The World Psychiatric Association is pleased to send comments from several of its components. The President and Executive Committee of the WPA thank the leaders who provided comments.

The comments are posted as the expert opinion of the leaders of three of the WPA Collaborating Centres and six of its relevant scientific sections.

The comments do not necessarily reflect the views of the WPA Executive Committee. The consultation took place over a limited time and it was not possible for the Committee to collect and review the comments in the days available for consultation. Some comments have been edited for overall consistency.

1. WPA Collaborating Centres

1) Prof Kamuldeep Bhui, London

I have two comments:

Li or Valproate, no reference to pregnancy here nor other risks and Li monitoring costs which will be an issue in low resource areas – although technology may make blood tests a thing of the past here.

On indicated interventions in schools, well that requires screening which is costly but also criticised for potentially stigmatising and not offering an intervention in low resource areas, so should only be used if interventions are available and within a universal framework.

Professor Kamaldeep S Bhui CBE MD (Lon) FRCP(Edin) FRCPsych FRSA PFHEA Centre Lead for Psychiatry, Wolfson Institute of Preventive Medicine Barts & The London School of Medicine & Dentistry. Queen Mary, University of London
2) Prof Dan Stein, Capetown

Thank you for asking for inputs.

The document looks comprehensive and rigorous to me.

It refers to anxiety disorders, but in DSM-5 and ICD-11 these now exclude OCD and related conditions, as well as PTSD and related conditions. So I would suggest using the phrase “anxiety and related disorders”.

3) Prof. David Ndetei, Nairobi

On #5. – This is an important point. There should be full participation of the countries and local stakeholders

On #9, second paragraph - I think there is a need for each country to determine the most frequently used methods for suicide. While banning hazardous pesticides may play a role in reducing suicide, this requires public participation and especially the economic costs to crops and food production if there is a blanket ban. School-based intervention will have to go hand in hand with training for service delivery for children who need help.

On a more general note, I think a lot has been done on the mhGAP-IG and in attempt to respond to the WHO Mental Health Action Plan 2013-2020. Different countries and research institutions and organizations will have contributed in many different ways. Grand Challenges Canada have requested us to share with WHO what our Centre has been able to achieve through their grants to us. We are using a different platform for this.

Prof David M. Ndetei
Professor of Psychiatry, University of Nairobi
Founder and Director, Africa Mental Health Research and Training Foundation, Nairobi, Kenya

2. WPA Scientific Sections

1) Dr. Kostas N. Fountoulakis
Chair, Section on Evidence Based Psychiatry

First of all why (not?) death by suicide only? We know that mental disorder is related to premature death (loss of life years).

Bipolar disorder: valproate has no hard data concerning the long-term efficacy (while other agents with today similar cost do have) and it is contra-indicated in young females. Lithium needs monitoring. How feasible is this in low income countries?

I completely disagree (on the basis of data) with I13, I15 and I18

It has been proven that severity should not be a factor influencing the choice of treatment modality.
For adolescents antidepressants might not work at all and psychotherapy also probably not. Therefore percentages do not correspond to data. If I am right, then the following tables with cost/benefit are not valid.

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Editor-in-Chief, Annals of General Psychiatry

2) Dr. Gregor Hasler
Chair, WPA Section on Pharmacopsychiatry

I share Kosta’s concern about valproate treatments, excluding most women. However, I think that there are ways to use lithium in low income countries (e.g., low dose). Why not add interventions for bipolar disorder that involve antipsychotics?

In table 2, P3, I don’t understand why indicated prevention is more expensive than general prevention, and why costs are the same in high income and low-income countries. It would be good to know more about these interventions.

Regarding psychosocial interventions/treatment: I think WPA should think about how to train people responsible for mental health in low income countries. Experience by the International Red Cross shows that this can be highly effective.

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3) **Prof Jan Scott**  
Chair, WPA Section on Affective Disorders

This landed with a short turn round during a very very busy academic week...  
Given the above-  
I have three immediate comments...although some may be undermined somewhat as I have not got time to refer to the original articles...

