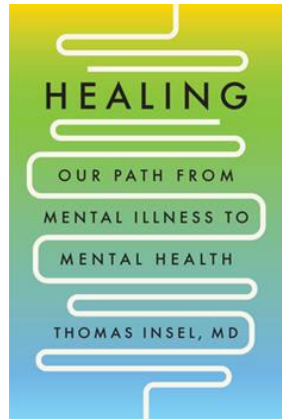# Addressing the mental health crisis: lessons from the Global South

Vikram Patel

The Pershing Square Professor of Global Health

Harvard Medical School

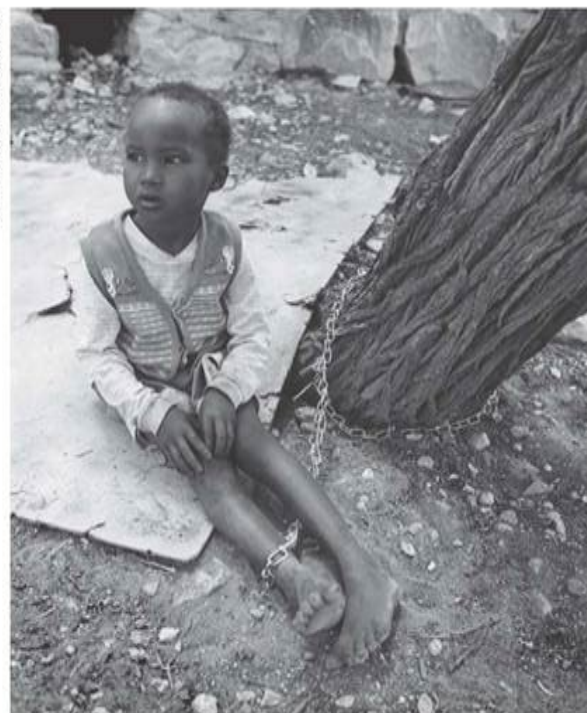"The mental health crisis is a crisis of care"

COMMENT

Improving treatment for children with mental illness, like this girl in Somalia, is an urgent priority.

Grand challenges in global mental health

A consortium of researchers, advocates and clinicians announces here research priorities for improving the lives of people with mental illness around the world, and calls for urgent action and investment.

Schizophrenia, depression, epilepsy, dementia, alcohol dependence and other mental, neurological and substance-use (MNS) disorders constitute 13% of the global burden of disease (Table 1), surpassing both cardiovascular disease and cancer[1]. Depression is the third leading contributor to the global disease burden, and alcohol and illicit drug use account for more than 5% (ref. 2). Every seven seconds, someone develops dementia[3], costing the world up to US$609 billion in 2009 (ref. 4). By 2020, an estimated 1.5 million people will die each year by suicide, and between 15 and 30 million will make the attempt[5].

The absence of cures, and the dearth of preventive interventions for MNS disorders, in part reflects a limited understanding of the brain and its molecular and cellular mechanisms. Where there are effective treatments, they are frequently not available to those in greatest need. In 83% of low-income countries, there are no anti-Parkinsonian treatments in primary care; in 25% there are no anti-epileptic drugs[6]. Unequal distribution of human resources — between and within countries — further weakens access: the World Health Organization's European region has 200 times as many psychiatrists as in Africa[7]. Across all countries, investment in fundamental research into preventing and treating MNS disorders is disproportionately low relative to the disease burden[8].

To address this state of affairs, the Grand Challenges in Global Mental Health initiative has identified priorities for research in the next 10 years that will make an impact on the lives of people living with MNS disorders. The study was funded by the US National Institute of Mental Health (NIMH) in Bethesda, Maryland, supported by the Global Alliance for Chronic Diseases (GACD), headquartered in London. Answers to the questions posed will require a surge in discovery and delivery science. We use the term 'mental health' as a convenient label for MNS disorders. We exclude conditions with a vascular or infectious aetiology (such as stroke or cerebral malaria) because these fell within the scope of the two previous grand challenges initiatives — in global health and in chronic non-communicable diseases[9].

