common mental disorders of mild and moderate severity, since they are characterized by a relatively higher treatment gap than the prior group. These findings are not confined to Israel. Other countries that carried out similar surveys under the coordination of Harvard University and the World Health Organization have reported similar findings (2).

The stigma attached to mental disorders and psychiatric services has been recognized as one of the factors present in the individual, family and community that prevent or delay mental health consultations. This issue of the Israel Journal of Psychiatry reports the results of a study on the attitudes of the Israeli public towards psychiatric disorders and the preferred site for mental health care (10).

The combined findings of two recent community-based studies, the INHS, that explored the gap between people with diagnosable disorders and those actually treated (2), and the paper by Struch et al. (10), build a strong case for action. Creative and well-articulated public mental health programs are required to reach out to the untreated public and tailor to the respective characteristics of the different subgroups of the population. If such programs were appropriately designed, implemented and sustained

over time, then it is possible that the treatment gap be narrowed. For example, Richards et al. recently reported the use of collaborative care as a powerful organizational tool for improving depression treatment in the United Kingdom (11). In a larger study based on 18 primary health care clinics in the U.S.A. that participated in a randomized controlled trial, called the IMPACT program (Improving Mood: Promoting Access to Collaborative Treatment), Unützer et al. demonstrated the feasibility and effectiveness of the collaborative care model for the management of late-life depression (12).

Despite those two encouraging reports, a large number of studies have shown that program trials based solely on the training of doctors (general practitioners or family physicians) focused on the identification and management of depression have yielded modest results (13). We submit that a more adequate strategy to treat depression and mental disorders requires the participation of a variety of community agents, such as nurses, clergy, teachers, hairdressers or any other culturally-sanctioned sources of emotional and spiritual support (14–16).

The current realignment of mental health services, whereby primary health care is being given a central role in the delivery of mental health care within the psychiatric reform could be a welcome development. However, the mere transfer of responsibility of care to the Health Maintenance Organizations is not likely to reduce the treatment gap with regard to the anxiety and depressive disorders. The public seems to hold a different view than planners, inasmuch as a substantial proportion of the community respondents stated that they prefer the specialized psychiatric clinics for care (10). Thus the central role given to the primary health care practitioners by the HMOs within the framework of the Psychiatric Reform may not render the expected results if appropriate training programs are not made available, complementing the additional program components noted above. Recall here that studies have shown that general practitioners too often hold ambivalent attitudes toward the person with a mental disorder, and may yet need to command the knowledge, skills and time to enable early recognition and effective treatment (1). The INHS Survey showed that "of individuals with a 12-month diagnosis of major depression only 13.6% received any antidepressants within the same period" (17). If the parameter of assessment had been the use of cognitive behavioral therapy (CBT), the results would have surely been even more disappointing.

The treatment gap is wide in mild and moderate disorders. What should ideally be available to the front-line physicians? Antidepressant medications are not considered the first choice for mild depressive disorders, and physicians may not have the time to learn or practice CBT. In the NICE guidelines in the United Kingdom (18), a five-step guide to the identification and management of depression in general practice is recommended. Following the first step of identifying and assessing depression in the patient, the second step involves the management of mild depression by the General Practitioner team using "watchful waiting, guided self-help, computerized CBT, exercise and brief psychological interventions" for mild depression. The third step for moderate and severe depression includes medication and psychological interventions, and only in the fourth step for resistant, psychotic or atypical cases, are the services of specialized mental health teams involved (18).

The following are a sample of themes for discussion among planners and other mental health stakeholders. First, it is essential to recognize that the current treatment gap is considerable and, given the suffering, disability and burden, worrisome. Second, mental health authorities need to include a multipronged approach in the design of public mental health programs. Mechanic, who discussed the implications for care of the European Study of the Epidemiology of Mental Disorders (ESEMeD) study (19), similar to the INHS, proposed a multi-axial program in Europe for the easy and reliable identification of sufferers from anxiety and depression. Trials are needed to ascertain the effectiveness of programs in the Israeli context that would follow such a model. This component of the local health service research agenda would need to demonstrate that untreated sufferers ultimately seek care, that there are positive outcomes of the care for service users and families, and that there is a reduction of the burden of disease. Fourth, armed with all these findings, we envision a need for advocacy and mental health education targeting the decision-makers, including health economists at the Ministry of Fi-

nance, showing that it is better to invest in mental health care and recover the costs on reduced disability costs (20). Current efforts by the planners of the health services are aimed at meeting the needs of people turning to psychiatric help. It is to be hoped that the development of treatment alternatives during the era of Psychiatric Reform will undertake the challenge of reaching out to those whose needs have not been recognized or have not sought help.

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