“Think globally, act locally” – Local approaches to global mental health

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Introduction

“Think globally, act locally” is a slogan that dates to the 1900s Patrick Geedes. It considers approaching global issues with a local context by becoming more intentional in acknowledging and including the relevant people and resources to address global health issues. This essay aims to discuss the use of local approaches for global health issues, namely mental health. I plan to describe the current situation, discuss the epidemiology, and then analyse the global level approaches. Following this, I will investigate local approaches, expand on projects targeting disorders such as depression and suicide, and conclude which approach makes appropriate steps in addressing mental health. For clarification, the American Psychiatric Association (APA) defines mental illness as “health conditions involving changes in emotion, thinking or behaviour (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities”.

Epidemiology

Much work is needed to address the significant burden of mental health conditions and the substantial gap between the need for treatment and the relevant individuals receiving it. In low- and middle-income countries, between 76% and 85% of people with mental disorders receive no treatment for their disorder. Groups of society such as the "less-educated and extremes of age" are often associated with less treatment. (Wang et al, 2007). This allows their conditions to continue to affect their life and disadvantage them from contributing and participating in society through their home life, work or education and other activities they interact with. According to the WHO, mental health conditions now cause 1 in 5 years lived in disability. Not being able to participate as they usually would in work, for example, has a knock-on effect on other circumstances such as their economic stability, especially of concern in lower-income countries. This issue further increases stress and anxiety and perpetuates the person's mental ill-health, adding to the cycle. In addition, if most individuals are not receiving treatment, it reduces the available data on current health care for such conditions. This would be useful in looking at the

effectiveness of treatment and enable considerations for changes, improvements, greater funding, and research for other new interventions. The WHO also recognises that in some countries, people with mental health conditions often experience severe human rights violations, discrimination, and stigma. An attitude of disregard and undervaluing of affected individuals can affect how authorities address mental health issues. This manifests itself in the funding of mental health care services and resources, resulting in fewer people having access to services. The global median of government health expenditure that goes to mental health is less than 2% (WHO). Also, people may be living in fear to avoid discrimination and stigma. Individuals suffering from mental health conditions may not want to discuss it with family members, people at work or school, or even health care professionals as they worry that it will be of detriment to them such as losing their job or being ostracised in their community. The individual themselves may be in denial or choose to ignore signs that are conclusive to mental health conditions and may feel they need to continue fulfilling their role in society regardless of how they are coping. This leads to people going unnoticed and overlooked, therefore not getting the support they need to better their health outcomes and improve how they interact with others and function. In terms of the effect of stigma in health care settings, health care professionals may overlook signs and clinical presentations of mental health conditions based on traditional or cultural norms and stigma, resulting in patients not coming forward with their concerns. Furthermore, there could be a lack of exposure and training for such conditions based on the taboo associated with mental health/illnesses. In addition, approximately one in five people in post-conflict settings have a mental health condition. This shows the importance of other global issues and how it affects the population on multiple levels. The challenges that arise from conflicts, such as safety and security, housing, and forced migration, add to the stresses already present for many individuals.

Global approaches

In recent years, the need for addressing global mental health issues has been gaining traction. With reports from the WHO in 2001 to the Lancet Series in 2007, organisations are highlighting the global burden of mental health disorders. An example of a global approach is the Movement for Global Mental Health. Made in 2007, the Movement for Global Mental Health (MGHM) aims to improve services for "…people living with mental health problems and psychosocial disabilities worldwide, especially in low- and middle-income countries (LMICs) where effective services are often scarce." (MGHM). The movement focuses on scientific evidence and human rights and

highlights the need for treatment for those affected, particularly in LMICs. MGHM also hosts events that support networking, knowledge-sharing and international campaigning. Such efforts make steps to initiate change and bring awareness to a global audience. Moreover, the encouragement of evidence-based initiatives, further aids areas for potential research. As well as this, the idea of 'task sharing' is hoped to be used to scale up their efforts (Cooper 2016). This would be beneficial in reducing the burden on current health care professionals. Spreading the workload by training non-professionals will also enable services to reach a wider population. Despite the advantages stated, there are various criticisms of the organisation. Summerfield (2013) suggests that western ideals drive interventions and fail to consider the cultural views on the nature of mental illness and its treatment. This lack of acknowledgement when interacting with patients could lead to misdiagnosis and the development of interventions that are not appropriate to the region. In addition, Mills and Fernando (2014) highlight the medicalisation of everyday distress that could arise from a lack of awareness and understanding of the social context of various countries different to that of the western world. For example, different cultural interpretations of symptoms (Lund et al 2018). Additionally, the drive for scientific evidence and medical treatment of mental health conditions could perpetuate the financial agenda of the pharmaceutical industry (Cooper 2016). One of the ways this could be mitigated is through integration and partnership with local approaches, some of which I will mention later.

