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Mental health challenges and possible solutions

Mohammad Taghi Yasamy¹

Introduction

The World Health Organization (WHO) was established 60 years ago based on a constitution that in its first paragraph stressed that its principles are basic to the “happiness, harmonious relations and security to all people...”. The stress on mental health aspects was repeated in the definition of health to show that this was not an incidental choice of words [1].

Again 30 years ago when the declaration of Alma Ata was introduced to the world [2], the definition was reaffirmed and a new opening to scaling up mental health interventions through integration into primary health care was put forward.

Yet, although considered formally an integral part of general health worldwide, and the WHO definition of health and its constitution implies that mental health is an integral part of health and as important as physical health [1], mental health is a somewhat paradoxical area of health. In reality, convincing data on the great burden of mental health [3,4] is juxtaposed with the low political will and insufficient resource allocation to deal with and avert the burden [5,6]. In fact, the low priority of mental health is not just a technical problem but an important moral one as well [7]. There is international documentation on the conspicuous shortage of mental health services in low- and middle-income countries [8] in the face of the increasing burden as a

result of rapid economic and social change [9]. What are the reasons for this service gap and how can the problem be resolved? This paper tries to tackle these issues and propose possible future directions.

Burden of mental disorders

The updated projections of global mortality and burden of disease, 2002–2030 based on country projections for 192 WHO Member States in 2006 support the groundbreaking work of Murray and Lopez a decade earlier and indicate that the burden caused by mental disorders continues to rise as predicted by them [3,4]. In a recent review it has been highlighted that, in addition to the 14% of the global burden of disease attributed to neurological/psychiatric disorders, the indirect burden of mental health problems should be sought beyond the realm of mental disorders and encompass a wide range of communicable and noncommunicable diseases; in fact, the indirect burden may even negatively influence progress towards the achievement of the Millennium Development Goals [10].

Current status of mental health services in developing countries

Despite the global advocacy for mental health early in the new millennium and a

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call for action by the ministries of health following the publication of the 2001 World Health Report [11,12], improvements have been inconspicuous, and there remains a wide gap in the provision of services for mental health worldwide. The shortcomings in mental health services, particularly in low-income countries, can be summarized as follows.

- The treatment gap for serious mental disorders ranges from 76.3% to 85.4% in developing countries and resources are insufficient in this regard [13]. For example, about a third of people with schizophrenia do not receive any treatment in their life.
- Scarcity of resources is evident in different areas: about a third of the countries do not have a mental health policy. Although the majority of countries have legislation on mental health, this has not been updated for 15 years in half of them.
- People with mental disabilities do not even benefit from disability benefits in 45% of low-income countries.
- Only about half of the low-income countries have community mental health services. About a quarter of low-income countries do not even provide essential antidepressant medicines, for example.
- Low-income countries have a median of 0.05 psychiatrists and 0.16 psychiatric nurses per 100 000 populations, while the same figures are about 200 times higher in developed countries.
- In most developing countries there is no specified public budget or there is only a small budget for mental health insurance.
- Not only is access to mental health services limited but service utilization is also quite low [6], Which is commonly due to lack of awareness about mental illness,

attributing it to superstitious causes or due to stigma attached to mental illness which is further intensified by dominance of isolated hospital based interventions instead of integrated services [14].

Main policy challenges and possible solutions

Needs assessment

Most countries tend to confine needs assessment to measurement of the burden of disease through large-scale epidemiological surveys. In situations where the mental health service gap is estimated to be about 90% – simply due to unavailability of trained manpower and resources – measuring burden in such a way is not a prudent policy.

Mental disorders are universal and very common. No country can postpone service development until the finalization of national level epidemiological surveys. It should be noted also that such surveys are very costly and the quality of mental health research is low in most developing countries; errors of measurement may sometimes exceed the confidence interval of measurements in the sample. Thus, in such situations emphasis on exact figures may create false precision. Most of the time, a simple and less costly qualitative study will provide the health system with information on the main priority areas. It would be more feasible to conduct a sound mapping of the mental health system that is directly needed before beginning any planning activity. The WHO assessment instrument for mental health systems (WHO-AIMS) is a useful tool developed for such a purpose and currently reports from 37 countries are published on the WHO website [15,16]. The important issue is that “the need for more research should

not be used as an excuse to delay scaling-up of mental health systems" [17].

