Opinion

Rethinking mental health care: bridging the credibility gap

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Innovations in global mental health have focused on addressing the 'supply side' barriers to reduce the treatment gap and, in doing so, have redefined three core assumptions regarding mental health care, namely, what comprises a mental health care intervention, who is a mental health care provider and what is a mental health care setting. However, such innovations alone will not reduce the treatment gap because of the gap between the understanding of mental disorder that mental health specialists use, best illustrated through the diagnostic systems and the epidemiological instruments arising from them, and how the rest of the world conceptualises psychological suffering. It is this 'credibility' gap that needs to be bridged in three key ways: first, to distinguish mental disorders that could benefit from biomedical interventions from milder distress states; to offer interventions for distress states mainly through low intensity psychosocial interventions delivered outside the formal health care system; and to base the descriptions of diagnostic categories on the patterns of phenomena observed in general populations, rather than those observed in specialist settings.

Keywords: diagnosis, explanatory models, global mental health, treatment gap

Introduction

Global mental health has been heavily influenced by the concept of the '*treatment*' gap, i.e. the proportion of people with a mental disorder in a population who are not in contact with services and benefiting from evidence based treatments (Patel & Prince, 2014). In an effort to reduce this gap, a growing number of innovative models of care have emerged across a range of low resource settings that are challenging three core assumptions about mental health care: what mental health care should comprise; who is a mental health care provider; and where mental health care should be provided. Before I turn to the issue of the credibility gap, I will briefly consider how innovations addressing the treatment gap are redefining each of these assumptions.

Redefining assumptions

First, consider the assumption of *what* comprises mental health care. Much of the discourse on mental health care has focused on structured treatment guidelines, best exemplified by the World Health Organization's *Mental Health Gap Action Programme (mhGAP) guidelines,* emphasising drug and psychological interventions (Dua et al., 2011). At the heart of these guidelines is the privileged status of biomedical diagnostic categories, such as depression and schizophrenia. However, it is now clear that the use of these labels and their associated biomedical explanations is often not necessary and may even be counterproductive. Integrating culturally appropriate explanatory models and nonspecialist labels into interventions, going even as far as not using terms such as depression at all, is the hallmark of accessible and effective mental health care interventions (Patel et al., 2011). Incorporating interventions that target the outcomes tha matter to affected persons and their families—for example, independent social functioning in people with schizophrenia—has equal status to or even greater salience than treatments focused on psychiatric symptoms (Balaji et al., 2012). Mobilising personal and community resources, for example existing social welfare schemes, is

critical to address the practical social determinants and consequences of mental disorders. Mental health interventions, then, must go well beyond narrowly defined biomedical constructs and treatments.

Second, consider the assumption of *who* is a mental health care provider. The assumption that mental health care providers are analogous to mental health specialists has been robustly challenged by innovations that include task sharing, frontline mental health interventions involving community and lay health workers. A substantial body of evidence, probably the largest for any noncommunicable disease, is testimony to the effectiveness of this approach (van Ginneken et al., 2013). By being able to utilise such widely available and affordable human resources to deliver frontline care, we achieve a paradigm shift from focusing on the lack of specialist human resources to the effective mobilisation of available human resources. Of course, these human resources need carefully designed training and, even more importantly, continuing supervision to deliver care with sustainable quality. Reliance on specialists to train and conduct supervision presents another potential bottleneck to improving access to task sharing models of care. However, recent empirical evaluation has shown that, as competency is achieved, lay counsellors can assess the quality of counselling sessions with comparable accuracy to specialists (Singla et al., submitted). This model of task sharing of supervision means that the role of specialists becomes even more focused on designing programmes, quality assurance and providing referral for complex or treatment resistant cases, thus permitting much larger population coverage for each specialist.

Third, consider the assumption of *where* mental health care can be provided. A unique aspect of innovations in global mental health is that virtually none are delivered within specialist settings. Primary health care centres are, of course, a predictable delivery platform, but, perhaps more creatively, mental health care is now delivered in a range of other '*non health*' platforms, notably in the homes of patients and in schools for children. In doing so, some of the major time, stigma and cost barriers to treatment access and adherence are being addressed, leading to higher treatment completion rates and, consequently, better outcomes.

