

Priorities for research promoting mental health in the south and east of Asia

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Summary

Progress in promoting mental health, preventing mental illness, and improving care for people affected by mental illness is unlikely to occur if efforts remain separated from existing public health programs and the principles of public health action. Experts met recently to discuss integrating public health and mental health strategies in the south and east of Asia, especially in low- and middle-income countries. Areas of research identified as high priority were: 1) integrating mental health into perinatal care; 2) providing culturally-adjusted support for carers of people with mental and physical disorders; 3) using digital health technologies for mental health care in areas with limited resources and 4) building local research capacity. Selection of these areas was informed by their relative novelty in the region, ease of implementation, likely widespread benefit, and potential low costs. In this article, we summarise available evidence, highlight gaps and call for collaborations with research centres, leaders and persons with lived experience within and beyond the region.

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Introduction

Countries in the south and east of Asia face high levels of unmet need for mental health. Global estimates indicate the World Health Organization (WHO) South-East Asia Region accounts for around 27% of all cases of depression and 23% of all cases of anxiety.¹ In 2016, India's National Mental Health Survey reported 10% prevalence for common mental disorders (depression, anxiety and substance use disorders) with a treatment gap of 85% for depression and 86% for substance use

disorders.² Nepal's first ever national mental health survey in 2019–20 reported the lifetime prevalence for any mental disorder was 10% amongst adults and 5% amongst adolescents.³ The value of mental health prevention and promotion has been recognised in Asian countries, such as Thailand.^{4–6} However, more action and local research is needed to respond to such high levels of unmet need.

The International Mental Health Development Group (IMHDG) steering committee recently convened a meeting of mental health experts from the south and east of Asia with the objective of forming a local research network. The committee consists of two previous World Psychiatric Association presidents,

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experienced clinicians and researchers in public mental health from high-income countries (HIC) and middle-income countries. Meeting participants are listed in [Appendix 1](#). Prior to the meeting, the committee used their own knowledge, experience, and opinion to propose potential areas of public mental health research for the region. A focus group method was used at the meeting to evaluate the proposals and identify areas of highest priority with value for both HIC and low- and middle-income countries (LMICs). Participants were asked to consider the potential for future research to 1) be carried out with ease by building on existing efforts and avoiding reliance on expensive technologies, 2) yield results immediately useful for mental health and public health policy makers, 3) require limited new financial or human resources (particularly in early phases) and 4) produce evidence with utility for other regions. Full details of this meeting are published elsewhere.⁷

Four areas of research priority for the region were identified: integrating mental health in perinatal health care; improving the mental health of carers for people with a range of disabilities; using digital health technologies (DHTs) in psychiatry (particularly in isolated areas); and enhancing local mental health research capacity. In this article, as part of the ongoing work of IMHDG, we summarise existing research in these areas, and highlight gaps as well as opportunities for responses involving collaborations from within and beyond the region.

Areas of research priority in countries in the south and east of Asia

Integrating mental health care in perinatal care

Poor perinatal mental health (PMH) can have an enduring impact on parents and offspring. A mother's emotional wellbeing before birth is likely to have implications for the health of future generations.⁸ Poor maternal and paternal mental health has also been linked to obstetric complications, including pre-term birth⁹ and increased infant mortality.¹⁰ Maternal depression is linked to higher rates of both externalising and internalising paediatric psychopathology.¹¹

PMH disorders are common in LMIC. The prevalence of postnatal depression is ~25%,¹² compared to ~10% in HIC,¹³ and maternal suicide remains a major cause of death.¹² Communities in LMIC, especially those with a high prevalence of intersecting psychosocial issues like gender-based violence, need special attention for PMH.^{14,15} In *Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services* (2022), WHO called for the inclusion of screening and treating mental illnesses in routine care for pregnant women and their families. Case studies from Asia, such as in Nepal, highlight how this can increase detection of psychiatric conditions and improve engagement with services.¹⁶ Psychiatric leadership bodies have advocated

for embedding mental health care into maternity services, globally, including for fathers and other family members.^{17,18}

Data on PMH from countries in the south and east of Asia is very limited. Available evidence indicates a need for action. Research from India has found anxiety and depression during pregnancy is associated with low birth weight.¹⁹ During the COVID-19 pandemic, prevalence of maternal depression in Nepal was ~33%.²⁰ In Indonesia, the COVID-19 pandemic was associated with an increase in social problems, such as early marriage amongst adolescent girls,²¹ which has been linked to earlier childbirth and poorer parental wellbeing.²² More data is needed to reveal the full extent of the burden in the region.