Service development

WHO conducted a qualitative survey at the global level to identify barriers to improvement of mental health services in low- and middle-income countries through a qualitative survey [8]. The barriers identified were:

- insufficient funding for mental health services
- mental health resources centralized in and near big cities and in large institutions
- complexities of integrating mental health care effectively in primary care services
- low numbers and limited types of health workers trained and supervised in mental health care
- mental health leaders often lacking in public health skills and experience.

The Mental Health Gap Action Programme (mhGAP) is an action plan developed by WHO to scale up services for mental disorders for low and lower-middle income countries [18]. MhGAP is meant to build partnerships for collective action and to reinforce the commitment of governments, international organizations and other stakeholders to scaling up mental health services. It will be formally launched in WHO in Geneva in October 2008.

Inadequacy of prevention and promotion programmes

Traditionally, most public health leaders in countries have been specialists in communicable diseases. With the emergence of noncommunicable diseases as a new priority in many countries, including some of the developing countries, public health leaders have come to understand the importance of prevention and promotion in noncom-

municable diseases. But still mental health is not well positioned within this context. For example, for noncommunicable diseases the modern approach is to focus on reducing the burden of risk factors (primary prevention); thus the risks have been identified and strategies to avert their burden, such as WHO-STEPPS [19], have been developed and launched on an increasing scale in recent years. The WHO-STEPPS approach focuses on obtaining core data on the established risk factors that determine the major disease burden [19].

So, should developing mental health risk aversion strategies follow the methodology of other noncommunicable diseases? One of the best measures to reduce stigmatization of mental disorders has been integrating mental health programmes within the mainstream of general health, especially noncommunicable diseases. However, the similarities between mental disorders and other noncommunicable diseases in terms of multiple causes, chronic course and prognosis, burden and appropriate treatment interventions should not lead to ignoring the differences.

There are good reasons why mental health cannot be technically dealt with exactly as other noncommunicable diseases. For example, the association between risk factors and mental health problems is more sophisticated compared with other noncommunicable conditions [20]. While evidence on risk factors for and prevention of mental disorders is being generated, we are at an earlier stage of identifying risk factors and we are still in need of more data on effective primary prevention [20,21]. Furthermore, most risk factors identified for common mental disorders are macro issues, which are not easily modifiable or lie outside the health sector [21,22]. In addition, the demand for management of mental disorders is stronger and effective interventions are

more available than strategies for prevention and promotion.

Now the main question that arises therefore is whether prevention should be confined mainly to primary prevention and controlling the risk factors as opposed to early detection and management. There remain a few conceptual issues that need to be answered first. When feasible, primary prevention seems to be preferable because it prevents incidence and is more effective than the earliest case detections.

But there are limitations as well. First, there is no universal definition for risk factor. Although most authors use the term to imply a factor that is associated with the development of a disease, Brotman defines it as “a variable with a statistical association with clinical outcome” [23]. Second, many well known risk factors such as diabetes and hypertension are in fact intermediate risk factors for other non-communicable diseases such as ischaemic heart disease or stroke. Obesity may be perceived as a risk factor of both, but it is clear that early detection and treatment of these 2 conditions, which are risk factors for ischaemic heart disease, will be a primary prevention for the latter. Secondary prevention of depression may similarly be viewed as primary prevention of suicide. Risk factors, therefore, are not realities per se, rather they are relative concepts. Even the statistical validity of risk factors has been questioned by some scholars [23]. Thus, effective secondary prevention will make early detection and active follow-up possible and will reduce the burden of mental disorders as primary prevention may do.