This initiative differs from previous priority-setting exercises for mental ▶

3

WE KNOW HOW TO DELIVER CLINICAL AND PREVENTIVE PSYCHOSOCIAL INTERVENTIONS IN AN AFFORDABLE AND ACCEPTABLE WAY IN <u>ANY</u> RESOURCE SETTING

>100 randomized controlled trials of psychosocial interventions from >30 low and middle income countries

Redefining mental health care

1. What?

2. Where?

3. Who?

4. How?

Kohrt et al. 2018, *Int J Environ Res Public Health.*
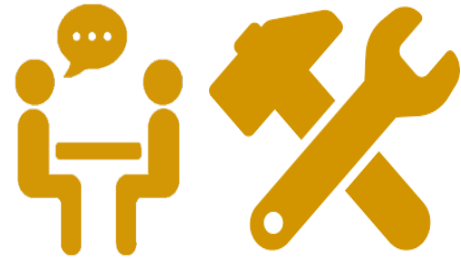
The Home Care Trial

Home Care Advisor
Non Pharmacological intervention provided as per individualised protocol addressing ADL and neuropsychiatric symptoms

Packages of Care for Dementia in Low- and Middle-Income Countries

Martin J. Prince[1]*, Daisy Acosta[2], Erico Castro-Costa[1,3], Jim Jackson[4], K. S. Shaji[5]

1 Health Service and Population Research Department, Institute of Psychiatry, King's College London, London, United Kingdom, 2 Universidad Nacional Pedro Henriquez Ureña (UNPHU), Santo Domingo, Dominican Republic, 3 Centro de Pesquisa Rene Rachou/Fiocruz, Belo Horizonte, Minas Gerais, Brazil, 4 Alzheimer Scotland, Edinburgh, United Kingdom, 5 Medical College, Thrissur, India

This is the fifth in a series of articles highlighting the delivery of "packages of care" for mental health disorders in low- and middle-income countries. Packages of care are combinations of treatments aimed at improving the recognition and management of conditions to achieve optimal outcomes.

Introduction

Dementia is a chronic organic brain syndrome, characterised by progressive impairment of multiple cortical functions, including memory, learning, orientation, language, comprehension, and judgement. Diagnosis requires decline in cognitive function and independent living skills (Box 1) [1]. However, for carers and people with dementia, the behavioural and psychological symptoms of dementia (BPSD) affect most quality of life, are an important cause of carer strain [2], and a common reason for institutionalisation [3]. Alzheimer's disease, vascular dementia, dementia with Lewy bodies, and frontotemporal dementia are the most common dementia subtypes, but mixed pathologies may be the norm [4]. Some rare causes (subdural haematoma, normal pressure hydrocephalus, hypercalcaemia, and deficiencies of thyroid hormone, vitamin B12, and folic acid) can be treated. Otherwise, the progressive course of dementia cannot be altered, but symptomatic treatments and support can be helpful.

Dementia mainly affects older people. Few cases start before the age of 65 y, after which prevalence doubles with every 5-y increase in age [5]. Globally, 24.3 million people are affected by dementia and 4.6 million new cases occur annually [6]. The prevalence of dementia is expected to double every 20 y, reaching 81.1 million by 2040, an increase of 100% in developed countries and of more than 300% in India, China, and their neighbours. Prevalence is lower in low- and middle-income countries (LMICs) than in high income countries (HICs) [6], perhaps because of underdetection of mild cases [7]. Nevertheless, most people with dementia live in LMICs—60% in 2001 rising to 71% by 2040 [6].

Dementia contributes 11.2% of years lived with disability among people aged 60 y and over, a higher proportion than stroke (9.5%), musculoskeletal disorders (8.9%), cardiovascular disease (5.0%), and cancer (2.4%) [8]. Its global cost is estimated to be US$317 billion, 77% of this total arising in HICs where formal sector care costs increase with disease progression, and institutionalization is the main cost driver [9]. Family care is more important in resource-poor countries, accounting for 56% of costs in low-income countries, 42% in middle-income countries, and 31% in HICs [9]. In a pilot study in 26 LMIC centers, carers were economically disadvantaged [10]. A fifth of carers had cut back on paid work, and paid carers were common, which added to the economic strain [10]. Compensatory benefits were practically nonexistent [10,11].

