

## Development and policy

# Promotion of mental health in developing countries: a conceptual system

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### ABSTRACT

The global burden of neuropsychiatric problems is high, and is predicted to rise. An urgent need to address this issue is being expressed worldwide. The purpose of this paper is to present a conceptual model based on the systems approach to promote mental health in developing countries. In a health system, service providers, consumers, available services and the current demand form the primary elements of the system. A hierarchical pathway for promoting mental health through advocacy at international, national and community levels is presented. The possible inputs and outputs at each of these levels in promoting mental health have been reviewed. The role of education and skill development; availability of

micro-credit facilities; and sociocultural attitudes regarding sex, disability and stigma have been reiterated. The simultaneous development of resources and expansion of the service base in conjunction with education of consumers in utilisation of services has been suggested. The importance of international/national non-governmental organisations, legislators and policy makers in the success of such a programme has been highlighted.

**Keywords:** community mental health, developing countries, primary mental healthcare, promotion of mental health, systems approach

## Introduction

It was planned to achieve 'health for all' by the year 2000, but despite improvements in public health in the last few decades this goal still remains elusive, and mental health has the lowest priority in most public health programmes of developing countries.<sup>1,2</sup> Recently there is an awareness of the need to reverse this trend as the human, economic and societal costs of mental ill-health have been found to be staggering.<sup>3</sup> In 1999, neuropsychiatric illness made up 12% of the global burden of disease with the projection of 15% by 2020, when it would only be surpassed by cardiovascular disease.<sup>3,4</sup>

The undefined burden of loss of productivity, unemployment, strained relationship, alienation,

crime, propensity to addiction, suicide and increased healthcare cost to the family and the nation, together with the hidden burden of stigma, discrimination, social exclusion, violation of rights and freedom are even more difficult to estimate.<sup>5</sup>

The World Health Organization (WHO) defines mental health as 'a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'.<sup>6</sup> If mental illness is the tip of the iceberg then the submerged mass of people who though not ill, are not in a state of complete mental well being can be imagined.

There is no mental health policy in 78 countries; 37 have no legislation on mental health; 69 have no community care facilities, and 73 have no primary health care (PHC) facilities. Most middle- and low-income countries allocate a very small part of their gross domestic product (GDP) to health and spend less than 1% of their health budget on mental health.<sup>3</sup>

International collaboration and consistent pressure by health and human rights organisations/donor agencies that have a direct or indirect impact on determinants of mental health could ensure implementation of WHO guidelines for improving mental healthcare by all states. These guidelines are summarised in Box 1.

### Box 1 World Health Organization guidelines

- Strengthen linkages within WHO and with its collaborating centres.
- Ensure that all countries adhere to principles of basic human rights.
- Enforce evidence-based policies committed to equity ethics and gender issues.
- Promote democracy.
- Prevent wars violence and torture.
- Ensure least-restrictive care.
- Promote each individual's self-determination and personal responsibility.
- Assist individuals to achieve their own highest attainable level of mental health and wellbeing.<sup>3</sup>

## Systems approach

A systems approach to problems demands that a piecemeal approach is replaced by an overall approach. In a system, all resources such as men, money, machines and materials each form a subsystem. Individual subsystems/elements making up the overall system are designed, fitted together, checked and operated so as to achieve the goal in

the most efficient way. The main advantage of this approach is that it exerts a unifying influence on management by tying together the many specialist techniques needed to solve complex problems.<sup>7</sup> Mental health is a multifactorial problem encompassing biological, psychological, social, cultural and economic issues in its causation, promotion, prevention, treatment and rehabilitation, and a systems approach seems ideal for its solution.

Thus the mental health of a population is dependent upon many determinants of health. One of these determinants is the formal mental health system, a complex combination of health providers, consumers, the service provided and the demand for it, all of which are interlinked and dependent upon one another (see Figure 1).

## A hierarchical system for mental health

This formal system can be influenced by reaching out to involve and partner with others in areas which are traditionally outside the scope of health (see Figure 2).