Demand and the credibility gap

While much of the innovation in global mental health summarised above has focused on addressing the '*supply side*' barriers to reduce the treatment gap, for example the shortage of specialist human resources, this gap can also be attributed to demand side barriers related to the vastly different views held by the community about mental disorders. Indeed, the primary hypothesis posed by this article is that supply side strategies alone will not significantly reduce the treatment gap. Even in the richest countries of the world that enjoy a universal health care system with free, multidisciplinary, community oriented, comprehensive and coordinated mental health care (such as countries in western Europe), a substantial proportion (even the majority in some countries) of persons with a mental disorder, in particular mood, anxiety and substance use disorders, diagnosed in surveys have not accessed specialist mental health care services (Wang et al., 2007). While reconfiguring the content of interventions, task sharing to non specialist human resources and delivering care in non health platforms may address these gaps to some extent, they are unlikely to be sufficient. I propose that a key problem lies in the gap between the understanding of mental disorder that mental health specialists use, best illustrated through the diagnostic systems and the epidemiological instruments arising from them, and how the rest of the world conceptualises psychological suffering. In short, this is the gap, which I refer to as the '*credibility*' gap, we need to bridge and, to do so, we may need to substantially review our concepts of

mental disorder and be prepared to abandon some devoutly held beliefs.

However, first, I need to clarify that my proposal does not deny the existence of mental disorders nor their biological underpinnings. There is no doubt (in my mind at least) that the phenomena that we describe as features of mental disorders and that we further categorise based on observed patterns of clustering have a biological basis in the brain. How else could we explain the universal human experiences of fatigue, anhedonia (the profound loss of interest that characterises the experience of depression), hallucinations or the craving for a harmful substance? Nevertheless, of course, these experiences are also inextricably linked to powerful social and cultural determinants and, perhaps uniquely to mental disorders, with a person's own identity of oneself. In this respect, mental disorders are quite distinct from physical health conditions: there is simply no similarity between a painful boil and feeling depressed or between a high fever and hearing voices. In the desire of some sections of the mental health specialist community (arguably, the more dominant sections) to belong to the powerful guild of medicine, there has been a deliberate tilt in the balance between the personal narrative and the biomedical concept toward the latter, adopting an increasingly arcane jargon of diagnostic categories to communicate with each other and, perhaps, to impress our colleagues in other branches of medicine. However, in so doing, we seem to have lost the ability to communicate with virtually everyone else in our own communities.

The recent controversies around the *Diagnostic and Statistical Manual-V* (Frances, 2013) are, in large measure, a reflection of this credibility gap. The criticisms focus on concerns that some of the diagnostic categories reflect a medicalisation of normative phenomena and are guilty of privileging the biological over the social. This is perhaps most true of diagnoses of mood and anxiety disorders, substance use disorders and childhood emotional and behavioural disorders, all of which represent artificial dichotomies imposed on naturally occurring dimensions of psychological responses to common human life experiences. Of course, imposing artificial dichotomies is also true of many physical health conditions such as hypertension and diabetes, but, as I pointed out earlier, there is a marked difference in how communities view these physical health conditions, notably that they are seen as '*diseases*' that are distinct and separate from one's personal identity. On the other hand, the vast majority of people who have a diagnosis of depression or harmful drinking, based on a psychiatric interview or clinical diagnosis, do not understand their problem as a distinct health condition with a biomedical causation; instead, they utilise culturally meaningful labels and causal explanations for their distress as being inextricably linked to their personal lives. Of course, in this respect, their views are completely consistent with the epidemiological literature on the determinants of these mental disorders.

None of what I have proposed is new; several authors have long argued that there was a need to review our concepts of mental disorders to accommodate the prevalent views of the community. Put simply, this credibility gap between the mental health specialist communities and the rest of the world is one of the major reasons for the treatment gap in all regions of the world. The credibility gap is exemplified by three critical observations: the medicalisation of emotional worlds and the imposition of artificial dichotomies on dimensions of psychological experiences that are normative; the use of ever more complex jargon terms, such as the new diagnostic label of *Disruptive Mood Dysregulation Disorder* in children; and the increasing emphasis on a biomedically oriented mental health care as the primary solution to these problems.

