

CHAPTER 1

General Introduction



MENTAL HEALTH IN LOW- AND MIDDLE-INCOME COUNTRIES (LAMIC)

Common mental disorders are highly prevalent world-wide and contribute to the burden of disease worldwide (1;2). Worldwide over 450 million people suffer from a mental disorder with the majority of sufferers living in LAMIC (3). On a global scale, approximately 150 million people suffer from a major depressive disorder at any moment, and almost a million commit suicide each year (4). Common mental disorders are associated with a significantly impaired quality of life (5-7), with excess mortality (8), substantial societal costs (9;10) and a considerable burden of disease. Major depression was ranked as the fourth most disabling medical disorder worldwide in 1990 (11) and 2002 (12), and is expected to be the second most disabling disorder after HIV/AIDS in 2030 (13).

Sadly, mental health and mental disorders are not given the same importance as physical health and therefore have been largely ignored and neglected. Only a small minority (less than 10%) of the 450 million sufferers worldwide have access to mental health care (3). It is obvious that despite the high worldwide prevalence and associated burden of common mental disorders, the need for treatment is not always met (2;14). The World Health Organization (WHO) indicates that the treatment gap for mental disorders in developed countries is 30-50% and in low- and middle-income countries (LAMIC) 76-80%.

This gap is mainly caused by a scarcity of human, mental health and financial resources, as a result of financial and policy factors in low- and middle-income countries. The inequity in access to mental health care that is prevalent in most low- and middle-income countries is an important factor as well. The socio-economic status of an individual determines whether he or she has access to facilities or not. The high prevalence of stigma and discrimination causes people to abstain from seeking help even if they do have access (16). Most LAMIC countries give low priority to mental health policies, with two-thirds of these countries having no mental health policy at all (4). A very small percentage of LAMIC countries health budgets are spent on mental health and the resources that are available are inequitably distributed (15). According to a study by the World Health Organization, 32% of the countries did not have a dedicated budget for mental health (16). Many countries in both South East Asia and Africa spent less than 1% of their total health budget on mental health, indicating the disparity between burden and resources (16). Since mental illness

make a substantial attribution to the burden of disease worldwide there has been a slogan endorsed by the World Health Organization 'no health without mental health' (17). The Lancet launched a special series on global mental health in 2007 consisting of five articles about global mental health, with an emphasis on low- and middle-income countries.

MENTAL HEALTH CARE IN SOUTH AFRICA

Mental health facilities during the apartheid regime were strongly institutional based and mainly focused on the severely ill patients (18). A visit of the American Psychiatric Association (APA) to South Africa in 1978 resulted in a report about the inhumane practices in psychiatric facilities in the country. Racial bias in mental health practice and the psychological impact of the apartheid system on the black South Africans were the main focus of the report published in the American Journal of Psychiatry in November of 1979. In a report on apartheid and health they indicate: *'South Africa is a rich country and could provide health care for all it's people. Yet the mental health services are grossly inadequate and discriminatory. There are no black psychiatrists in the Republic of South Africa, and no community-based mental health services for the black majority.'* (page 32 of 'Apartheid and Health' report 1983) (19).

South Africa was left with an under-resourced, fragmented and very inequitable distributed public mental health service in the aftermath of Apartheid. Under the new democratized government formed in 1994 a 'White paper for transformation of the health system in South Africa' was erected to develop and transform the mental health services (20). The paper included advocacy, promotion, prevention, treatment, rehabilitation (3;21), and de-institutionalization of mental health care services. There was an emphasis on establishing community-based services by integrating services with primary health care, which was in line with the World Health Organization's recommendations and the international trend. In collaboration with a range of stakeholders, a Mental Health Care Act was constructed in 2002 that conformed to international human right standards. While this is considered a move forward in the development of the mental health system in South Africa, it appears that the Mental Health Care Act on its own is not sufficient in reforming the mental health system in South Africa. For example, in 2008 only five of the nine

provinces in South Africa had actually made steps to translate the policy guidelines into provincial mental health policies (22).

The first nationally representative study of psychiatric co-morbidity in South Africa (SASH Study) indicates that about 30% of South African adults have had at least one DSM-IV disorder in their lifetime, including 16% with an anxiety disorder and 10% with a mood disorder (23). In a recent survey, only a quarter of South Africans with a recent DSM-IV diagnosis had been treated in the year preceding the interview (24). As in other developing countries, mental illnesses are under-diagnosed and undertreated in South Africa (25-27).

Mental illnesses are often under diagnosed and inadequately treated despite their frequency (4), while resources to treat them are scarce and unevenly distributed (4;25-27;28). When treated at all, mental health problems are largely managed face to face in primary care by psychiatric nurses and other healthcare workers who have large workloads and often lack training in mental health (29).

