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Community mental health: a brief, global perspective

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ABSTRACT

There is increasing realization of the magnitude of the disease burden attributable to mental, neurological and substance use disorders globally. This impact is disproportionately distributed, with slightly more than two thirds of this burden being situated within low and middle income countries. Furthermore, in both developed and developing countries, a significant treatment gap exists, but is greater in developing countries. Disparities in available financial and human resources for the provision of mental health services also exist, both across and within countries and regions of the world.

Despite this evidence, and the calls for urgent reform of mental health services globally, several key barriers continue to hinder progress. These include reduced access to services, inequalities in resource distribution, and stigma and discrimination. A 'balanced model of care' that takes into cognizance, the available resources and context; advances a task sharing approach and recommends the increased utilization of community mental health services, is a pragmatic approach that can help to surmount these barriers. Additional drivers of change, that can enhance the implementation of this approach are also presented and discussed.

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1. Background

Global attention to mental health issues is slowly but steadily gaining traction across the world, as a culmination of a series of important historical steps. The global burden of disease study, which utilized the composite measure of disability adjusted life

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years to rank all diseases and injuries was an important first step; which brought to the fore, the significant burden accruing from mental, neurological and substance use (MNS) disorders (Murray and Lopez, 1996). The World Health Organization (WHO) responded to these emerging facts with a renewed focus on mental health, as reflected in the theme of its world health report of 2001 titled *"mental health: new understanding, new hope"* (World Health Organization, 2001). Additional impetus was generated from the collaborative efforts by global mental health experts, which led to a series of powerful, evidence-based advocacy papers since 2007 (Prince et al., 2007; Patel, Simon, Chowdhary, Kaaya, & Araya, 2009; Patel & Thornicroft, 2009; Prince, Acosta, Castro-Costa, Jackson, & Shaji, 2009; Patel, 2012; Saraceno et al., 2007; Saxena, Thornicroft, Knapp, & Whiteford, 2007).

Furthermore, the WHO's world mental health surveys clearly highlighted that the majority of people with serious mental disorders were not accessing any treatment (Wang et al., 2007). Consequently, the WHO launched the Mental Health Gap Action Programme (mhGAP) in 2008, as well as the intervention guide (mhGAP-IG) manual to counter this treatment gap (World Health Organization, 2008; World Health Organization, 2010). The United Nations has also lent itself to the mental health cause with the launching of the WHO Mental Health Action Plan 2013–2020 (World Health Organization, 2013).

There is clear evidence to recommend that mental health interventions are best delivered in the community; or should be available within close proximity of the where people live. Community mental health services aims to prioritize the treatment as well as rehabilitation of individuals with mental disorders, and to improve their capacity to live and function optimally within their communities, without disrupting their fulfilment of major life obligations such as to family, friends, neighbours and work (Slade, 2009).

However, despite these sustained efforts over the last two decades to ensure that mental health is accorded priority attention, several hurdles have endured and continue to hinder the attainment of the provision of affordable, accessible and evidence-based, qualitative mental health care services for people in need, across the world. This article presents some of these challenges, as well as the rationale for rethinking the organization of mental health care services and a shift towards community mental health services.

2. What are the challenges?

A combination of several factors continue to hold back the progress of mental health reforms across the world, despite clear and available evidence. These factors act independently and in tandem, to reduce access to qualitative mental health care services, and they include:

2.1. Treatment gap

The world mental health surveys revealed that more than two thirds of people with serious mental illnesses across the world do not receive any care at all. This treatment gap is highest in low and middle income countries (LMICs) where nine out of ten people with serious mental disorders may not have accessed any care whatsoever, in the preceding year (Demyttenaere et al., 2004). Additionally, reports also clearly show that treatment coverage for physical disorders is much better than those for mental illnesses in both developed and developing countries (Ormel et al., 2008).

2.2. Reduced life expectancy

Individuals with mental illnesses suffer reduced life expectancy and die earlier than their counterparts without mental illness in a given environment (Fekadu et al., 2015; Lawrence, Hancock, & Kisely, 2013; Wahlbeck, Westman, Nordentoft, Gissler, & Laursen, 2011). The long held myth that mental disorders do not cause mortality is therefore, incorrect. Putative mechanisms underpinning this observed disparities include the high medical co-morbidities associated with mental illness and its treatment, as well as the poorer access to general health care services for physical disorders such as heart diseases (Lawrence et al., 2013).

2.3. Inequalities in the distribution of mental health resources

The burden of MNS disorders, as well as the human and financial resources required to address these burdens are not equitably distributed across the world. It is estimated that about 70% of the global burden of MNS disorders occur in LAMICs while high income countries enjoy about 90% of the global mental health resources (WHO European Ministerial Conference on Mental Health, 2005). Furthermore, the United States of America, a high income country; has more psychiatrists than the two most populous nations of the world, China and India; as well as all the countries of the African continent combined together (Patel & Thornicroft, 2009). Intra-country disparities also occur, with the majority of the mental health resources usually concentrated in the large cities and often times, in a particular region of a given country (Gureje, 2003). Superimposed on the insufficient numbers of available mental health professionals is the consistent loss of skilled manpower from developing countries to high income countries (Gureje et al., 2009). These practical realities ultimately culminate in reduced access to mental health services for the larger proportion of those in need.

2.4. Stigma and discrimination

Widespread stigma and discrimination of people with mental illness is still rife, with associated occurrence of human rights abuses. About 8 in 10 people with depression had experienced discrimination – usually within familiar settings such as with family members, friends, work relationships, marriage and divorce and with other interpersonal relationships (Lasalvia et al., 2013; Oshodi et al., 2014). Even more importantly, nearly forty percent of people with depression will not reach out for things they truly consider important in their personal and work life, out of fear (anticipated stigma) that they may be discriminated against (Lasalvia et al., 2013). This hinders progress, as the tendency is to hide family members with mental illness out of embarrassment, rather than bring them forward to access the treatment and care they need. Such individuals are thus, often at increased risk of suffering human rights abuses. Similar findings have also been reported for people with schizophrenia (Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009).

3. The 'balanced care model' of mental health services

It is a truism that effective mental health care services can neither be delivered exclusively within the hospital setting, nor can this be achieved exclusively within the community. Some individuals may experience very serious mental disorders that will necessitate in-patient hospital care; while some others will still be able to function within the community, albeit with some challenges, on account of less serious symptoms. It is therefore pragmatic to consider options for integrating the different