The Centers for Disease Control and Prevention in the United States considers lack of mammography screening and lack of sigmoidoscopy or colonoscopy followed

by cigarette smoking as risk factors of cancer [24]. In the same vein, why shouldn't we coin “lack of screening for mental disorders” as a risk factor for the burden of mental disorders. It would be reasonable to conclude that, hand in hand with searching for robust associations between modifiable risk factors and mental health outcomes, we should expand the mental health prevention paradigm to consider early detection and treatment of mental disorders as a legitimate approach to avert the mental health-related burden.

Integration of mental health into primary health care

There is growing evidence in favour of integration of mental health into primary health care, and there is a tendency to accept that it is more cost-effective compared with hospital-based services [17,25]. Like all other branches of medicine, it is difficult for non-professionals to diagnose and treat all conditions. But it has been shown that well trained general practitioners are capable of diagnosing and treating most common mental disorders. There is some evidence from developing countries that mental health can be scaled up at the national level through involvement of multipurpose health workers with limited education as the first point of contact with the primary health care system [26,27]. However, still more evidence needs to be generated and systematically reviewed on how integration can be implemented in the most cost-effective way. In the absence of strong health systems, integration is out of the question. Revitalizing the primary health care initiative provides a positive prospect for the future. Until strong primary care systems are in place, community-based interventions should be considered as possible alternatives.

Prevention and management of substance abuse

Overall, there is more intense commitment toward containing substance use problems worldwide compared with other areas of mental health. The impact of injecting drug use on the transmission of human immunodeficiency virus (HIV) has added to the importance of substance abuse. In addition, the fact that substance abuse was identified as a risk factor for health by WHO also contributed to its prominence [28]. This concern, positive as it is, has however had some unwanted negative consequences in some countries and has resulted in the neglect of the rest of mental health. In some countries they have even separated the units and they are sometimes functioning under different divisions.

This raises a number of issues that need to be addressed. First, there is a need to ameliorate the general attitude towards substance use and to consider it a public health problem and not only a legal issue. Substance abusers need to be dealt with as patients and not criminals; in fact recent evidence indicates that restrictive measures are not consistently associated with better drug control [29]. In many countries developing or amending policies and legislation would be a prerequisite in this regard. Second, evidence-based approaches in promotion and prevention need to be encouraged. Third, there is a need to advocate for and scale up harm reduction services. Since 2006, methadone and buprenorphine have been included in the WHO essential list of medicines following the 14th WHO Expert Committee on the Selection and Use of Essential Medicines. But still in many countries these medicines are not available in the treatment and harm reduction services, where injecting drug users are vulnerable to HIV infection and hepatitis

and can spread the infection among others in the community. Amendments of policies and legislation are important measures to be taken in these countries.

On 24 May 2008, the 61st session of the World Health Assembly adopted an important resolution on strategies to reduce the harmful use of alcohol [30]. The resolution calls for the development of a draft global strategy to reduce the harmful use of alcohol by 2010. It is expected that implementation of the strategy will have positive implications in terms of reducing the disease burden. An important issue would be how to adapt the strategy to different regional and country situations, especially in some countries of the Eastern Mediterranean Region where alcohol is already prohibited. Regional committee resolutions would be complementary guidelines in this respect.

Brief interventions to manage substance abuse have provided the most cost-effective managements applicable at the primary health care level. The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for WHO by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings. The package has been translated/adapted for different cultures/languages and currently the Arabic version is being prepared [31,32].

Protecting the dignity and rights of patients

Little progress has been made in most countries to include people with mental illness in the society and improve attitudes and reduce discrimination towards them, although different strategies have been proposed [14]. However, still more evidence is needed to identify the most cost-effective interven-

tions in this respect. WHO stresses that, “mental health legislation is necessary for protecting the rights of persons with mental disorders in institutional settings and in the community” [33]. But it is not claimed that the development and formal adoption of a piece of legislation would be sufficient to promote the rights of people with mental illness in all situations. WHO has identified the different obstacles to implementing legislation and how to work out factors that can facilitate implementation [33]. Legislation and policy development may be considered a top down approach, which seems to work best in the presence of strong public infrastructures and an organized, advanced and aware civil society. In failed states as a consequence of chronic conflict or crises and in some socioeconomically less developed conditions, a bottom up approach toward improving the quality of services and promoting the dignity and rights of patients seems to be more promising. The chain-free initiative initiated by the WHO Regional Office for the Eastern Mediterranean (EMRO), which was commenced as pilot projects in Somalia and Afghanistan in 2006, is a bottom up approach which starts from concrete measures in the hospitals (removing chains from mental health patients and improving hospital care), extends through homes and ends up with community level advocacy dealing with the “invisible” chains affecting the human rights of patients in general [34].

