

Neither myth nor stigma: Mainstreaming mental health in developing countries

Octavio Gómez-Dantés, MD, MPH,⁽¹⁾ Julio Frenk, MD, PhD.⁽²⁾

Gómez-Dantés O, Frenk J.
Neither myth nor stigma: Mainstreaming mental health in developing countries.
Salud Publica Mex 2018;60:212-217.
<https://doi.org/10.21149/9244>

Gómez-Dantés O, Frenk J.
Ni mito ni estigma: integrar la salud mental a los servicios de salud convencionales de los países en desarrollo.
Salud Publica Mex 2018;60:212-217.
<https://doi.org/10.21149/9244>

Abstract

Mental and substance use disorders account for 18.9% of years lived with disability worldwide. A rising prevalence of mental disorders was identified in the past decade and a call for global attention to this challenge was made. The purpose of this paper is to discuss new strategies to address mental health problems in developing nations aimed at dealing with them within the frame of the overall health system. Mainstreaming mental disorders implies five dimensions of integration: i) incorporating mental health interventions to the global strategy to address non-communicable diseases; ii) moving away both from the biological and sociological reductionisms around mental health prevalent in the past century; iii) addressing the whole range of conditions related to mental health; iv) migrating from the idea that mental disorders have to be treated in secluded clinical spaces, and v) the use of a comprehensive approach in the treatment of these disorders.

Keywords: mental disorders; substance use disorders; mental health; developing countries

Resumen

Los problemas de salud mental y el abuso de sustancias concentran 18.9% de los años vividos con discapacidad. En la década pasada se identificó una creciente prevalencia de padecimientos mentales que obligó a hacer un llamado global para atender este reto. El propósito de este artículo es discutir nuevas estrategias para enfrentar los problemas de salud mental en los países en desarrollo, en el marco de los servicios de salud convencionales. La incorporación de la salud mental al sistema de salud comprende cinco niveles de integración: i) sumar la salud mental a las estrategias globales vinculadas con las enfermedades no transmisibles; ii) alejarse de los reduccionismos biológico y sociológico asociados a la salud mental prevalentes en el siglo pasado; iii) atender todo el rango de condiciones relacionadas con la salud mental; iv) alejarse de la idea de que los trastornos mentales deben tratarse en espacios clínicos aislados, y v) tratar de manera integral los padecimientos mentales.

Palabras clave: trastornos mentales; abuso de sustancias; salud mental; países en desarrollo

(1) Centro de Investigación en Sistemas de Salud, Instituto Nacional de Salud Pública. Cuernavaca, Morelos, México.

(2) University of Miami. Miami, Florida, USA.

Received on: November 14, 2017 • **Accepted on:** December 20, 2017

Corresponding author: MPH Octavio Gómez-Dantés. Instituto Nacional de Salud Pública.
Av. Universidad 655, col. Santa María Ahuacatlán. 62100 Cuernavaca, Morelos, México.

E-mail: ocogomez@yahoo.com

The presence of mental and substance use disorders in the global health profile is expanding at a distressing pace. According to the Institute for Health Metrics and Evaluation, these disorders account for 18.9% of years lived with disability (YLDs) worldwide.¹ A rising prevalence of mental disorders was identified in the past decade and a call for increasing global attention to this emerging challenge was made.² This call was followed a decade later by the launching of the *Mental Health Action Plan 2013-2020 (MHAP 2013-2020)*.³

The purpose of this paper is to discuss new strategies to address mental health problems in developing nations. The first part of the paper presents data on the global magnitude of mental and substance abuse disorders and the responses to them, with emphasis on developing countries. This diagnosis sets the stage for the central message of this paper: the high prevalence of mental health problems demands the mobilization of additional resources to expand mental health care coverage in developing countries, but also new ways of addressing these disorders. We argue that the new approach should aim basically at mainstreaming mental disorders, which means dealing with them within the frame of the overall health system.