In three qualitative studies in India, features of dementia were widely recognised and named [12–14]. However, dementia was perceived as normal ageing rather than as a medical condition. The consequences

were limited help seeking [13] despite disability and carer strain [15]. no structured training on the recognition and management of dementia, and no constituency to advocate for more responsive care services [14]. People with dementia were excluded from residential care [13]. Carers misinterpreted BPSD as deliberate misbehavior [14]. BPSD can also lead to stigma and blame attaching to the carers [2]. In India, likely causes of dementia were cited as "neglect by family members, abuse, tension and lack of love" [13].

In this article, we focus on the effective management of dementia in LMICs, reviewing the evidence on efficacy of interventions and their delivery derived from LMICs where possible. Given the paucity of relevant evidence from LMICs, we also cite systematic reviews and meta-analyses based on trials from HICs. On the basis of our review we propose a package of care—a combination of treatments aimed at improving the recognition and management of conditions to achieve optimal outcomes—for dementia.

The Evidence on the Management of Dementia

The principal goals of management of dementia are: early diagnosis; optimization of physical health, cognition, activity, and wellbeing; detection and treatment of BPSD; and the provision of information and long-term support to carers. The evidence base for dementia care comes, overwhelmingly, from HICs (Table 1). All the studies discussed below refer to HICs, unless otherwise specified.

Detection and Diagnosis of Dementia

Many cases of dementia, particularly in LMICs, go undetected, in part because of lack of awareness. Awareness of this disorder can be boosted by dissemination of information from governments, health care providers, and media. Help-seeking can be encouraged by improved case-finding. In India and Brazil, for example, community

World Health Organization

WORLD REPORT ON **AGEING AND HEALTH**

ICOPE

Integrated Care for Older People

"Healthy Ageing - the process of developing and maintaining the **functional ability** that enables wellbeing in older age."

Prevention of Late-Life Depression in Low & Middle Income Countries: the DIL trial

Effect of a Lay Counselor Intervention on Prevention of Major Depression in Older Adults Living in Low- and Middle-Income Countries
## A Randomized Clinical Trial

Amit Dias, MD; Fredric Azariah, MSc; Stewart J. Anderson, PhD; Miriam Sequeira, MA; Alex Cohen, PhD; Jennifer Q. Morse, PhD; Pim Cuijpers, PhD; Vikram Patel, MD, PhD; Charles F. Reynolds III, MD

+ Editorial

+ Supplemental content

IMPORTANCE Preventing depression in older adults living in low- and middle-income countries is important because of the scarcity of treatment resources and the risk of disability, suicide, and dementia.

OBJECTIVE To assess whether an intervention for depression prevention provided by lay

