Implications of Global Mental Health for Addressing Health Disparities in High-Income Countries

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ABSTRACT

The fields of cultural psychiatry and global mental health have distinct lineages but share domains of interest. The movement for global mental health has been successful in making mental health a priority in global health and securing grants to study interventions in low- and middle-income countries (LMICs). Lessons learned from global mental health efforts in LMICs are relevant to addressing health disparities and improving care for vulnerable populations in high-income countries. These interventions stress community collaboration in designing and delivering mental health care, integration of mental health into primary care settings, and engagement of trained and supervised nonspecialist health workers in care delivery. The framework of structural competence provides a path forward for psychiatry to collaborate with community organizations to adapt global interventions to local settings.

Global mental health and cultural psychiatry both have roots in the field of comparative psychiatry. Its early practitioners included Emil Kraepelin, a German psychiatrist considered the father of modern psychiatric classification, and W.H.R. Rivers, a British psychiatrist and anthropologist. These physicians undertook the first major expeditions in comparative psychiatry at the turn of the 19th century. Rivers traveled to the Torres Strait between Papua New Guinea and Australia to study mental illness and healing among its residents. Around the same time, Kraepelin traveled to Jakarta, Indonesia, to study the mental health of Javanese patients in a Dutch asylum and compared their symptoms to those of his German patients. He used his
observations to explore which aspects of mental health disorders could be observed across cultures and, therefore, may have a common psychopathology.2

These psychiatrists attempted to address questions that are mutual domains of interest among practitioners of global mental health and cultural psychiatry: which aspects of mental illness are universal or culture specific, and can interventions developed in one setting be modified to be effective elsewhere?

Developing from these shared origins, global mental health and cultural psychiatry have been shaped by contributions from different academic disciplines and continue to evolve. In the early decades of the 20th century, cultural psychiatry existed as a branch of medical anthropology called ethnomedicine, which focused on local theories of illness causation and techniques used by healers to diagnose and treat illness. Ethnopsychiatrists studied how psychopathology was expressed and treated in different cultures.3 The transcultural psychiatry movement began at McGill University in the 1950s and built on this framework to explore cross-cultural differences in risk factors, causes, and experiences of mental illness and applicability of mental health interventions across settings.7 Its practitioners conducted cross-country comparison studies such as the International Pilot Study on Schizophrenia.4 In recent decades, cultural psychiatrists made the analysis of psychiatric theory and practice a subject of their investigation.5

THE RISE OF GLOBAL MENTAL HEALTH

Early research conducted by cultural psychiatrists had limited public health and clinical application in international settings due to lack of economic and political support, and was mainly used to develop interventions for refugees living in high-income countries. Although mental health was included in the 1948 Constitution establishing the World Health Organization (WHO), it was not until the 1970s that the WHO began developing initiatives to improve population level mental health outcomes by incorporating mental health services into primary care in low- and middle-income countries (LMICs).6 However, when the Millennium Development Goals were signed by all United Nations member states in 2000 to commit world leaders to combat poverty, hunger, and disease, to reduce child mortality, and to improve maternal health by 2015, mental health and other noncommunicable diseases were still not included as priorities.7 This lack of inclusion has been highly criticized, as mental illness has been found to disproportionately affect the poor and marginalized and have a profound effect on maternal well-being and childhood failure to thrive.8 Global mental health advocates have argued that stigma against mental illness among all levels of society has been a major barrier to implementing mental health policy to improve overall health outcomes for both developing and developed countries.8

In the past 2 decades, inspired by the success of activists for HIV, mental health researchers, public health practitioners, and clinicians have advocated putting mental health on the global public health agenda. The growing use of the disability adjusted life year (DALY), an epidemiological research metric that measures the global burden of health problems by combining morbidity and mortality attributed to them, has been helpful in aiding this cause. DALY analyses have demonstrated that mental, neurological, and substance use disorders account for a large portion of the global burden of disease, and that mental health problems are increasing worldwide, especially in LMICs.9 The 2007 Lancet series on global mental health emphasized these findings and highlighted the gap between the burden of mental illness and the availability of effective mental health services, which exceeds 75% in LMICs.10