At the international level, the United Nations (UN) could be a force to promote mental health, as most issues of mental health promotion are closely related to human rights, equity and vulnerability. WHO, the World Bank and other donor agencies could link promotion of mental health to assistance offered to governments of developing countries. They could pressurise governments for developing policies and legislations that reflect the WHO guidelines. A population-based mental health programme, preferably integrated with existing primary healthcare facilities, should be instituted by all developing countries with support from WHO. Intersectoral collaboration between the health sector and other sectors that indirectly influence health, such as education, environment, housing, social security, and respect for human rights, needs to be promoted at the national level. While this may seem too idealistic and difficult to achieve, there is

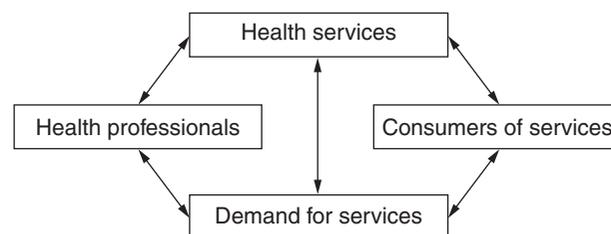
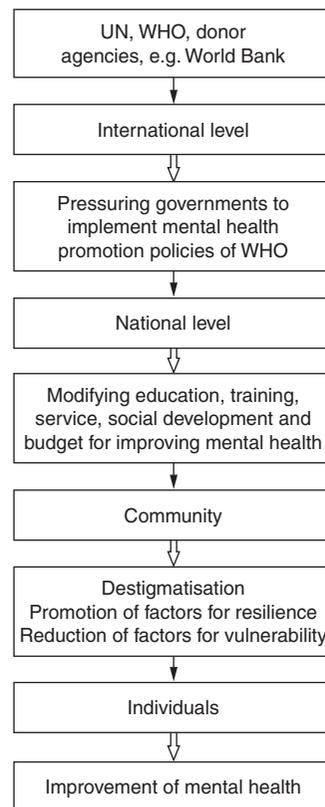


Figure 1 Primary elements of a health system



**Figure 2** A hierarchical system for promoting mental healthcare. ↓ Represents input; ↓↓ represents output

emerging scientific evidence that an integrated public health approach has the power to significantly reduce the burden of mental and behavioural disorders.<sup>2</sup>

Incorporation of indicators for mental health in the national health management systems could lead to allocation of resources for mental health, in accordance with evidence-based need. Policies to avoid stigma and discrimination in education, employment, places of recreation and healthcare for people suffering from neuropsychiatric problems ensures better integration of affected individuals in their communities and need to be developed and implemented.

There is a vicious cycle of poverty and mental illness, and lack of education has the most consistent statistically significant relationship with depression;<sup>5</sup> thus providing means for subsistence at the rural/urban level through skill-based education and micro-credit facilities at national level could minimise the detrimental impact of globalisation and urbanisation on mental health.<sup>8</sup> Financial barriers are being cited as more important than stigma as impediments to appropriate mental healthcare;<sup>9</sup> developing states need to enhance their health budgets in order to provide, if not universal at least equitable health, cover to their underprivileged

populations. A strong political commitment to improve governance and management of healthcare institutions is the key to the success of the suggested interventions.<sup>10</sup>

At the community level, schools are institutions where children learn socialisation early in life, and provide an important setting for health promotion and preventive interventions for children and youth through social-emotional learning and ecological interventions.<sup>11</sup> Promoting respect, tolerance, empathy and appreciation of diversity should begin early in life.

Professional schools and colleges for doctors, nurses, and other paramedical services could include behavioural science as a longitudinal theme in their curricula. Indeed, if medical education is to be evidence based, then the curriculum time devoted to mental health/illness should only be second to that allocated to cardiovascular disease, as by 2020 it is said that the prevalence of depression will only be surpassed by cardiovascular disease.<sup>4</sup> The departments of general practice/family medicine should pay special attention to mental health/illness, as most of the affected initially seek assistance from family/general practitioners.<sup>12</sup>

The principles of advocacy, promotion, prevention, cost-effective, high-quality treatment and

rehabilitation should be applied to mental health in a manner similar to physical health. Promotion of mental health needs to be pursued in the same way as heart health and tobacco control programmes.<sup>6</sup>

At the authors' institute, behavioural science, communication skills, community health science and ethics are longitudinal themes across the five-year undergraduate curriculum, and a structured four-week clerkship in psychiatry is mandatory. Similarly the residency programme for family medicine includes four months' clerkship in psychiatry. Other medical colleges in developing countries could modify their curricula based on local needs.

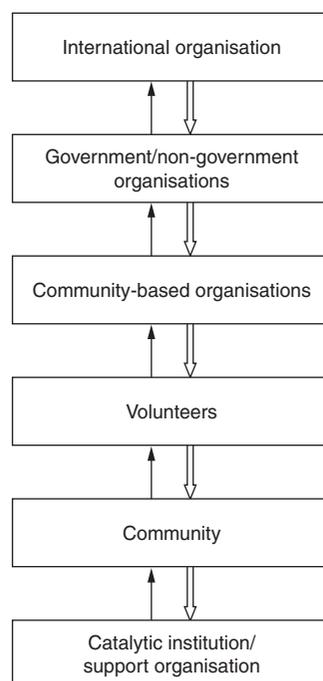
Once mental health does get affected, an effective partnership of healthcare professionals with the consumers becomes necessary. The recent National Institute for Clinical Excellence (NICE) guidelines recommend that all decisions should be shared with the users as this improves compliance. Contextually acceptable psychological treatments such as problem-solving therapy, cognitive-behaviour therapy and counselling can be as effective as drug treatment, and should be also offered as treatment options.<sup>13</sup> The concept of post-psychiatry also emphasises the importance of users in successful implementation of preventive and curative mental health services.<sup>14</sup>