Figure 3. Mean 12-Item General Health Questionnaire (GHQ-12) Scores (Pointwise 95% CIs by Visit and Treatment
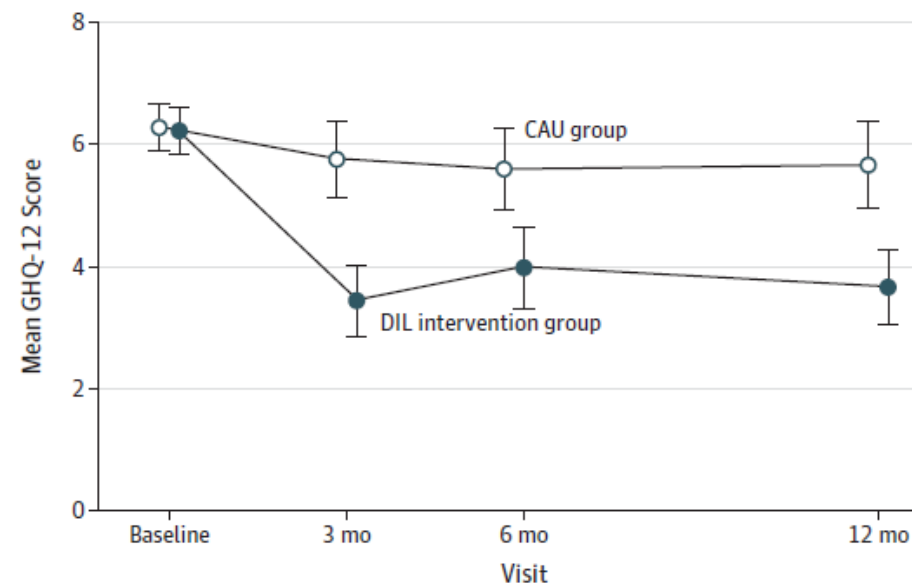
Mean GHQ-12 scores over time improved to a significantly greater extent in the depression later in life (DIL) intervention group than in the care as usual (CAU) group (overall group × time interaction P < .001). Scores