The Lancet series officially launched the Movement for Global Mental Health, which is now a worldwide organization with open membership.11 Advocacy efforts by its members were successful in increasing awareness of mental health as a global health priority. In 2013, 194 ministers of health at the World Health Assembly (the decision-making body of the WHO) adopted the WHO’s Comprehensive Mental Health Action Plan, pledging to provide comprehensive and integrated mental health services and social services in international community-based settings.12 Meanwhile, the National Institute of Mental Health, Grand Challenges Canada, and the Wellcome Trust (United Kingdom) have committed funding to global health initiatives and research.13 Interdisciplinary research collaborations over the past decade have produced a body of knowledge about effective strategies to improve mental health for people living in globally underserved and poorly resourced settings.

GLOBAL MENTAL HEALTH AND COLLABORATIVE CARE

The interventions found to be most effective in closing the treatment gap are rooted in the health care delivery model called integrated collaborative care, in which task sharing is a central feature.14
In this model, nonspecialists contribute to detection, diagnosis, treatment, and prevention of mental health disorders in a collaborative, stepped-care approach that can be delivered in community and primary care settings. Nonspecialists include skilled health professionals such as nurses and primary care providers, along with community health workers, volunteers, people with lived experience, and caregivers. The role of specialists shifts from service delivery to training and supervision. The rationale for engaging nonspecialists via task sharing is that they are numerous, affordable, and make mental health services more accessible to communities. There is robust evidence from different settings in LMICs demonstrating that community health workers and lay people can deliver effective psychological and psychosocial interventions for depressive and anxiety disorders, schizophrenia, and dementia. A Cochrane review found that nonspecialist health workers and teachers in LMICs improve patient outcomes for general and perinatal depression, posttraumatic stress disorder, alcohol use disorders, and dementia. Meanwhile, a systematic review of 21 qualitative studies done in LMICs showed that task sharing was viewed as feasible and acceptable by health care providers and service users. The WHO has adopted a strategic plan to address mental illness called the Mental Health Gap Action Programme, which emphasizes task sharing and has become a major practical tool in global mental health interventions.

An important component of integrated collaborative care is that the majority of care should be delivered outside of specialty mental health care settings and focus on homes, schools, work, or primary care centers. Additionally, interventions should actively involve patients and families in their design and implementation, and mental health care should be integrated with social and economic interventions. Use of technology is encouraged because tools like telemedicine can increase access to specialty care, and use of mobile phones may improve follow-up and adherence.

**LESSONS LEARNED FROM GLOBAL MENTAL HEALTH**

There has been a growing recognition that practices developed to improve health in LMICs may be effective in addressing health needs of marginalized communities in high-income countries (HICs). Such strategies include empowering community-based organizations, activating community leadership, using technology to improve access to health care, centering campaigns on community-identified health issues, linking clinical care with public health and social services, and connecting health with economic development. An example of an organization that leverages initiatives that use proven global health strategies to improve health in underserved communities in the United States is Global to Local (G2L). To address the gap between clinical care and a healthier lifestyle in Somali and Latino communities in Washington State, G2L has employed community health workers of similar backgrounds to run healthy lifestyle groups in local community centers. In a similar way, key lessons learned from efforts to decrease the mental health treatment gap in LMICs may be used to address mental health disparities in HICs like the US. Effective global mental health strategies discussed previously can be adapted to local context based on community characteristics, availability of human resources, and priorities of stakeholders that include policymakers, service providers, and patients and their families.

Some critics argue that the movement for global mental health relies on psychiatric categories that are not valid cross-culturally and imposes Western disease concepts and treatments on developing countries. Global mental health architects in turn argue that although interventions do require some standardization to be scalable, measurement tools and treatments are systematically adapted to be appropriate to local context before they are transferred between cultures. Community priorities are an integral component in intervention design.