1. **The cost-effectiveness issue**-  
   It would be helpful if some estimate of cost was provided versus e.g. either relative risk reduction or NNT (which tend to be much higher for community preventive interventions)....  
   And some notes on whether unit costs were calibrated per country and based on their unit costs (not an international benchmark)- as this will give greater insights into affordability (versus GDP)  
   By giving some indication of costs versus RRR or NNT it may help clarify how the apparent costs of universal and targeted interventions in different countries could be seen as equivalent  

2. **Psychological interventions**- the efficacy and effectiveness of interventions varies significantly with the model used....e.g. CBT for panic or anxiety is estimated to be x6 more effective in preventing relapse than a non-directive approach...  
   So - I worry that using global terms like ‘psychological interventions’ is very unhelpful.....in countries where resources are scarce it is especially important to fund wisely.....and offering ‘model-free/theory-free’ psychological interventions that lack any evidence-base is inappropriate....  
   However- there are simple brief interventions that are easy to use that can enhance medication adherence in individuals with severe mental disorders across cultures.... i.e. the general statements made about psychological therapies are potentially misleading  

3. I concur with comments made by gregor hasler regarding medications in affective disorders...also- when recommendation by WHO are non-concordant with other international clinical practice guidelines it would help if WHO could add footnotes to explain the rationale...  
   There may be very good reasons- but it must NEVER look as if we are offering a suboptimal intervention in different countries or cultures...no matter what the challenges of service delivery in such places...  
   Apologies these are ‘off the top of my head’ type comments... But the imminent deadline means I have little time to offer more detailed reflections

4) **Dr Norito Kawakami.**  
Chair, WPA Section on Epidemiology & Public Health

I am sure that there is plenty of evidence that low-cost psychological interventions improve depression and anxiety in the community and workplace.
I wonder why the WHO did not include such universal interventions other than school-based interventions. Is this because cost-effectiveness was not fully investigated?

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5) Dr Anthony P. S. Guerrero  
Co-chair, Child and Adolescent Psychiatry Section

One view, coming from the child and adolescent psychiatry world, is that, other than with suicide prevention, there did not appear to be as much coverage for other child/adolescent conditions, for which there is evidence of effective prevention and early intervention approaches (e.g., conduct/violence problems, autism spectrum, ADHD, child maltreatment, etc.) I’ve attached a few articles of potential interest.

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6) Dr Carlos Augusto de Mendonça Lima  
Chair, WPA Section of Old Age Psychiatry

First I think that the title should be changed: it let think that the interventions concerns much more mental health problems than those mentioned by this strategic plan. By focusing Suicide prevention in adolescents, the group of older adults (with the highest suicide rate in all ages and in all cultures) is excluded. Choosing only Psychosis, Bipolar Disorder, Anxiety Disorder and Depression other mental health problems are excluded such as Mental Retardation, Neurocognitive Disorders (both associated with high impact per year lost) and Sleep Disorders (most frequent mental health problem). This is a political choice and (the document) should at least explain these restrictions.

At Annex 1, Paragraph 2 it is said that Mental health is closely related to attainment of several other SDGs such: poverty reduction, achievement of gender equality, sustainable economic growth and decent work for all and reduction of inequality within and between countries: Shouldn't we include in this list (i) stigma and discrimination reduction and (ii) equal attention for people across the life span?

Economic parameters were assessed for two country income groups: Low and Lower-Middle Income Countries and Upper-Middle and High-Income Countries. The choice of countries means that the two groups have equivalent number of population (about 2.500 billion for the first group, about 2.400 billion for the second group) but the difference in the distribution of the group of ages are quite different. The second group has much more older
adults than the first group: what consequences could this have on results when we consider the impact of interventions for this specific group of age?

At Table 1:
- Population-based interventions: I call WHO to include in the future a P4 group on Prevention of Suicide in Old Age.

- Individual interventions

a) Psychosis: it is necessary to remember that in several countries newer anti-psychotic drugs are not allowed by law to be prescribed by Primary Care doctors. Was this considered in the estimation of the cost-effectiveness of the intervention that include these drugs when compared to the older anti-psychotic drugs?

b) Bipolar disorder: I join my colleagues when they have made considerations on the use of lithium and valproate. We need to know if the cost of the drug monitoring of lithium and valproate (recommended by good practice international guidelines) were considered when the estimation of the cost of these treatments was made.

c) Anxiety disorders: this is a very complex group of disorders and it is not possible to limit the interventions to only those proposed. The exclusive use of antidepressants as reference drug treatment is not adequate. As well the kind of psychological interventions proposed is not clear. I call WHO to drop out by now this mental disorder group and open discussion for further debate. This is particularly important for the group of older adults with high prevalence of somatic expression of anxiety and high risk of multimorbidity and anxiety.

d) Depression: why not include a I22 group on Psychological treatment and antidepressant medication of recurrent moderate-severe cases on a maintenance basis?

