Managing the global burden of depression: lessons from the developing world

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Around the globe - be it Liverpool, Los Angeles or Lahore - primary care doctors (PCPs) are increasingly aware that depression is a prevalent condition associated with significant morbidity and mortality. With an estimated point prevalence of 2-4% in the community and 6-8% in primary care settings (1), depression is associated with levels of morbidity and dysfunction rivaling that of other chronic medical conditions (2). According to the World Health Organization, by 2020 depression is expected to be a

leading cause of disability worldwide, second only to cardiovascular disease (3). Because depression is typically detected and treated in primary care settings instead of the specialty mental health sector, health care systems are challenged to develop strategies that address both the mental and medical health needs of the patients they serve. David Goldberg's cross-national review in this issue of World Psychiatry describes a wide range of approaches to this problem. Weighing the relative merits and drawbacks of disparate paradigms, the reader is provided with an opportunity to learn from several innovative approaches, especially those used in developing nations.

Health care systems vary widely across the globe. They differ not only on the economic and societal constraints within which they operate, but also on the philosophical issue of whether mental and medical care should be delivered conjointly. At one end of the spectrum is the fragmented organization of care often found in the United States, where mental health care is 'carved out' from the rest of medical care; at the other end are more holistic models that address patients' broader needs. In the former example, reimbursement for mental health care is completely dissociated from primary care reimbursement, a system that actually prevents PCPs from receiving reimbursement for treating psychiatric illness, even when mental illness is the patient's primary medical problem (4). By contrast, in a Chinese model, 'village health workers' function at a local level to identify patients in need and refer them to medical personnel in local clinics. In Iran, health workers staff 'health houses', from which they screen local inhabitants for mental and physical illnesses, including stress-related conditions. Some psychosocial interventions (i.e., stress reduction techniques) are provided within the health houses; complicated cases are referred for more intensive treatment. In Tanzania, moderately trained physician-extenders meet both the general medical and psychiatric needs of the communities in which they are present. They are responsible for screening patients in primary care for mental and physical disorders, triaging cases by severity and offering interventions to less ill patients. These models from developing nations, all arising in response to physician shortages, rely on relatively inexpensive personnel to serve as the initial contact point for patients, thereby extending care to large numbers of patients despite limited resources.

It is striking that these models do not partition mental and medical health care. When initial triage is conducted by trained community members, even patients in rural settings have an opportunity to obtain care for both their medical and mental health conditions. In the face of limited access to specialized mental health services and antidepressant medications, several developing countries have evolved grass-roots systems of care that creatively overcome these apparent hurdles. In fact, the Chinese, Iranian, and Tanzanian solutions to this problem may offer important lessons to developed nations striving to evolve better methods for integrating depression care into their general medical settings.

While appealing, most of the models of care in developing nations have not been subject to rigorous systematic evaluation. Thus, David Goldberg's review points to the urgent need for more empirical cross-national comparison and outcome research on mental health services delivery around the globe. Indeed, several strategies developed in the so-called less developed world may prove equivalent to - or even better than - mental health care delivered in the developed world to patients in primary care settings.

References

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