Vikram Patel, one of the architects of the movement for global mental health, argues for an approach he calls SUNDAR (an acronym that is the Hindi word for “attractive”), derived from a task-sharing model implemented by his nongovernmental organization based in India. He proposes that this approach can help tackle the persistent mental health treatment gap in HICs. He hypothesizes this gap developed from an overreliance on heavily medicalized interventions that do not adequately harness community resources, delivery of mental health care in specialized settings that are not embedded in the community, and use of psychiatric terminology that alienates people.

The components of SUNDAR are listed in Table 1.

Other experts have similarly argued that fundamental changes need to be made in the way health systems are organized in HICs. Services are expensive, inefficient, and do not adequately involve patients and families in the design of services. This leads to a treatment gap, particularly for more marginalized communities. It also causes a recovery gap in which service providers prioritize biomedical outcomes instead of the social and economic outcomes that matter most to service users.

The lessons learned from global mental health initiatives described above are not exactly new to psychiatry in the US. Integration with primary care and collaboration with commu-
TABLE 1. Components of SUNDAR

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Component</th>
<th>Example</th>
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<tbody>
<tr>
<td>S</td>
<td>Simplify mental health terms</td>
<td>Use terminology that is culturally salient and avoids stigmatization</td>
</tr>
<tr>
<td>Un</td>
<td>Unpack interventions into easy to deliver components</td>
<td>Provide guides for identification, diagnosis, and treatment that incorporate culturally salient components</td>
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<tr>
<td>D</td>
<td>Deliver care as close as possible to people’s homes</td>
<td>Deliver care in the community (e.g., at home, schools, workplaces, and community health centers)</td>
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<tr>
<td>A</td>
<td>Recruit and train Available members of local communities to deliver interventions</td>
<td>Train and supervise community members such as peers to deliver services, or teachers and parents in case of children</td>
</tr>
<tr>
<td>R</td>
<td>Reallocate specialized health workers to supervision and support of community mental health agents</td>
<td>Role of psychiatrist shifts from care delivery to training, consultation, and supervision</td>
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Adapted from Patel.36

Conclusions to provide care in everyday contexts were key tenets of community or public psychiatry after deinstitutionalization in the 1960s and 1970s.30 However, repeated funding cuts for community mental health efforts in the US have resulted in a fragmented mental health system in which a large proportion of care has been transferred from asylums to other institutions such as residential facilities and prisons.31 Commitment to community-based mental health has seen a resurgence in recent years with the implementation of the Affordable Care Act, which created funding for health system interventions that meet the triple aim of improving patient experience of care, improving population health, and reducing costs.32

FUTURE DIRECTIONS IN GLOBAL PSYCHIATRY

Existing methods developed by global mental health advocates can inform improvements and innovations in mental health care for diverse communities in the US. In particular, focusing on community-level collaborations in local research and initiatives can lead to progress in addressing social and economic factors affecting mental health.33 Psychiatrists and other mental health providers should further investigate effective adaptations of task sharing, with special consideration for local needs and priorities.

Structural competency, a growing movement within psychiatry (and medicine in general), provides one framework for such engagement with health systems. The concept of structural competence was developed by Hansen and Metzl,34 both psychiatrists and social scientists, to make social determinants of health the focus of clinical interventions. One of its aims is to train clinicians to design and implement structural interventions that focus on institutions and policies in collaboration with community organizations, nonhealth sector institutions, and policymakers.34 Psychiatrists and other mental health professionals can use this concept not only to change the focus of their clinical interventions, but to also focus their research on institutional level interventions to tackle health disparities. For example, engagement of peers to deliver mental health services in the US is a form of task sharing that can begin to help address structural barriers to recovery from mental illnesses. Peer mentorship has been effectively implemented in various locations in the US, including in the San Francisco Bay area, with a remarkable reduction in rehospitalizations (down 72% in the year after the peer mentoring intervention) and a significant cost savings of over $800,000 in prevented hospitalizations.35 There are ongoing efforts to evaluate this approach in collaboration with the National Alliance on Mental Illness at the University of California, San Francisco, and a structural competency-informed approach would explore whether peers are more acceptable and effective in helping patients navigate transition to the community and the stigma associated with mental illness.

REFERENCES


