BJPsych | The British Journal of Psychiatry (2023) 223, 446–447.

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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RE: Reconceptualising the treatment gap for common mental disorders: a fork in the road for global mental health?

Reconceptualising the treatment gap: a paradigm shift is urgently needed

I read with great interest the article by Roberts et al on reconceptualising the treatment gap, which highlights that the reason we have a gap in mental health treatment is not necessarily the shortage in effective treatments (pharmacological and psychological) – instead, it may be the fact that distressed individuals may not view their distress in medical or psychiatric terms but in terms of the causes of distress being related to socioeconomic circumstances that doctors and medical or psychological treatments cannot help with. The article also highlights the importance of addressing these socioeconomic determinants of health and well-being as a way of tackling the 'prevention gap'.

I particularly enjoyed reading the brief description of four qualitative studies carried out with people in India, Mexico and Uganda and with young Black people in central London, which show, in the words of the participants, the limitations and the negative perceptions of the medical model that sees symptoms of illness and attempts to treat them instead of addressing the real causes of people's distress.

In this context, I believe that the paper did not address the part played by psychiatrists, representing mental health services, driven by a push to see quick results and under pressure from pharmaceutical companies, in medicalising and pathologising human distress. There seems be a tendency among psychiatrists to view people's distress as a manifestation of a mental illness or, worse still, as a sign of brain malfunction or chemical imbalance, as a way perhaps of justifying the use of medical or psychological treatments to the individual.

We find that psychiatrists translate the individual's expression of distress, often expressed in 'down to earth' ordinary language, into a medical or technical language (a diagnosis or a disease code), thereby turning the sufferer into a 'patient' who requires a medical treatment and therefore locating the fault or the dysfunction in the individual instead of the society, the system or the set of circumstances that may have led to the individual's distress.

In this way, the individual will be convinced, as told by the medical expert, that their suffering is a medical condition, called anxiety, post-traumatic stress disorder, etc., rather like diabetes or renal failure, and that their poor sleep, as they stay up all night worrying about the money running out before their pay day, is called 'insomnia', a sign of a medical condition called depression. The individual therefore believes that the 'cure' is in the hands of the doctor. It is clear that this approach leads to the 'patient' feeling less empowered to change or challenge their circumstances, whereas it grants the psychiatrist more power to continue to feel relevant and to practice so-called 'evidence-based medicine' derived from randomised controlled trials carried out in artificially sterile and pure laboratory conditions that have no resemblance to the complex realities that most distressed individuals live in.

This article is written from a global mental health perspective, focusing especially on low- and middle-income countries. However, the perspective proposed in the article has the potential of being greatly beneficial, albeit challenging, for psychiatrists operating in high-income countries such as the UK, if psychiatrists were to genuinely listen to people's suffering, as communicated by the people themselves, and to see this suffering through a truly biopsychosocial lens.

Declaration of interest

None

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doi:10.1192/bjp.2023.29

Author's Reply. RE: Reconceptualising the treatment gap for common mental disorders: a fork in the road for global mental health?

We thank Dr Alachkar for his thoughtful response to our article on 'reconceptualising the treatment gap'. Whereas our article described the perspective of (potential) patients and the common misalignment between how people facing ongoing adversity see their problems and how they are conceptualised by mental health services, Dr Alachkar provides a psychiatrist's perspective on the inadequacies of the psychiatrist's toolkit in the face of problems that are largely driven by social injustices, such as poverty and discrimination. As Dr Alachkar notes, translating individuals' expressions of distress into a decontextualised medical diagnosis can disempower people in challenging situations of exploitation, leading them to focus on medical routes to recovery rather than identifying the social or political factors that shape their experiences.

We are pleased to see mental health professionals critically engaging with these issues as they relate to their own practice. Dr Alachkar is by no means alone in observing that the tools available to mental health practitioners are limited in what they are able to achieve. Practitioners in many realms of mental health recognise the poor 'fit' between their tools and needs of patients.[1] The big question is how such practitioners can use insights from critical social science to rethink their role and better meet the needs of those they serve. First, we contend that psychiatrists and other mental health professionals are well placed to advocate for the needs of their patients and believe that there is an important role for professional bodies representing this group to speak out against policies that are harmful to people's mental health, such as punitive welfare policies that both worsen the mental health of those already in the mental health system and increase the number of people in the population experiencing psychological distress.[2] Maintaining political neutrality while governments and private interests create worsening conditions for mental health – despite clear evidence on the social determinants of mental health and the actions necessary to reduce mental health inequalities[3] – is to support the status quo. For individual practitioners, who see the pernicious effects of the social, political and commercial determinants of mental health in their clinics every day, there is an opportunity to empower patients by developing formulations of their distress that acknowledge the links between their individual experiences and the structural forces that shape their lives, as described by Bhui[4] and others, and as reflected in traditions of social medicine

https://doi.org/10.1192/bjp.2023.93 Published online by Cambridge University Press

that are practiced in Latin America and other Southern countries, which aim to centre the complex societal structures that drive poor health.[5] Within the global North, many mental health practitioners already think more broadly than psychiatric care in terms of how to meet patients' needs, by referring to social workers, non-governmental organisations, occupational therapists and other professionals to address housing needs and provide advice on rights and benefits, access to food banks, etc. However, such referral pathways are absent in many lower-income settings, and intersecting dimensions of social need cannot be fully addressed in parallel. Innovative models are needed that work across multiple levels of social need, bringing these services together in a single hub. This is by no means an easy task, especially in low-resource settings, and may entail individuals working against or outside of the system within which they are situated, as in Davis's description of 'counter-clinics',[6] but the benefits for patients of having the complexity of their situation acknowledged and their core needs addressed would be enormous.

In conclusion, we agree with Dr Alachkar that psychiatrists have an important role in reproducing the systemic issues that we discuss within the clinic, but we believe that they – along with their clinical colleagues from other disciplines – can also play an important part in changing the nature of mental healthcare to better address patients' social needs and in advocating for action on the causes of their despair.

Declaration of interest

None

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doi:10.1192/bjp.2023.93