Most of the ideas contained in these integration proposals refer to the second objective of the *MHAP 2013-2020 (To provide comprehensive, integrated and responsive mental health and social care services in community-based settings)*: some are new and some are expansions of various ideas discussed in this plan. It is important to mention that this paper does not intend to promote specific clinical treatments for mental disorders. It is a health systems reflection, and, as such, it offers general ideas to increase access to mental health services and improve their quality.

Magnitude and response to mental health problems

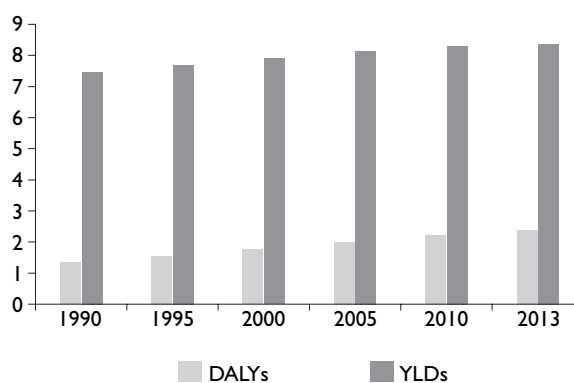
It is estimated that 15% of all adults aged 60 and over worldwide suffer from a mental disorder.⁴ A larger proportion of children and adolescents are affected (20%).⁵ Depression alone afflicts about 350 million people worldwide.⁶ It is the second single most important cause of disability after low back pain and will be the first one by 2030. Substance use is also increasing at an alarming pace. The number of users of illicit psychoactive substances alone is estimated at over 200 million worldwide.⁷ To this we should add the abuse of over-the-counter and prescription drugs, such as sedatives, painkillers and stimulants, which, according to the International Narcotics Control Board, occupies the second place in the list of most abused and trafficked types of drugs worldwide, after cannabis.⁸

In terms of burden of disease, in 2015, mental and substance use disorders were the sixth leading disorder category of disability-adjusted life years (DALYs), which combines losses due to premature mortality and disability.⁶ The contribution of these disorders to the global burden of disease increased from 4.15% in 1990 to 6.57% in 2015 (figure 1).⁶ This last figure is much higher than that attributed to HIV / AIDS and tuberculosis (4.35%). Within the mental and substance use disorders category, major depression accounted for most DALYs (2.19% of the global total), followed by anxiety disorders, drug use disorders, and schizophrenia (figure 1).

This picture is part of a larger epidemiologic transition characterized by the rise of chronic problems. The rapid pace of change has led to the growing importance of non-communicable diseases or NCDs, which are now the main causes of death in most countries, producing 38 million deaths annually, 28 million of which occur in low- and middle-income countries.⁹

On top of the human suffering they generate, mental disorders have a huge economic impact. It is expected that, by 2030, mental disorders will cost one third of the projected US\$ 47 trillion incurred by all NCDs worldwide.¹⁰

In most countries, the social response to this huge challenge is dolefully inadequate. Millions of people suffering from mental illness do not seek help due to lack of services and / or stigma. Indeed, the gaps in treatment are appalling. Around 80% of people with severe mental disorders in low- and middle-income countries receive no treatment.¹¹ The corresponding figure for



Source: Institute for Health Metrics and Evaluation. GBD Compare¹

FIGURE 1. PERCENTAGE OF DISABILITY ADJUSTED LIFE YEARS (DALYs) AND YEARS LIVED WITH DISABILITY (YLDs) ATTRIBUTED TO MAJOR DEPRESSIVE DISORDERS IN DEVELOPING COUNTRIES, 1990-2013

developed nations is around 40%—still an unacceptable proportion. In the face of such gaps, families bear the brunt of untreated disease and disability.

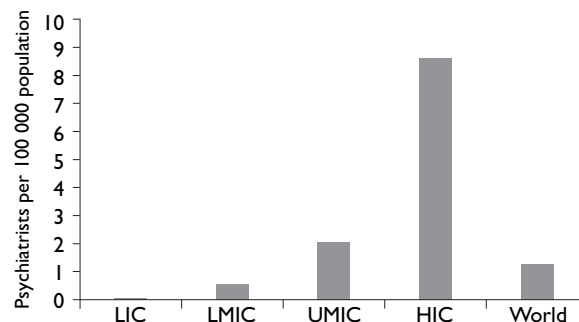
When formal services are reached and utilized, patients face huge problems of quality. In primary care settings, most mental diagnoses are overlooked, and treatment is most of the time scarce and usually symptomatic. The quality situation is no better in hospitals or even specialized units, which all too often operate as custodial rather than therapeutic institutions.