During apartheid, expenditure on health was inequitably distributed across population groups and provinces. The post apartheid era since 1994 has seen mental health resources distributed more evenly across the country, but there is still a huge difference in the availability of resources between provinces. Services are still characterized by patterns created by racial segregation and inequities during the Apartheid system (30;31). One can say that despite the efforts in South Africa to reform the mental health system, racial and monetary inequality in psychiatric care continue to exist (29).

One of the major constraining factors in development of adequate mental health services is the lack of resources. In 2001 there were 429 registered psychiatrists of whom about 73% were actually practicing (many are working abroad) (30). That will give South Africa approximately one registered psychiatrist per 100 000 inhabitants. This figure is not very different from other developing countries, but most problems are related to the unequal distribution of psychiatrists in the country (32). The majority is working in the major cities such as Cape Town and well-developed regions like Gauteng. In the most recent survey, about 56% psychiatrists are working in private practice, 7% spent time working in rural areas, and only 10.8% could communicate in one or more African languages (33). The psychiatrist working in private practice provide first-world standards of care for the

approximately 20% of population who can afford it (29). The other 80% of South Africans are reliant on public services for their mental health problems. The small proportion of psychiatrists working in the public services are not well distributed over the provinces either (29). In 2001 the North-West Province had no full-time state psychiatrist, and Northern Cape and Mpumalanga had one each.

CLOSING THE TREATMENT GAP

As many South Africans do not have access to mental health services, there is an urgent need to scale up services and to provide access to treatment. An important type of treatment that may be useful in reducing the disease burden of depression and anxiety disorders in LAMIC countries, are psychological treatments. These treatments have been well-studied in Western countries and a considerable number of well-designed studies have shown that these interventions are effective in the treatment of common mental disorders (34-37). Furthermore, most patients in western and non western countries prefer psychological treatments above pharmacotherapy as treatment for depression (38;39).

Psychotherapeutic treatment for mental disorders has been found to be effective (40), but most of the evidence-based publications derive from high income countries (40;41). While more than 85% of the world's population lives in LAMIC countries (42), only 6% of the mental health publications (dating from 1992-2001) focus on LAMIC countries (40). Between 2002 and 2004 only 3.7 % of published papers emerged from low- and middle-income countries (43). One may take the issue a step further and question the generalisability of efficacy data on (western) psychotherapy in relation to the African context (44). There are several possible reasons why data on psychotherapy from high income countries may not be generalisable to LAMIC. First, neither health nor ill health occurs randomly within populations; they are both rooted in social processes. Overlooking the culturally bound nature of Western theories of psychology when duplicating a Western treatment in non-Western countries may result in neglect of cultural factors that may influence the efficacy of the intervention in that specific country. Cultural factors can influence the conceptualization of mental health and psychotherapy by both patient and care provider.

The explanatory models of both therapist and patients are important factors for treatment adherence. Explanatory models in many low- and middle-income countries may be less likely to acknowledge the role of biomedical causes in psychological distress (45;46). This affects the attitudes of people with regard to what kind of help is needed and the acceptability of psychiatric interventions (47). The literature reports that the attitudes of people in developed and developing countries often differ regarding the kind of help that is needed to resolve a disorder (48). Studies have suggested that compatibility of patients' and therapists' explanatory models are essential for a successful psychotherapeutic process (48), indicating the importance of considering culture in psychotherapy.

Secondly, the infrastructure of health systems in high-income and LAMIC countries can diverge considerably. The applicability of treatment research from developed in LAMIC countries can be influenced by the scarcity of mental health manpower, the growth of the private medical sector, and the rising health costs and changing health care financing systems (47). They may need to be adapted to the African context to make them efficacious, and a range of issues around their feasibility and acceptability also needs to be considered – such as the lack of resources noted above, and the possible unwillingness of people to use psychotherapeutic treatments due to particular belief structures or due to mental health illiteracy.

As mentioned earlier, around a third of countries do not have a mental health budget and of those who do have a designated budget, 21% spend less than 1 % of their total health budget on mental health (50). Many of the countries with an allocated budget are not informed by research evidence on mental health needs and efficacious treatments within the countries. This can cause policies to endorse specific service delivery programs for which no success is demonstrated. Research has indicated that many people who are seeking help in LAMIC countries are not treated with evidence based interventions (15). Since most of the low- and middle-income countries do not allocate adequate resources and are ill- equipped to deal with mental health needs, The WHO called for increased investment in mental health research in LAMIC (49) and the scaling up of services (50). Evidence-based research can reinforce the commitment of policymakers and provide a concrete evidence based programme for scaling up care for mental disorders in LAMIC. In this way the treatment gap

for mental disorders in LAMIC countries could be filled by scaling up evidence-based practice.