The Mental Health Gap Action Programme (mhGAP) is another global approach in the field. Launched in 2008, it is part of the WHO's attempt to address the substantial gap between the need and provision of mental health services. It focuses on primary health care settings to provide psychosocial assistance and medication. Its primary care focus aids community integration and support for locals. Despite this, contextual challenges are highlighted in reviews of the program (Keynejad et al 2021). Suggestions are made, emphasising the need to integrate the "biomedical model with cultural perspectives". This is crucial to address stigma and raise awareness of traditional practices that influence attitudes towards mental health disorders. Focus groups and workshops with the relevant stakeholders would be beneficial in targeting this. As well as this, it recommends the consideration of staff workload and enhancing trainee competency. In doing so, services provided can be effective and uphold the best practices possible.

A further example of global approaches is the WHO MiNDbank: More Inclusiveness Needed in Disability. It is an online platform that collates international resources and policies regarding

mental health and other areas. The initiative is part of WHO's QualityRights campaign which aims to end discrimination against those with mental disabilities. The online database provides free access to various national and international policies, laws, and reports. As well as this, they offer access to WHO resources for authorities to use. This catalogue aids the integration and dialogue between states. Countries can learn from others and keep up to date with other policies and reports that could influence the improvement of their legislation. Doing so takes steps towards enhancing awareness globally and initiating potential research and funding. In addition, the program promotes the enforcement of human rights and practice standards. Individuals, groups, and organisations can be aware of their rights and use this to have the confidence to ask for change. Although MiNDbank provides an excellent tool for collaboration and change, it has limitations. The responsibility for improving the conditions of those with mental illness still lies with the individual countries and regions. They must be willing to explore the database and apply findings to their systems to begin to augment their current approaches. In addition, whether practitioners and health care professionals adhere to relevant practice guidelines may not be known or be varied (Panesar et al 2020).

Local approaches

Various approaches target mental health disorders at a grass-root level, focusing on addressing issues within communities. I will expand on two examples within India that are helping to improve mental health outcomes in the region. According to Shidhaye (2020), the proportional contribution of mental disorders to the total burden in India almost doubled from 1990 to 2017. An example of an initiative trying to confront this issue is the Healthy Activity Program (HAP). It is a psychological treatment that provides lay counsellors to patients with depression in routine primary healthcare settings in Goa, India (Patel et al 2017). The intervention showed better results for primary and secondary outcomes than usual care, including an increase in remission (improvement of health) by almost two-thirds. In addition, the treatment was considered cost-effective in the setting studied. This is a positive consideration in scaling up the project whilst maintaining its sustainability. In addition, the training of non-specialists as part of the intervention draws on the ideas of task sharing (Cooper 2016). The study also draws on other interventions such as behavioural activation, which has associations with cognitive behavioural therapy (CBT) (Dimidjian et all 2011). Another strength of this example is that many patients had little awareness of depression and often presented with physical symptoms. This shows the trial can increase

recognition of mental health disorders and help the individuals involved to begin to equally consider their physical and mental health. Unfortunately, there are limitations to the study. A third of patients were still depressed post-treatment. The study suggests that the limited time of the intervention might be the cause of this. Also, the study does not focus on the long-term recovery of depression but rather on the response to treatment. Based on the shortness of the intervention, it is difficult to determine whether the treatment could be scaled up or has long term substantial effects. Scaling up of services and expansion of research ventures in the future could be aided through collaboration with global movements such as MHGM as mentioned previously. In addition, the intervention is carried out by non-specialists, this could have potentially decreased the effectiveness of the treatment. To analyse this further, a controlled study with the same method but carried out by specialists or trained mental health care practitioners could be considered.

Another example of a local approach is the VISHRAM programme. VISHRAM is a grass-root community-based project addressing mental health risk factors for suicide in villages in Vidarbha, India (Shidhaye et al 2017). The main aim of the programme is to increase the demand for care by improving mental health literacy and the supply of services for depression and alcohol users. Treatment was carried out by non-specialists as well as general physicians and psychiatrists, aiding collaboration, and distribution of workload. Results of the study included a six-time increase in contact coverage, showing significant success in achieving the aims set. Additionally, improvements in mental health literacy such as “conceptualisation of depression and intention to seek care” were noted. This change in mindset enables patients to adapt how they view their mental health and address future concerns. Although the study observes the contact coverage (contact with health services), whether the services patients encountered were effective is unclear. The review admits that analysing this within the study would have been beyond available resources. This could be addressed through partnerships with global organisations such as WHO’s mhGAP. Furthermore, some individuals were not able to be contacted in the study, potentially leading to selection bias as it excludes those who do not have a means of communication. Moreover, the increase in contact coverage may be due to a general increase in service quality rather than solely the VISRHAM programme. Despite these limitations, the intervention has had a substantial effect in addressing the availability and uptake of mental health services and hopes to scale up their efforts through the National Mental Health Program in India.

Conclusion

In conclusion, there is an appreciation for the contributions made by various global level organisations due to the large-scale funding and exposure to resources. However, the targeted focus of local approaches is essential in addressing mental illness. The increased awareness of specific issues affecting groups of people adds context and a greater understanding that allows more effective support for individuals with mental health conditions. Moreover, global, and local approaches working together to collaborate on knowledge and resources have the potential to increase the capabilities and productivity of services. And therefore, enable individuals to receive the treatment they deserve and have the chance to function and thrive in society.

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