The low availability and quality of treatment are a reflection of the lack of resources. As mentioned before, mental disorders concentrate 7.4% of the global burden of disease. Yet, on average, only 2% of national health budgets is devoted to mental health programs.⁷ In low-income countries, expenditure in mental health is less than 25 cents per person per year, while in high-income countries is US\$ 44.8 per capita.

Regarding physical resources, globally there are 0.61 mental health outpatient facilities per 100 000, but with huge differences. There are 0.04 outpatient facilities per 100 000 population in low-income countries versus 2.32 outpatient facilities per 100 000 population in high-income countries.¹¹ Similar variations are observed in the availability of mental hospitals. The global median rate of mental hospitals is 0.03 per 100 000 population, ranging from 0.002 hospitals in the World Health Organization (WHO) Western Pacific region versus 0.16 in the WHO European region. Differences are also huge in terms of mental hospitals' beds. The rate per 100 000 population in the WHO African region is 1.7 versus 39.4 in the WHO European region.

Concerning human resources for mental health, half of the population of the world lives in a country where, on average, there is less than one psychiatrist per 100 000 population (figure 2).⁶ In contrast, the supply of psychiatrists is 8.6 per 100 000 population in high-income countries.

This gloomy picture led the WHO Executive Board to approve a resolution (WHA 65.4) calling for a comprehensive and coordinated response to the global challenge represented by mental disorders.¹² This call was followed by the launching of the WHO *MHAP 2013-2020* which has four objectives: i) to strengthen effective leadership and governance for mental health; ii) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; iii) to implement strategies for promotion and prevention in mental health; and iv) to strengthen information systems, evidence and research for mental health.³ This document has been followed by other global initiatives intended to expand and renew the options to confront the challenge represented by mental



Source: World Health Organization. Mental Health Atlas 2011⁷

FIGURE 2. MEDIAN RATE OF PSYCHIATRISTS IN LOW, LOWER-MIDDLE, UPPER-MIDDLE, AND HIGH INCOME COUNTRIES, 2011

and substance abuse disorders.^{13,14} The proposals that follow have that same purpose.

Mainstreaming mental health

As these brief epidemiological account illustrates, mental disorders represent a major challenge. In our rapidly changing world, mental disorders demand an immediate and far-reaching global response, which initially means mobilizing additional resources for mental health, but also implementing a different strategy to address them. The new approach should aim at mainstreaming mental disorders, which means dealing with them within the frame of the overall health system.

The keyword is integration. Mainstreaming mental illness implies five dimensions of integration: i) incorporating mental disorders to the global and local agendas related to NCDs; ii) moving away both from the biological and sociological reductionisms around mental health prevalent in the past century; iii) addressing the whole range of conditions related to mental health; iv) migrating from the idea that mental diseases have to be treated in secluded clinical spaces, and v) expanding the use of a comprehensive approach in the treatment of these disorders, which includes medication, psychotherapy and other types of therapies.

Incorporating mental health interventions to the global agenda related to NCDs

First, we need to make additional efforts to strengthen the presence of mental disorders in the global and local agendas related to NCDs. The basic concern of the

health agenda in the 20th century was the control of communicable diseases, along with maternal and child health problems. Fortunately, the awareness efforts made in the first decade of this century allowed for the inclusion of NCDs, which are now the main cause of death and disability in middle-income countries, into the post-2015 agenda. The Sustainable Development Goals, in fact, include objectives related to NCDs and mental health and substance abuse (3.4 and 3.5), but emphasis is made on premature mortality, a relatively minor consequence of mental disorders, which tend to produce chronic disabilities more than deaths.¹⁵ New efforts should aim at increasing awareness around the growing importance of mental disorders; incorporating this topic to local health agendas; and mobilizing additional global and local resources to deal with all their consequences (disability and premature mortality) in low- and middle-income countries.