In Pakistan a study done to assess perceptions regarding psychiatric illness in patients coming to a family medicine clinic revealed that 30% thought it was caused by supernatural powers, 40% were reluctant to accept a psychiatric diagnosis, and 70% thought that such a diagnosis carried a stigma.<sup>15</sup> Exploring patients'/families' perceptions and beliefs,

and providing information about causation, risk factors and available modalities of treatment, both pharmacological and non-pharmacological, could change help-seeking behaviour and make psychiatric diagnosis and treatment more acceptable for users.<sup>16</sup> A systematic review involving users in the delivery and evaluation of mental health services has revealed that this approach leads to clients having greater satisfaction with personal care and fewer hospitalisations.<sup>17</sup>

## A bottom-up system for mental health

Bearing in mind the difficulties of implementing the above system, an alternative, a bottom-up or grass-root approach, could be advocated (see Figure 3). The community could be mobilised for identification, prioritisation of needs, planning, implementation, monitoring, and evaluation of primary healthcare activities (including mental health). This could also be a step towards encouraging sustainability. This process would not start spontaneously, but an interested institution or a support organisation will be required to act as a catalyst. This is the model being used by our institution with considerable success, as the vision of the university is to improve the healthcare of populations, with special emphasis on under-privileged communities.



**Figure 3** Grass-root or bottom-up approach for improving mental health. ↑ Represents input; ↓ represents output

The capacity of different stakeholders in the proposed population to conceptualise the principles of self-help/self-reliance for identification and fulfilment of their own needs could be utilised. Active community participation and enthusiastic local leadership with involvement of public leaders in government and non-governmental organisations, and other resourceful persons in the community would be necessary for the success of the proposed system.

It is expected that capacity building would lead the community members/leaders to form strong community-based organisations (CBOs), which would identify the needs of their areas and present them to the local government departments for the allocation of funds and implementation of schemes for improving primary healthcare. It is envisaged that with the passage of time, sustainability will be achieved, and CBOs will become capable of fulfilling the community's needs by continuation of the activities introduced by the organisation that initially takes up this task of capacity building of communities. This will be achieved with the aim of improving health on a self-help rather than a charity basis, even after the initiating organisation withdraws. Ideally the results could be quicker and better if both the models could be simultaneously implemented.

## Subsystem of mental health services (see Figure 4)

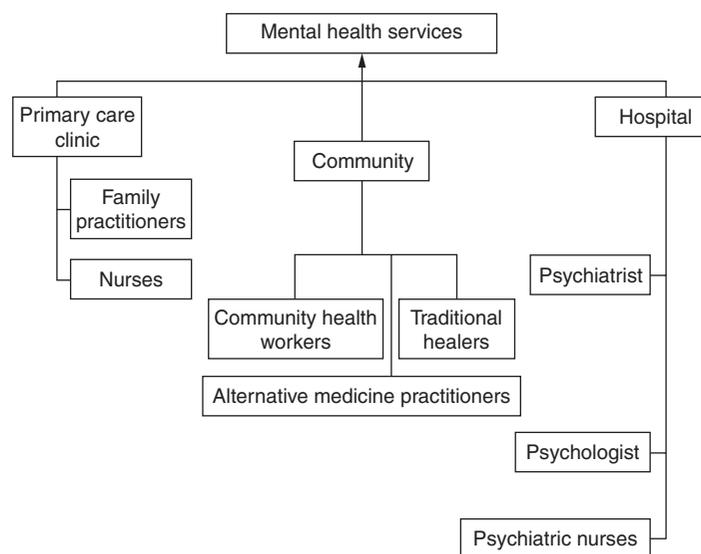
Due to the high prevalence of mental health problems and dearth of human and financial resources in

the low-income countries, one model of mental healthcare advocates integration of mental healthcare into existing PHC facilities.<sup>18,19</sup> In Pakistan, a randomised controlled trial using minimally trained community counsellors drawn from the same community revealed a statistically significant improvement in anxiety and depression in women of their own community after a series of weekly sessions spread over 8 weeks.<sup>20</sup> A significant improvement began after four sessions of counselling, and lasted for at least 8 weeks post-counselling.<sup>21</sup>