The evidence for targeted PMH interventions is compelling, particularly for common disorders, such as perinatal depression.²³ Models of PMH care with demonstrable benefit do exist in the region (e.g., Mother Baby Units in Bengaluru, India and in Colombo, Sri Lanka), though most countries lack specialised services.²⁴ In some countries (e.g., Hong Kong, Singapore, Malaysia, Taiwan), specialised outpatient perinatal psychiatric services are integrated into the public health system. In others (e.g., Malaysia, Indonesia) care is offered through consultation-liaison psychiatrists. In Nepal, some non-governmental organisations run initiatives for screening, treatment and referral of PMH disorders (e.g., Health Foundation Nepal's SMILE Mother Project), though this is not integrated into the public health system. In Thailand, since 2013 routine screening for perinatal depression is mandatory at all primary care antenatal visits, though treatment is not standardised, nor outcomes routinely monitored.^{25–27}

The IMHDG meeting identified two areas of future work. The first was targeted studies mapping the full extent of available PMH services in selected countries. This can begin with multi-centre surveys of clinicians and lived experience service users.²⁸ This work lays the foundation for clinical trials comparing different approaches to care in the region. The second was investigating the psychosocial effects of births on families. This may start with epidemiological studies on the impact of first births and comparing differences in responses according to psychosocial factors. This can help identify population-level strategies for PMH prevention tailored to particular countries and cultures.

Supporting the health of carers looking after people with mental and physical disabilities

The health of people who informally care for community and family members with a range of mental and physical disabilities ('carers') has been neglected. Yet, as a result of processes such as deinstitutionalisation, carers now form a fundamental part of health systems

and supports for consumers.²⁹ The limited available data indicates carers suffer higher rates of physical and mental ill-health compared to non-carers.³⁰ Few communities adequately meet the needs of this critically important group.

The literature is scarce on the health and experiences of carers from LMIC, particularly countries in the south and east of Asia.³¹ A scoping review of studies about carers for children with mental health or neurodevelopmental conditions in LMIC presented stark findings: most carers in India lack sufficient support; many in Nepal experienced strained family relationships, marital difficulties and poorer quality of life; and carers in Pakistan report depression and stigma associated with their role.³² A longitudinal study conducted in Thailand reported high psychological distress among carers. The authors mention the significance of Buddhist culture and beliefs about supporting family members, but did not report any specific effects.³³ A recent qualitative study in Pakistan highlighted how carers of people with psychosis frequently believed their loved one's illness was due to spiritual and social factors (e.g., relationship breakdowns). Shame, stigma and family beliefs influenced help-seeking and preferences for non-medical help.³⁴

Evidence for strategies to support carers in the region is also limited. Most available data concerns carers for people with dementia. One scoping review of 30 studies in Asia reported data about interventions for carers of people living with Alzheimer's disease (AD) or Alzheimer's-related dementias (ADRD). These included psychoeducation about AD/ADRD; stress reduction techniques (e.g., self-care); and skill building (e.g., anticipating behaviours and problem-solving). While some studies came from China, Thailand, India, and Pakistan, most evidence originated from HIC,³⁵ even though more than 70% of people with AD/ADRD globally are predicted to live in LMIC by 2050.^{35,36} Although not strictly within the region of interest, one systematic review of 23 studies on interventions for carers of people with dementia in China found that teaching carers behavioural management techniques, providing psychosocial support, psychoeducation about dementia, case management and coping strategies may improve carer quality of life.³⁷

The IMHDG meeting involved two proposals about carer health. The first concerned more rigorously documenting the experience of carers in the region, and examining how this differs according to cultural, economic and health system factors. The second involved defining the minimum support needed for carers in the region and training for professionals to identify carers and their needs. This work should be led by carers with support from clinicians and researchers. This can contribute to the basis for subsequent work evaluating interventions specifically targeting carer health.

Using digital health technologies for mental health care provision and training

DHTs take advantage of the ubiquity of personal technologies to overcome contextual factors limiting access to care and training.³⁸ This is especially valuable in regions where rates of mobile device ownership and internet use are high, but access to or use of face-to-face services is low.³⁹ DHTs are used in psychiatry for delivering evidence-based, best-practice interventions (e.g., exposure therapy via virtual reality), as adjuncts to face-to-face care (e.g., online cognitive behaviour therapy) and to offer new pathways for engagement (e.g., chatbots and social media).³⁸ WHO's online 'Step-by-Step' program is a recent example of using DHTs in resource-limited settings. It delivers psychoeducation, behavioural activation, and training in stress management techniques via an internet-connected device. A recent trial found the program was associated with significant reductions in depression, anxiety, post-traumatic stress and personal problems among Syrian refugees living in Lebanon.⁴⁰

A large proportion of Asia has access to a mobile device. One report in 2022 on the Asia-Pacific region found ~75% of the population use a smartphone, and ~45% use mobile internet.⁴¹ However, research on using DHTs for mental health in Asia, particularly in countries in the south and east is limited.⁴² Yet, there is certainly strong interest. A survey of 192 early-career psychiatrists, junior doctors, and medical students from India, Nepal, Indonesia, Thailand, Pakistan, and Japan found 77% believe DHTs can be as effective and useful as face-to-face care, though most lacked formal training in their use.⁴³ In Nepal, clinicians are interested in using smartphone apps, such as those offering decision-support for primary care physicians,⁴⁴ and wearables for identifying adolescent mothers at risk of postpartum depression in isolated areas.⁴⁵ Pilot studies suggest using internet and video to train rural generalist clinicians can improve knowledge of mental disorders.⁴⁶