Moving away from the biological and sociological reductionisms around mental health

Second, we should abandon the two reductionisms associated to mental disorders that were prevalent during the past century: the idea that they are nothing more than the expression of defective brain chemistry and that they should be addressed through a strictly medical/pharmacological approach, and the conviction that mental diseases do not exist and, thus, do not require specialized medical care. There is now agreement around the idea that many mental disorders are grounded in brain functioning,¹⁶ but this does not mean that all of them are or that they can be reduced to it or fully explained through it. On the contrary, like with any other health challenges, it is crucial to understand and act upon the social determinants of mental disorders (poverty, unemployment, social isolation, social exclusion, food insecurity and adverse features of the built environment, such as poor quality housing and neighborhood, lack of green areas and lack of public spaces for social interaction), some of which are common to other NCDs.^{17,18} We should also take distance from the idea that mental health problems are a myth and that conventional psychiatric care provides little help. The management of mental disorders should be guided by evidence regarding both the origin of these disorders and the effectiveness and safety of all available treatments.

Addressing the whole range of conditions related to mental health

Third, when addressing mental health we should consider that, in addition to psychiatric diagnoses in

the strict sense, it is also necessary to analyze the deep connection with other conditions that are not usually seen as part of the mental health agenda. We need to recognize that there is no health without mental health.¹⁹ To do so, we must move beyond the Cartesian dualism between mental and physical health. To begin with, there is a mental component in most diseases, as shown by the key role that stress plays in the development of many physical conditions. For example, the link between stress and cardiovascular diseases, particularly hypertension, is well documented.²⁰ Stress also plays a major role in the development of one of the most common causes of consultation worldwide, irritable bowel syndrome.²¹ But the mental-physical connection also operates in the opposite direction. In particular, chronic conditions, such as diabetes, heart diseases and cancer, very often produce mental distress.^{22,23} We should also consider the poor general health conditions of many patients with mental disorders, which result from side-effects of medications combined with lifestyle factors such as smoking, lack of physical activity and inadequate diets.²⁴ In sum, this aspect of integration has to do with addressing physical and mental health as a continuum.

Migrating from the idea that mental disorders should be treated in secluded clinical spaces

The fourth aspect refers to the need to leave behind the old idea that mental disorders have to be treated in special, isolated clinical facilities. This approach has contributed to the stigmatization of mental patients, with terrible consequences in terms of the violation of their human rights. The organization of mental health care in the 21st century should be based on the now generally accepted consideration that so-called mental abnormality is not socially dangerous and, in most cases, is part of the normal variability of human behavior.¹¹ The blurring of the borders between the distressed but mentally healthy, the sick with mental problems, and the mentally ill should be expressed, among other things, in the gradual incorporation of mental health care to regular ambulatory facilities. The latter demands the training of general practitioners and family physicians in the comprehensive management of mental disorders and improving access to specialized psychiatric attention in community and ambulatory facilities specifically designed for mental patients. This does not exclude the need for community and ambulatory services specifically designed for mental patients nor the need for psychiatric units in general hospitals or specialized psychiatric hospitals for patients requiring temporary confinement.²⁵

Expanding the use of comprehensive approaches in the prevention and treatment of mental disorders

A fifth and final level of integration is related to treatment. The so called psychopharmacology revolution has favored a therapeutic approach based on the assumption that these disorders are the expression of chemical imbalances which drugs can correct. However, no consensus regarding the biological bases of most mental disorders, including the most prevalent ones, has been reached.²⁶ For this and other reasons, we should encourage the use of comprehensive, evidence-based therapeutic approaches to mental disorders. This inclusive therapeutic vision of mental diseases is reflected, for example, in the most advanced treatments for depression, which tend to be pluralistic and favor the combined use of exercise, pharmacotherapy, cognitive behavioral therapy, psychotherapy and other therapies.^{27,28} Finally, in the realm of prevention, we need to design comprehensive interventions to promote emotional hygiene and deal with environmental and risk factors associated to mental symptoms and disorders.