Here are my possible comments in the short time was given for us to analyse this very important text.

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President, WPA Section of Old Age Psychiatry
Councillor. EPA Section of Old Age Psychiatry
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7) Dr Massimo Moscarelli and Dr Dominic Hodgkin
Chair and Secretary, WPA Section on Mental Health Economics

Thank you for the opportunity to share our comments on the draft of the WHO discussion paper on cost-effective interventions for mental health.

1. The document needs to state the perspective of the cost-effectiveness analysis: whether it is computed based on societal cost or on cost to the health care system. E.g. If one uses a health care system perspective, some interventions may look more cost-effective because they require more labour from family members, which is a cost to society but not to the health care system.
2. Similarly, the analysis does not appear to consider the patient’s perspective on treatment’s effectiveness. Recent work on patient-reported outcomes could be relevant.

3. Do these analyses reflect up-to-date costs of all medications? e.g. in the last decade, some novel antipsychotic and antidepressant medications have become less expensive as generic versions become available. This is relevant if taking the perspective of the health system.

4. It is good that the document notes that "global analyses such as these should be accompanied by analyses in the local context. Other tools, such as the One Health Tool are available to help individual countries cost specific interventions in their national context." This is an important qualification, as these cost-effectiveness ratios will vary by country, for example with different wage rates and drug prices. But maybe WHO needs to highlight this qualification even more prominently, to discourage policy-makers from reflexively applying these exact C/E ratios to their own country. In addition, policy-makers should be encouraged to and carefully verify the likely impact of each “cost/effective” intervention for their own country context, to check for a potential substantial difference between “theoretical” and “real” cost-effectiveness. An example would be if the menu includes large and irreversible changes (e.g. closure of psychiatric hospitals to be substituted by C/E outpatient care).

8) Prof. Wolfgang Gaebel and Prof. Peter Falkai

WPA Section on Schizophrenia

- How were the 10 countries selected to give a representative sample of low/lower-middle and upper-middle/high countries?
- Table 1; P3: The jump from „interventions in schools” to „regular bans of highly hazardous pesticides“ comes somewhat unexpected and needs some introduction in the text above why and how this examples were chosen? Literature search? Survey of member states?
- Individual interventions – Schizophrenia: Basic psychosocial support and older and then next newer antipsychotics. Why is this differentiation made? We know that there are no differences between these groups in effectiveness, but in side effect profiles. Both groups have an intermediate, but no direct effect on functioning. What does improved functioning mean? Overall recovery? The recovery rate of schizophrenia is 15%. How is functioning measured?
- Individual interventions – Bipolar disorders: Why was Valproate chosen? Then Lithium? Lithium is the Gold Standard to treat Bipolar disorder with a mood stabilizer.
- Individual interventions – Anxiety disorder/depression: The questions from above appeal in the same way.
- Table 2: Even if the origin of the numbers can be deducted from the quoted papers, it would be nice to introduce the three columns. Cost, health impact and average cost/effectiveness ratio? Were such measures calculated for other countries and did successful prevention programmes arise from that?
9) Prof. Dave Baron

WPA Section on Medicine, Psychiatry and Primary Care

The treatment of mental health problems are among the most costly health expenditures worldwide. Numerous prospective assessments of mental health related health care costs are highlighted in the extant medical literature.

In the USA, one of the worlds largest healthcare economies, mental health was the most costly health condition, with over $201 billion spent in 2013(1). Over the past 6 years this number has risen dramatically, in part based on the cost to treat opioid addiction and related mental health problems. These sobering statistics have demonstrated the need to integrate mental health care into primary care settings as much as possible. An important role for behavioral health providers will be to increase liaison activities with primary care providers. The capacity to provide mental health care assessment and treatment in the primary care setting is critical, as the number of psychiatrists worldwide will likely never be sufficient. A key role for psychiatrists and behavioral health care educators will be to work closely with primary care providers from all disciplines to better train non mental health providers how to recognize and treat primary and co-morbid depression, anxiety, substance abuse, and other prevalent mental health disorders. Collaborations between Wonca(World Organization of Family Doctors) and the WPA(World Psychiatric Association) have begun and will need to continue to grow. Based on existing data, this may be one of the most cost effective strategies available to lower the global cost of health care.