for the GHQ-12 can range from 0 to 12; a higher score indicates greater symptoms of depression and anxiety. Error bars indicate 95% CIs.

The benefits of this approach
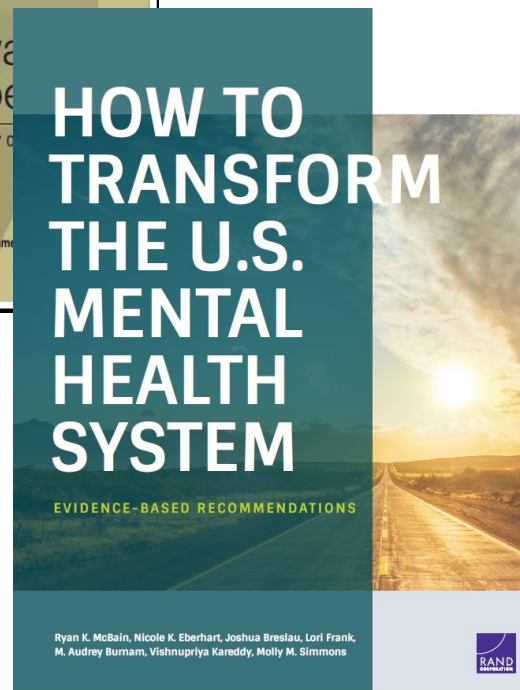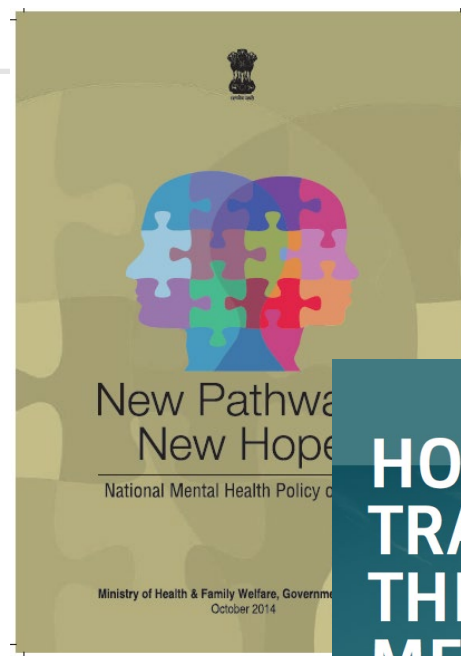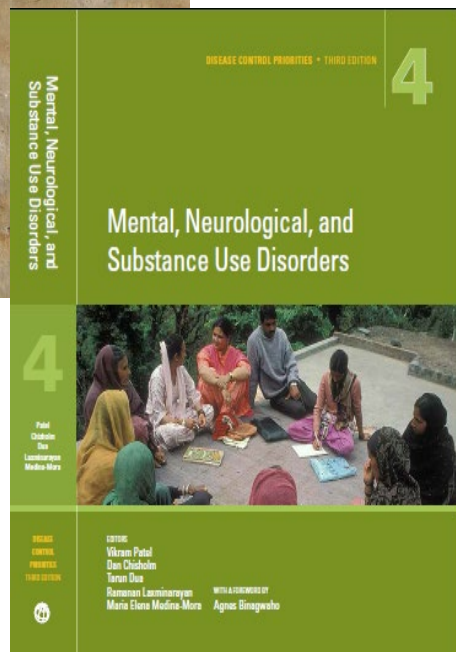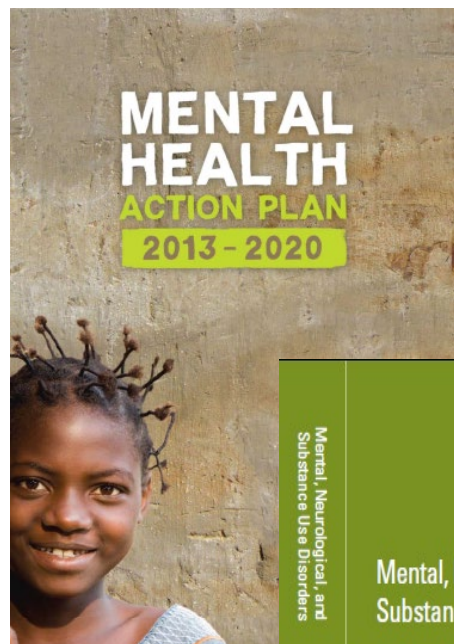
Improves access to evidence-based care

