

Global mental health in low and middle income, especially African countries

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Mental health for all is the main goal of the global mental health movement. Central characteristics to achieving this are examination of the social determinants of health and a more preventive approach; greater task shifting or task sharing; emphasis on common as well as serious mental disorder; a strong research base and a commitment to human rights. Putting the interventions in place in countries with limited resources and particularly African countries that will best promote mental health is challenging and requires a careful balancing of priorities and approaches. Evidence in the form of randomised control trials and cost-effectiveness studies are necessary but not sufficient to achieving the set objectives. This editorial points to various considerations that may contribute towards the quest for mental health for all.

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Mental health for all lies at the centre of the movement for global mental health. Taking even a fairly modest conception of mental health as a state of being that enables a person to lead a socially and economically productive life, it is clear that much work still lies ahead for this movement. Global mental health evolved in large part from the public health importance given to Disability Adjusted Life Years (DALYs) rather than just mortality following the Global Burden of Disease Study in 1990 (Murray & Lopez, 1996) and the resultant emergence of mental health as a major health concern; together with the World Health Report of 2001 that sketched possibilities for real change in mental health (World Health Organization, 2001). Though it is early in the lifespan of this movement to properly and scientifically assess its impacts and outcomes in low and middle income countries (LMICs) (especially outside relatively small research sites) the approach and practices as well as appropriate allocation and use of resources that commonly categorise this approach need close examination.

The essential characteristics of global mental health can be debated at length, however five features stand out. First, the social determinants of health and a more preventive approach are embraced. Second, task shifting or task sharing is promoted. Third, ‘common’ mental disorder is recognised as critical to overall disease burden. Fourth, global mental health is

predicated on a strong research base. In particular controlled intervention trials and cost effectiveness/benefit analysis are seen as fundamental. Last, there is the strong belief in the rights of persons with mental disabilities.

In Africa as well as other LMICs there is extensive use of traditional interventions in mental health. Many such interventions are successful and appropriate to people’s beliefs and circumstances, but in a rapidly changing world and given the effectiveness of a number of interventions, there is good reason for expansion of ‘modern’ mental health care in LMICs. The global mental health movement have been central to calls for such growth. However, given the upstream issues that account for much of the mental health burden, direct mental health interventions may not be the best or most cost-effective way of improving population mental health. Some progress has been made in understanding these determinants with pointers to broad causes such as poverty, violence, poor education, unemployment, lack of housing, oppression and to narrower ones such as stigma, poor maternal mental health, bullying, trauma and being held with a mental disorder in a cruel or harsh environment.

Advocates of global mental health often (correctly), decry the lack of funding to mental health services in LMICs, but the call for additional funding is not always done with due consideration of the required upstream investments. In fact resources allocated to upstream programmes, even those with no intended mental health consequences, may foster better mental health than even the most cost-effective mental health services. Hence even if it were possible for a

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government to shift existing budgets away from certain programmes and towards mental health care this could impede rather than improve population mental health. Similarly, given that chronic diseases (both communicable and non-communicable) may lead to mental disorder, it must be asked whether interventions for the prevention of these diseases may be a better investment option than mental health treatments once patients have these co-morbidities. Moreover, it is unclear what proportion of a country's mental health budget should be put into the narrower programmes that have been shown to prevent mental ill-health. For example should a limited mental health budget in a LMIC go into preventing bullying in schools or to treatment of a child with depression that may have resulted from bullying?

Nowhere in the world is there a good formula for deciding the percentage of the fiscus or even of the health budget that should go to mental health. The suggestion that the percentage allocation from the health budget should be based on the burden of disease is nonsensical as there are various context as well as country specific issues that must be taken into account. If allocation as a percentage of DALYs were to be universally adopted, common mental disorders would get ten to twenty times more of the health allocation than severe mental disorders. Given the costs of comprehensive care for a person with severe mental disorder that may for example include medication, residential care, periodic hospitalisations and so on, and given the severe disruption that may be caused to self and community by a person with untreated severe mental disorder, such proportional allocation would be reckless.

The costs of providing a significantly scaled-up package of specified cost-effective interventions for prioritised MNS disorders has been estimated at US \$3–US\$4 *per capita* of total population per year in low- and lower- middle-income countries (Patel *et al.* 2015). While this does not appear to be excessive, it also does not mean it is affordable or the best use of resources. Where budgets are highly constrained very careful consideration is needed in allocating resources between (a) different government departments; (b) mental health and physical health within the health budget; and (c) different mental health conditions. This is no easy task and perhaps needing more consideration in global mental health debates.