In many respects, the approaches adopted by global mental health innovators described earlier specifically aim to address some of these challenges. Many eschew the use of complicated diagnostic categories and jargon (for

example, most of the successful trials for the psychological treatment of depression in developing countries do not use the term '*depression*' in their educational component for patients), use lay health workers to deliver interventions, broaden the definition of a mental health intervention to incorporate mobilising personal and community resources and strategies that are contextually relevant, and deliver the interventions where the person prefers, even in their own homes or in other community settings. However, global mental health innovators need to beware of falling into the same trap that mental health care systems find themselves in rich countries, i.e. care that is heavily professionalised and inflexible, driven by biomedical diagnostic categories and narrowly defined treatment models, and with top-down delivery systems that exclude communities from playing an active role. I propose a set of strategies that, I hope, might reduce the yawning, and perhaps even widening, credibility gap between mental health professionals and their communities.

Strategies

First, we need to abandon our use of prevalence estimates generated by epidemiological surveys as the source of evidence to define the denominator of the fraction that indicates the treatment gap. This is likely to be a provocative suggestion; however, to be sure, only a small fraction of the global population truly believes any of the astonishingly large figures that these surveys throw up. Those figures simply lack face validity because they conflate emotional distress with mental disorders that need specific biomedical interventions. Of course, diagnoses matter. Nevertheless, perhaps the way to bridge the credibility gap in this context is to set thresholds for diagnoses of specific disorders not solely on the clustering of symptoms and their impact, but also on the likelihood of benefitting from available biomedical interventions, particularly in reducing impairments in key tasks of daily living. If this were done, perhaps up to half of those who receive diagnoses of substance use or mood and anxiety disorders, between them accounting for 75% of the global burden of mental disorders, would probably no longer qualify as '*disordered*'. Perhaps the label of '*distress*', which carries less biomedical significance, without further distinction into subcategories, may offer a way to describe these individuals who, while not meeting the threshold criteria for a specific disorder diagnosis, are still not quite functioning optimally. This proposal is supported by the substantial empirical evidence that, at the milder end of the dimensions of common mental health syndromes, it is exceedingly difficult (and, arguably, entirely artificial) to distinguish subcategories of '*disorders*'.

Second, we need to recognise that, while individuals who are '*distressed*' (but not '*disordered*') could be helped to cope better, with help provided in completely different ways outside the formal health care system, for example through low-cost social interventions such as befriending, providing practical help for economic difficulties, mobilising and strengthening existing nonbiomedical sources of help that are contextually acceptable (such as spiritual interventions in some places) and promoting self-help delivered through books or the Internet (Fairburn & Patel, 2014). These are not only cheaper, but are also consistent with the person's understanding of their problem, the course and outcome of these distress states and the treatment evidence.

Third, as I have argued elsewhere (Jacob & Patel, 2014), the descriptions of diagnostic categories must be based on the patterns of phenomena observed in general populations, rather than those observed in specialist settings. If we were to follow this axiom, then there would probably be no justification for the diagnostic separation of mood, anxiety and somatoform disorders (at least in nonspecialist settings), as, for the vast majority of people, the phenomena associated with these

diagnoses co-occur, and, not surprisingly, these disorders share similar aetiologies and benefit from similar interventions. The concept of common mental disorders, championed for over two decades by primary care mental health practitioners, remains the most valid construct to describe these heterogeneous experiences in the population.

Conclusion

In conclusion, mental disorders are real forms of human suffering, observed globally in all populations, with remarkable similarities in phenomenology across cultures. This does not, however, imply that the top-down, biomedical, psychiatric constructs and therapeutic paradigms are universally applicable and helpful. There is a yawning gulf, which I refer to as the credibility gap in this article, between such paradigms and the beliefs held by vast sections of the communities in all countries. This gap is to a large extent due to the fundamental differences between *'somatic'* and *'psychological'* illnesses in the way they are conceptualised, influenced by social determinants and addressed by interventions. This observation is by no means original nor novel: the communities of professionals and advocates working in humanitarian settings have offered a similar perspective about the conceptualisation of the mental health consequences of conflicts and other emergencies. These fundamental differences that set the practice of mental health care apart from physical health care are, in fact, the very essence of its uniqueness and attraction. Rather than being glossed over in the desire to become respected by and part of the monolith of medicine, these differences need to be championed and emphasised, if we are to close the credibility gap between mental health specialists and the communities we serve. In doing so, we would only reassert our rightful place in the unique space between medicine and society that mental health practice has historically occupied.

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