Frees up specialist services to work at the 'top of their license'

Reduces stigma

Person-centred

Benefits the providers

From evidence to action to transform mental health globally

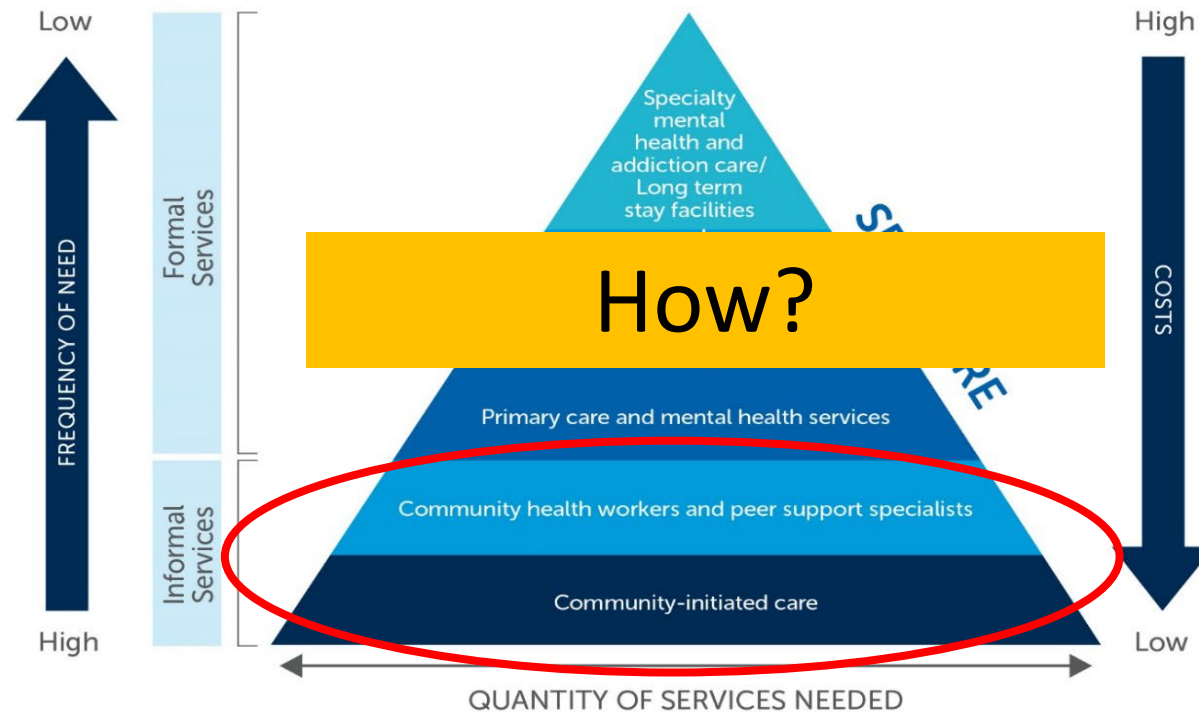# Build the front-line workforce

Figure 1: Framework for Mental Health and Addiction Workforce (Revised from WHO) World Health Organization. (2009). Improving health systems and services for mental health (978 92 4 159877 4). WHO Press. https://www.who.int/mental_health/policy/services/mhsystems/en/

EMPOWER
BUILDING THE WORLD'S MENTAL
HEALTH WORKFORCE

A digital solution
for learning, mastering, and
delivering quality-assured psychosocial
interventions

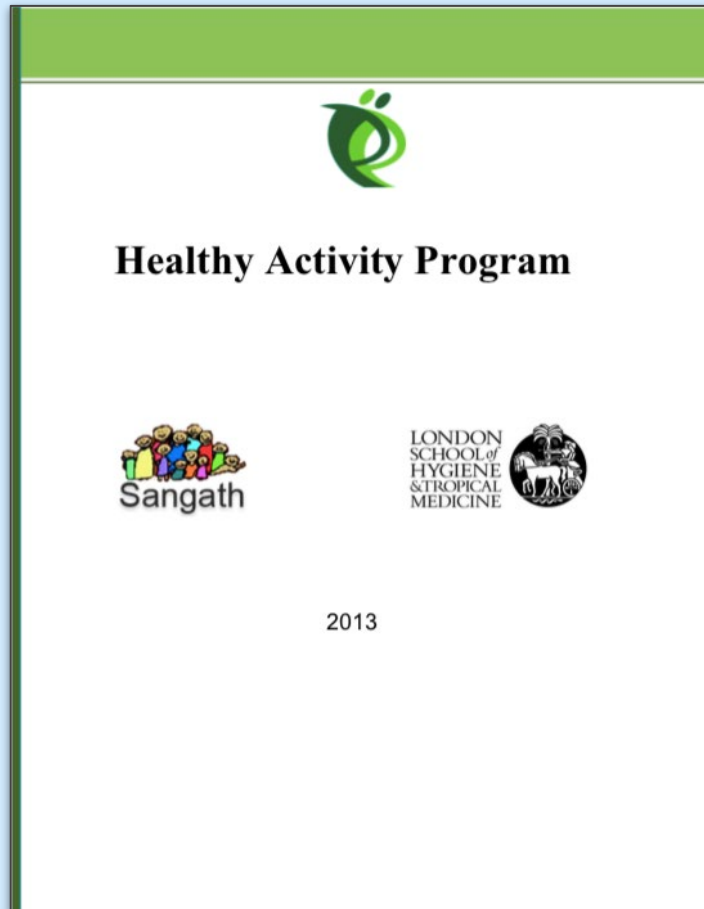www.empower.care

The deployment of technology

Digitally delivered curriculum on any LMS

Remotely delivered competency assessments, including assessments of skills through self-recorded or observed role-plays rated with psychometrically validated measures

Bespoke digital app (designed in partnership with DIMAGI) for measurement based peer supervision and quality measurement

Data science driven evaluation of digital data from training to competencies to quality of care, ultimately linked with patient outcomes

Evidence-Based Manual for Treatment of Depression

HARVARD MEDICAL SCHOOL | DEPARTMENT OF Global Health and Social Medicine

Sangath

Healthy Activity Program

Sangath LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

2013

HEALTHY ACTIVITY PROGRAM (HAP)
A lay counsellor delivered brief behavioral activation treatment for depression, evaluated in India and digitized as a prototype in Hindi