Emergency mental health

Development of the Interagency Standing Committee Guidelines (IASC) has been a turning point in the history of mental health and psychosocial support in emergencies [35]. There is now universal agreement that there should be coordinated activities to provide a safe and secure environment

for survivors of emergencies and to apply psychological first aid instead of single-session debriefing. The issue of pre-existing mental disorders and services needs particular attention. Great emphasis is put on demarcating between distress and disorder in the new approach. A desirable skill mix of non-professional and interdisciplinary professional contribution is recommended as well [35]. What seems to be in need of further elaboration is i) how to apply non-pharmaceutical interventions for people suffering from disorders and severe distress and ii) how to address the issue of service coverage and how it can be optimized in large scale disasters.

Advocacy, fund-raising and strengthening mental health services

Mental health is a health area that has long been discriminated against and it needs to be supported by affirmative action. There is a considerable amount of advocacy work going on in the countries. The problem is that it is mostly ad hoc and on the occasions of mental health days or weeks. There is no evidence about the impact of such advocacy. Advocacy and anti-stigma activities at the country level need to be planned within a results-based framework with clear outcome measures.

Mental health units are not powerful enough within many ministries of health and non-existent in others. They need to be established, strengthened and provided with budgets. In countries where mental health and substance abuse units lie in separate units there is a lot of duplication of work and consequent waste of time and energy. Unification of mental health and substance abuse units under one umbrella would save on human resources and costs.

Fund-raising is equally important and all mental health policies should, accordingly, have a fund-raising component. WHO/AIMS has included an item for budget for mental health, the problem is that there has been no uniform approach to calculating a mental health budget. Most countries spend less than 3% of their health budget on mental health [6]. In 2007, EMRO supported by WHO/Headquarters initiated a new approach: the mental health sub-accounts within the national health accounts exercise [36]. The framework for methodology, classification and glossary was prepared and it is expected that the new approach will allow more precise estimations of mental health expenditures. A prudent approach would be to include a mental health sub-account exercise in all countries where a national health account initiative is in process.

In brief, mental health services need to be integrated in the mainstream of the health systems. At the same time, while such services need to operate horizontally across many health areas, vertical affirmative action is also vital to prevent mental health from being sidelined and to give it its due prominence.

Possible solutions

Although not meant to be comprehensive, the following are some possible solutions to current policy-related problems in regard to mental health.

- Development of cheaper, user friendly methodologies and instruments to assess mental health needs.
- Scaling up of mental health services through fund-raising, and equitable distribution of such services.
- Identification of risk factors for mental disorders through well planned research and systematic reviews so that primary prevention strategies can be built on the evidence generated. Unavailability of early detection and management could be considered a risk factor for disease burden as well. Relevant research in the second area is equally required.
- Development of policies and legislation (top down approaches) to improve quality of services and the dignity and rights of patients' needs to be complemented with bottom up approaches such as the chain-free initiative.
- Support of harm reduction strategies globally, hand-in-hand with evidence-based prevention and promotion interventions to deal with substance abuse problems. Developing/amending legislation may be important to facilitate harm reduction. Brief interventions in primary health care are effective means to manage the problem of high numbers of substance and alcohol users in the community.
- Adherence to IASC guidelines complemented further on how to provide full coverage to survivors and how to apply psychological interventions at different levels of need.
- Planning of advocacy activities, anti-stigma campaigns and fund-raising within results-based formats.
- Strengthening and support of mental health directorates/units in ministries of health with appropriate budgets.
- Unification of substance abuse and mental health units under one umbrella.

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