India has developed a community-based rehabilitation model comprising three tiers, in which the first tier is outpatient care, the second is involvement of community case workers, and the third tier is community rehabilitation initiatives. Case workers are drawn from the populations they are going to serve, and offer a service to users, their families, and communities.<sup>22</sup>

Similarly, a study in Chile revealed that despite few resources and marked deprivation, women with major depression responded well to a structured, stepped-care treatment programme, which is now being introduced nationwide.<sup>23</sup>

The strength of the primary care approach is the wide coverage, holistic concept of health, low cost and high accessibility. The downside is the poorly maintained government PHC infrastructure, a perennial shortage of drugs, and negative perceptions about quality of care which have led to an increasing use of private general practitioners as the first port of call.<sup>24</sup> Healthcare costs are borne privately by 77% of consumers in Pakistan and 87% in India.<sup>25</sup> In the current situation two approaches can be followed; one is to improve the functioning of government-led primary care facilities through better governance and management; the other is



**Figure 4** Subsystem of mental health services

to enhance the capacity of private healthcare professionals to diagnose, treat and refer appropriately.

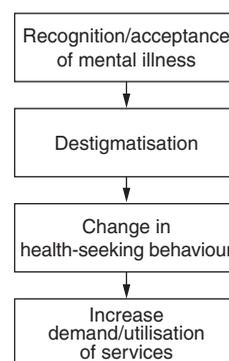
It is known that mental illness is poorly diagnosed and poorly treated by many general practitioners.<sup>12,26</sup> People who commit suicide have usually visited their physicians in the recent past and were not detected to be actively suicidal.<sup>27</sup> A review of published studies indicates that on an average, 45% of the suicide victims had had a contact with primary care physicians within one month of suicide, when the time period is extended to six months, 82% of those dying from drug overdose had made a medical visit.<sup>28</sup> There is evidence that physicians with more thorough training and favourable attitudes towards treatment of mental disorders have higher rates for treating depression.<sup>29</sup>

As indigenous practitioners (ayurvedic practitioners and hakims) and faith healers usually represent the initial point of contact in developing countries, increasing their ability to detect and refer through a simple educational intervention could also be a step towards detection and appropriate management of mental health problems.<sup>30,31</sup>

General practitioners use a holistic approach, and there is a body of evidence highlighting the value of this in terms of promoting health, both physical and mental, at individual, family and community levels.<sup>9</sup> Recognition and treatment of depression is better when continuity of care and personal doctor-patient relationships are known to exist.<sup>32,33</sup> General practitioners have traditionally played a role in educating patients, families and communities in changing their behaviours and beliefs to improve health outcomes, and thus are in a better position to actively destigmatise mental illness by removing the negative stereotypes and misconceptions surrounding it. All concerned individuals could work towards dismantling the discriminatory practices in homes, schools, workplaces, and places of recreation, particularly for the high-risk populations like refugees, minorities, and women and for those affected by neuropsychiatric illness.

### Subsystem of demand for mental health services (see Figure 5)

For promotion and utilisation of mental health services a demand has to exist. The key issue to be addressed is how to enhance this demand. The barriers for non-utilisation of available services are firstly the lack of acceptance that mental illness is a medical problem by the consumers, and secondly the excessive medicalisation of mental illness by the providers, with undue emphasis on correcting



**Figure 5** Subsystem for increasing demand/ utilisation of mental health services

neurotransmitter dysfunction by pharmacological means. The former could be addressed by opportunistic/systematic mental health education, including issues of causation, factors of resilience/vulnerability, available modalities of treatment, possible sociocultural interventions,<sup>34</sup> and prognosis in general practice clinics, hospitals, schools, work places etc. Healthcare professionals/educationists/sociologists/human right activists could organise seminars in schools, colleges, community centres and religious congregations to enhance awareness and to promote healthy lifestyles; the latter are common for improving both physical and mental health.<sup>9</sup> Print, theatre and electronic media could also be utilised for dismantling the myths and propagating the truth relating to mental illness.

### Conclusion

Mental health promotion is a complex multi-disciplinary challenge and requires a multipronged approach. The positive influence of education, skill development, employment, availability of micro-credit facilities, increased social support, respect for human rights, and equity has been described. Lack of information and detrimental sociocultural attitudes regarding sex, disability and stigma have been identified as barriers for the promotion of mental health, and some possible methods of minimising these have been highlighted.

A conceptual framework based on a system approach has been developed. The primary elements of a health system have been identified and an hierarchical pathway to promoting mental health, using international, national, community and individual resources as its subsystems has been outlined; the input and output of each subsystem, have been described, and ways to modulate each for the overall efficiency of promoting mental health have been suggested.

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#### CONFLICTS OF INTEREST

None.

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