Global mental health advocates generally agree that the introduction of large numbers of clinicians such as psychiatrists and psychologists in LMICs are unaffordable and a practically unlikely scenario. Moreover providing mental health as a vertical service is seen as an anathema to both good quality and holistic care and often to the cultural understanding of ill health, such as in many Africa cultures where the

physical, mental and spiritual merge within traditional healing practices.

The alternative usually offered within a global mental health framework is integration of mental health within general health care and a task shifting or task sharing approach. Both research and logical argument support these shifts, but even these low cost interventions cannot be done without additional resources. While some health workers may not be fully utilised and this would indeed be an opportunity to add mental health, presuming underemployment of generalists is often a false assumption. Mental health consultations are often time consuming and can require a health worker to spend up to an hour with a single patient. This severely blocks turnaround times in general health services. If mental health is to be included in the work of generalists then in most cases more generalists are needed. Moreover creating new categories with proven cost effectiveness such as community mental health workers to deal with mental health problems may also be a 'best buy', but is only feasible if resources exist that can be 'shifted' from somewhere and this usually cannot be done without negative consequences elsewhere.

Burden of disease studies have played an important role in catapulting mental disorders into the vision of health planners but in so doing have made mental health resource allocation in LMICs more complex. In 2010, mental and substance use disorders accounted for 7.4% of all DALYs worldwide making this the fifth highest cause of overall burden. Depressive disorders accounted for 40.5% of DALYs caused by mental and substance use disorders, anxiety disorders 14.6%, illicit drug use disorders 10.9% and alcohol use disorders 9.6% (Whiteford *et al.* 2013). Severe mental disorders were all found to be lower than this. Prior to burden of disease studies in most LMICs mental health care was virtually synonymous with care for severe mental disorders – albeit that many people with severe mental disorders received no care at all and that care was mainly provided in institutions rather than in communities. There was though a strong movement led by the WHO towards de-institutionalisation, with the principle that the money spent on a patient in institutional care should follow them into the community. In other words community care should not be a cost saving exercise but a human rights one.

So the question arises, if the resources for care and treatment in LMICs should not be shifted from care of severe mental illness, and if they should also not be taken from social determinants or from other health conditions that impact on mental health, where should they come from? Chisholm and others show that for each dollar invested in depression and anxiety disorders there will be a return of around \$4 (Chisholm

et al. 2016), and though this is extremely relevant from a cost-effectiveness point of view the initial investment has to come from somewhere and hence may never occur in most LMICs. Moreover, because the same returns would be less for a person with schizophrenia than say depression, does this mean that the person with depression should get priority? Again finding balance, with economics as only one of the variables considered, is critical.

The mental health intervention model is also very important. There appears to be relatively little work in LMICs and in Africa specifically as part of the global health movement where the mental health intervention is directly linked with socio-economic development or where an intervention assists a person with common mental disorder to understand and act upon the potential underlying reasons for their condition. Current approaches appear to expect people recovering from mental disorder to themselves link into economic activities, either self generated or existing, which can be extremely difficult – especially where employment rates can be as high as 50%. Successful programmes for common mental disorder may need to deal with the social and economic issues that people experience while at the same time addressing the mental health issues – as for example Basic Needs does with people with severe mental disorder (Basic Needs, 2016).

Moreover the interventions that research shows to be most effective (including cost effective) in LMICs tend to be psychotropic medication, cognitive behaviour therapy and interpersonal therapy or variations of these (Patel *et al.* 2007). In many cases the reasons why a person is experiencing a mental disorder may be irrelevant or inconsequential and symptom alleviation is a laudable outcome, but in other instances this may merely help to cover up an underlying dysfunctional (personal or social) situation. It is often important in counselling to understand the reasons for feeling a particular way and to act accordingly. For example helping a depressed woman who is being regularly beaten by her husband or a depressed worker who is expected to work 15 h a day to simply feel better, without addressing any underlying reasons that may be contributing or even causing their condition, may entrench negative social determinants or causes of mental ill health. Such intervention may even be said to be worse than useless.

The fundamentals for improved mental health in LMICs have been well developed through the global mental health movement, however further debate and unpacking concerns raised here may take this movement to even greater heights.

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