PROBLEM SOLVING THERAPY

Researchers are currently investigating the development of easily accessible, evidence-based, and cost-effective treatments. Problem solving interventions are potentially one such form of treatment. Problem solving therapy (PST) is a brief cognitive behavioural treatment applicable for use in primary care (51). The treatment derives from the idea that psychological symptoms, like depression and anxiety, are often caused by the practical everyday problems that people face. It starts with increasing the patients' understanding of the link between their current symptoms and everyday problems. It thereafter improves the patient's ability to clearly define their current problem and teaches them specific ways to better cope with problems by taking a well-structured step-by-step approach. The expectation is that depressive and anxiety symptoms will improve when actively and successfully resolving their problems. It is a "here and now" treatment approach aiming at increasing people's confidence and feelings of self-control. It aims to teach patients better ways to cope with problems in the future, setting goals and minimizing feelings of incompetence and stress (52). In short, the intervention empowers people and gives them the confidence that they do not need to be overwhelmed by their problems, but that there are practical and effective steps they can take to try and solve them.

PST is available in different formats. There is a brief self-help format to let patients work through this form of structured psychotherapy at home independently or with minimal support. They learn this approach themselves in a step by step fashion. Brief PST can be guided by a book, phone, interactive voice response, CD-ROM, television, video or the Internet. PST can also be conducted in a group format. In this format people receive the reading material and have weekly group meetings which mainly function as 'homework groups', where homework is discussed. In these brief group meetings, the counsellor has solely a supporting and facilitating role. Counsellors do not interact on the basis of a traditional therapist-patient relationship, but rather with the intention to guide participants through PST. Research in guided self-help found promising efficacy in anxiety disorders (53-

55), unipolar depression (55-58), alcohol addiction (59), sexual dysfunction (60), weight loss (60), and phobias (61). These studies found that brief PS improved depression and anxiety significantly more than control conditions did, and as much as face-to-face care. According to many studies in high income countries, briefly-guided PST approaches were as efficacious for common mental disorders as was therapy that requires longer therapist contact (62;63). Research indicates PST can effectively be conducted by non-mental health professionals and in a community setting, which makes it particularly useful in under resourced areas (64;65).

RESEARCH AIMS

The literature review points out a number of issues that are interesting to study in light of mental health care in South Africa. This thesis will address some of these issues. We know there is a major burden of disease in South Africa that can be attributed to mental disorders. Addressing that burden can be done by effective treatments we know exist for these disorders.

The main aim of this thesis was to develop and test a low cost intervention in South African communities which have little or no access to mental health services. We wanted to gain insight into the use of (web) guided self-help interventions in deprived communities around Cape Town. To provide a general context for the program we reviewed the current status of psychiatry in Africa. Another objective was to determine whether there was efficacy evidence for the use of psychotherapeutic treatments for anxiety and depression in low- and middle-income countries. This was to possibly steer our discussion on what type of treatment we would pilot in our target community in South Africa. Since no meta-analytic study has been conducted as yet, our aim was to do so. Since literature indicates self-help interventions to be effective and we assumed they might be extremely suitable for low resourced areas, we also aimed to review the evidence for the internet-guided self-help methods. The efficacy of methods that limit the personal contact between a patient and therapist needs to be carefully assessed. Another objective therefore was to address the efficacy of self-help methods for depression and anxiety disorders by providing a systematic review of meta-analyses in this area. Mental health literacy and stigma in communities hold implications for the accessibility of mental health care in South Africa. Our last objective

therefore was to gain insight into the beliefs and attitudes associated with mental health of the people participating in our program.

OUTLINE

The thesis is structured as follows. Chapter 2 reviews the literature on psychotherapy in Africa relevant to create a context for the other chapters. Chapter 3 presents our meta-analysis conducted on the evidence of efficacy for psychotherapeutic treatments for anxiety and depression in low- and middle-income countries. Chapter 4 reviews the evidence of self-help interventions. Chapter 5 presents the results of our web-guided self-help intervention in deprived South African communities and the problem encountered in the process. The next chapter, chapter 6, will present the feasibility, acceptability and effectiveness results of our guided problem solving self-help program. Chapter 7 explores the mental health literacy and stigma towards mental health problems held by the participants of our self-help program. Chapter 8 draws on the accumulated results presented in the previous chapters in relation to our research aims and provides future directions for research.

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