The region faces certain challenges for DHT research and adoption. This includes unreliable or no access to high-speed internet in some areas, limited digital literacy in certain groups (e.g., the elderly), concerns about costs of some technologies and a lack of policy to regulate use.^{43,47,48} Some challenges can be overcome. For example, India has released telepsychiatry guidelines to help support and regulate service development, and tele-mental health centres of excellence are being established. Longitudinal research is needed to determine the full value of these initiatives.^{49–51}

The IMHDG meeting called for studies examining the scope of DHT use for mental health care in the region and whether guidelines are being applied (e.g., World Psychiatric Association Telepsychiatry Global Guidelines⁵²). Work is needed to determine preferences for different models of care (e.g., self-management or

hybrid models), particularly in remote communities, and the consumer, carer, clinician and system factors influencing implementation. Collaborations with people with lived experience to examine issues such as data handling and privacy specific to the region are also needed.

Research capacity building in the south and east of Asia

Research capacity refers to the ability of local researchers to carry out studies, analyse results, communicate them and apply findings in their communities.⁵³ The lack of local evidence in the mentioned areas highlights the importance of building mental health research capacity in the south and east of Asia. The IMHDG meeting involved bringing leaders from the region together to find ways of using collaborations not only to address specific public mental health issues, but also to grow and help sustain local research efforts more broadly.

An expanded local research workforce is needed. Attempts to do this in the region have involved structured research training and mentoring. Some success has been achieved, but not fully sustained.^{54,55} Training is needed for health workers in the areas discussed. For instance, WHO has emphasised the need to evaluate interventions for improving PMH in maternity services and use this evidence to improve services.¹⁶ This requires culturally-validated tools for screening for common mental disorders to be developed, and is best informed by the insights of local experts and community members. Similarly, electronic devices used for mental health in the region may offer rich sources of data, but local leaders are needed to guide interpretation. Initiatives in the region for building a local research workforce should be based on a 'train-the-trainer' approach and be maintained by practical incentives for continuing work beyond any single source of funding.⁵³

Research in the region needs to expand beyond acute health care settings. In some HICs, co-designed enhanced primary care models for mental health care and substance use have been developed by researchers, clinicians, and people with lived experience to improve access and help reduce stigma, particularly among youth. These services operate on a 'walk-in' basis with no requirement for referrals (e.g., 'headspace' in Australia⁵⁶). They have a strong research focus. Similar services are being adopted in Asia, such as the Centre for Well Being at the National Institute of Mental Health and Neuro Sciences in Bengaluru, India.⁵⁷ As these services are rolled out, there is an opportunity to embed research practices into their functioning. Introducing research staff and routine data collection and analysis can help track and assess outcomes, as well as diversify regional research output. This work would be especially useful for exploring community carer health.

A productive and sustainable local research culture is needed to secure long-term funding and build enduring research collaborations. Practical challenges in conducting studies need to be addressed first. Many countries in the region lack consistent research funding. For instance, mental health research in Nepal relies mostly on financial support from non-governmental organisations. Securing governmental funding requires political support and community will. A recent positive step is member countries of the WHO South-East Asia Region adopting the Paro Declaration in 2022, which includes commitments from health ministers to improve local mental health research.⁵⁸ However, more is needed. Poor mental health literacy and stigma impedes the development of diverse collaborations between researchers, providers, policy makers and community members.⁵⁹ Celebrating the work of local leaders and elevating service users as collaborators and co-designers in research and innovation can help ensure political commitments are fulfilled.^{5,60}

Conclusions

The IMHDG meeting was the first step in generating new international responses to the significant mental health needs of communities in the south and east of Asia. In four priority areas of need we outline available evidence as well as critical gaps and potential areas of collaboration within and beyond the region. The areas are interconnected and reflect a range of intersecting challenges. However, they also offer opportunities to invigorate efforts to prevent mental illness and promote good mental health. Responses to any of the specific areas outlined can be expected to yield benefits across systems and set examples for change elsewhere. The IMHDG welcomes responses from all parties interested in collaborating to meet the substantial unmet mental health needs of people in the south and east of Asia.

Contributors

C.L. and C.S. led drafting (writing) of the article. Y.B., P.C., H.H., C.W.H. and N. Sa, all contributed equally to conceptualising, structuring, reviewing, and editing the article. S.D., S.S., N. Si, H.D., I.H. and A.J. all provided additional local expertise and references from the region of interest, as well as editorial advice.

The International Mental Health Development Group steering committee consists of H.H., P.C., C.W.H., Y.B. and N.Sa.

Declaration of interests

We declare no competing interests.

Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jlansea.2023.100287>.

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