Conclusion

Mental health challenges are inherent to the human condition. Although the explanations about them, their incidence and prevalence, the degree of stigma associated with them, and the approaches to treat them have varied in time and space, mental problems have puzzled and challenged societies for all of human history. Today, a globalized world undergoing an intense health transition requires new responses.

Mental health poses complex scientific, epistemological, ethical, social and economic questions. Only an integrated health system approach can address these issues in a manner that is commensurate with the magnitude of suffering caused by mental disorders and their stigmatization, the costs they impose on society, and the urgency of devising innovative solutions to one of the greatest challenges of all times.

Declaration of conflict of interests. The authors declare that they have no conflict of interests.

References

1. Institute for Health Metrics and Evaluation. GBD Compare [internet]. Seattle: Institute for Health Metrics and Evaluation, 2017 [cited 2017 Dec 6]. Available from: <http://vizhub.healthdata.org/gbd-compare>
2. World Health Organization. The world health report 2001—Mental Health: New Understanding, New Hope. Geneva: WHO, 2001.
3. World Health Organization. Mental Health Action Plan 2013-2020. Geneva: WHO, 2013.

4. World Health Organization. Mental health and older adults [monography in internet]. Geneva: WHO, 2017 [cited 2017 Dec 6]. Available from: <http://www.who.int/mediacentre/factsheets/fs381/en>
5. World Health Organization. 10 facts on mental health [monography in internet]. Geneva: WHO, 2017 [cited 2017 Dec 6]. Available from: http://www.who.int/features/factfiles/mental_health/mental_health_facts/en
6. World Health Organization. Depression [monography in internet]. Geneva: WHO, 2017 [cited 2017 Dec 6]. Available from: <http://www.who.int/mediacentre/factsheets/fs369/en>
7. World Health Organization. Mental Health Atlas 2011. Geneva: WHO, 2011.
8. Elkins C. Hooked on pharmaceuticals: prescription drugs abuse in the world [monography in internet]. Washington, DC: Drugwatch, 2017 [cited 2017 Dec 6]. Available from: <https://www.drugwatch.com/2015/08/10/worldwide-prescription-drug-abuse/>
9. World Health Organization. Non-communicable diseases [monography in internet]. Geneva: WHO, 2017 [cited 2017 Dec 6]. Available from: <http://www.who.int/mediacentre/factsheets/fs355/en>
10. Hock RS, Or F, Kolappa K, Burkey MD, Surkan PJ, Eaton WW. A new resolution for global mental health. *Lancet*. 2012;379(9824):1367-1368. [https://doi.org/10.1016/S0140-6736\(12\)60243-8](https://doi.org/10.1016/S0140-6736(12)60243-8)
11. World Health Organization. Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level [monography in internet]. Geneva: WHO, 2012 [cited 2017 Dec 6]. Available from: http://apps.who.int/gb/ebwha/pdf_files/EBI30/B130_R8-en.pdf
12. World Health Organization. Sixty-fifth World Health Assembly. Resolutions and decisions annexes [monography in internet]. Geneva: WHO, 2012 [cited 2017 Dec 6]. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA65-REC1/A65_REC1-en.pdf
13. World Bank, World Health Organization. Out of the shadow. Making mental health a global development priority [monography in internet]. Washington, DC: World Bank, 2016 [cited 2017 Dec 6]. Available from: http://www.who.int/mental_health/WB_WHO_meeting_2016.pdf?ua=1
14. National Institute of Mental Health. Global mental health: maintaining momentum on the road to scale [monography in internet]. Bethesda MD: NIMH, 2016 [cited 2017 Dec 6]. Available from: <https://www.nimh.nih.gov/research-priorities/scientific-meetings/2016/grand-challenges/solving-the-grand-challenges-in-global-mental-health-maintaining-momentum-on-the-road-to-scale-up.shtml>
15. United Nations. Sustainable Development Goals [site in internet]. New York: UN, 2015 [cited 2017 Dec 6]. Available from: <https://sustainabledevelopment.un.org/?menu=1300>
16. Mukherjee S. Runs in the family. New findings about schizophrenia rekindle old questions about genes and identity. *New Yorker* [series in internet] 2016 [cited 2017 Dec 6];92(7). Available from: <http://www.newyorker.com/magazine/2016/03/28/the-genetics-of-schizophrenia>
17. Shim R, Koplan C, Langheim FJ, Manseau M, Powers R, Compton MT. The social determinants of mental health: An overview and call to action. *Psychiatric Ann*. 2014;44(1):22-26. <https://doi.org/10.3928/00485713-20140108-04>
18. Frenk J, Gómez-Dantés O. Healthcare or sickcare: Reestablishing the balance. *Salud Publica Mex*. 2016;58(1):84-88. <https://doi.org/10.21149/spm.v58i1.7671>
19. Prince M, Patel V, Saxena S, Maj M, Maselko H, Phillips M, et al. No health without mental health. *Lancet*. 2007;370(9590):859-877. [https://doi.org/10.1016/S0140-6736\(07\)61238-0](https://doi.org/10.1016/S0140-6736(07)61238-0)
20. American Medical Association. Stress and blood pressure [monography in internet]. Dallas, Texas: American Medical Association, 2016 [cited 2017 Dec 6]. Available from: http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/PreventionTreatmentofHighBloodPressure/Stress-and-Blood-Pressure_UCM_301883_Article.jsp#
21. Anxiety and Depression Association of America. Irritable bowel syndrome [monography in internet]. Silver Spring, MD: Anxiety and De-