THE LANCET

PLOS

Scaling up the HAP
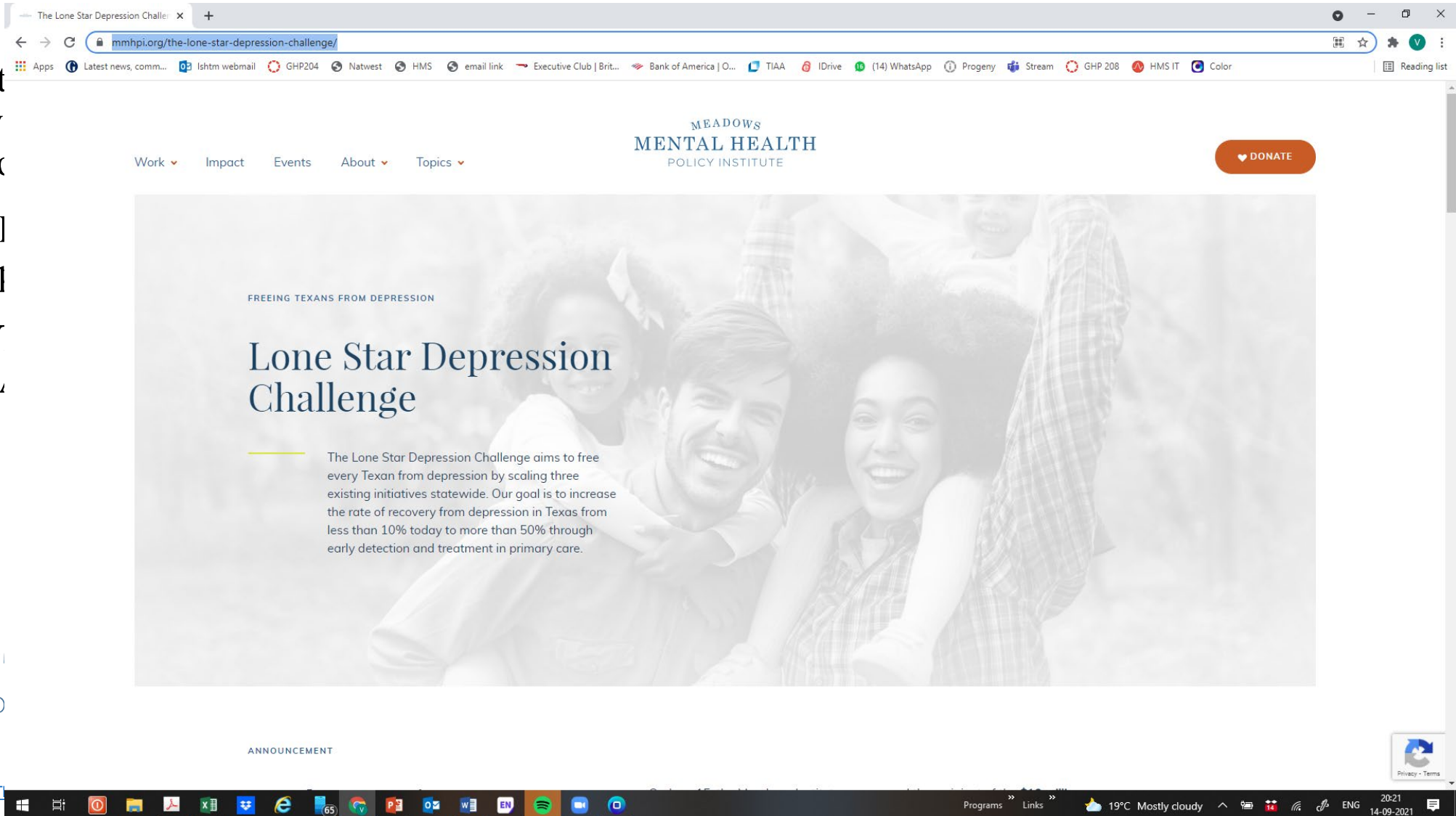
Launching EMPOWER in the US

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Lessons for **global** mental health

Scale up psychosocial interventions by deploying digital tools and products to enable a front-line workforce to learn, master, deliver and evaluate these interventions