pression Association of America, 2016 [cited 2017 Dec 6]. Available from: <http://www.adaa.org/understanding-anxiety/related-illnesses/irritable-bowel-syndrome-ibs>

22. Eaton J, DeSilva M, Regan M, Lamichhane J, Thornicroft G. There is no wealth without mental health. *Lancet Psychiatry*. 2014;1(4):252-253. [https://doi.org/10.1016/S2215-0366\(14\)70277-9](https://doi.org/10.1016/S2215-0366(14)70277-9)
23. Walker J, Holm-Hansen C, Martin P, Symeonides S, Ramessur R, Murray G, et al. Prevalence, associations, and adequacy of treatment of major depression in patients with cancer: a cross-sectional analysis of routinely collected clinical data. *Lancet Psychiatry*. 2014;1(5):343-350. [https://doi.org/10.1016/S2215-0366\(14\)70313-X](https://doi.org/10.1016/S2215-0366(14)70313-X)
24. The Lancet. The health crisis of mental health stigma. *Lancet*. 2016;387(10023):1027. [https://doi.org/10.1016/S0140-6736\(16\)00687-5](https://doi.org/10.1016/S0140-6736(16)00687-5)
25. Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D, et al. Evidence for effective interventions to reduce mental-health-relat-

- ed stigma and discrimination. *Lancet*. 2016;387(10023):1123-1132. [https://doi.org/10.1016/S0140-6736\(15\)00298-6](https://doi.org/10.1016/S0140-6736(15)00298-6)
26. Oldham J, Carlat D, Friedman R, Nierenber, Nagel M. The illusions of psychiatry: an exchange. *New York Review of Books* [series in internet] 2011 [cited 2017 Dec 6]. Available from: <http://www.nybooks.com/articles/2011/08/18/illusions-psychiatry-exchange>
27. Kupfer D, Frank E, Phillips ML. Major depressive disorder: new clinical, neurobiological and treatment perspectives. *Lancet*. 2012;379(9820):1045-1055. [https://doi.org/10.1016/S0140-6736\(11\)60602-8](https://doi.org/10.1016/S0140-6736(11)60602-8)
28. Wiles N, Thomas L, Abel A, Ridgway N, Turner N, Campbell J, et al. Cognitive behavioural therapy as an adjunct to pharmacotherapy for primary care based patients with treatment resistant depression: results of the CoBaT randomised controlled trial. *Lancet*. 2012;381(9864):375-384. [https://doi.org/10.1016/S0140-6736\(12\)61552-9](https://doi.org/10.1016/S0140-6736(12)61552-9)