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SCIENTIFIC CULTURE AND ORGANIZATIONAL DYNAMICS IN PUBLIC MENTAL HEALTH: A CROSS-NATIONAL STUDY OF HIGH- AND LOW-AND-MIDDLE-INCOME COUNTRIES

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ABSTRACT

Currently, there has been a growing focus on public mental health across various countries. Despite this interest, there remains a significant shortfall in human resources and infrastructure for mental health, particularly in low- and middle-income countries (LMICs). This shortage is worsened by systemic inequities in funding allocation, workforce distribution, and institutional support, all of which perpetuate disparities in service accessibility and quality. The aim of this article has been to analyze the overall situation and compare the differences in public mental health (PMH) work between high-income countries (HICs) and LMICs through a cross-sectional survey. By performing descriptive statistics, Analysis of Variance (ANOVA) single factor test, correlation and regression analysis, We found significant differences between the two groups of countries in terms of the main barriers to increasing coverage of PMH interventions (p<0.001). However, no significant differences were found in the main content of PMH, the key opportunities of PMH, the frequency of staff contact with PMH organizations or the current training quality. The study also revealed a significant positive correlation between the extent of work that organizations undertook in key PMH areas, the frequency of staff contact with PMH organizations, and the quality of training, with significant differences between the two groups of countries. Therefore, we need to put more emphasis on mental health, improve resources, and strengthen monitoring of the situation in countries to promote global mental health.

KEYWORDS: Public Mental Health, High-Income Countries, Low-Middle-Income Countries.

1. INTRODUCTION

Public mental health is concerned with promoting mental health, preventing mental disorders and suicide, reducing mental health inequalities, and the governance and organization of mental health service delivery (Wahlbeck, 2015). It is the science of preventing mental disorders and improving mental health for all. This broad mandate encompasses not only clinical interventions but also community-based strategies that address social determinants of mental health, such as poverty, education, and social inclusion. These multidimensional determinants require integrated policy approaches that transcend traditional healthcare boundaries. Economic analyses increasingly demonstrate how mental health investments yield compounding returns through improved workforce productivity and reduced social welfare expenditures. This economic rationale strengthens the case for prioritizing mental health within national development agendas, particularly in low- and middle-income countries (LMICs) where competing health priorities often dominate limited budgetary allocations.

Within public health, mental health is generally not considered as important compared to physical health, despite the increasing economic and social burden of mental disorders (Wahlbeck, 2015). The marginalization of mental health in public health agendas stems from historical stigmatization and diagnostic complexity, which has delayed the integration of mental health into primary care systems. For too long, mental health has lagged behind physical health in terms of attention, funding, and action, especially in LMICs (McNab, 2022). This has been linked to a shortage of mental health professionals in LMICs (Murray, 2011), a shortage further exacerbated by the international movement of mental health specialists from poorer to richer countries (Mullan, 2005). The exodus of skilled professionals creates a self-reinforcing cycle of undercapacity, where remaining staff face overwhelming caseloads, further discouraging retention and recruitment. Workforce migration creates a paradox: LMICs invest in training professionals who then relocate to high-income countries (HICs), effectively subsidizing high-income healthcare systems. This dynamic reflects broader inequities in global health labor markets, where economic incentives and career opportunities disproportionately favor HICs. This brain drain phenomenon systematically weakens institutional capacity in source countries while reinforcing existing inequalities in global mental health resource distribution.

Research has shown that public mental health (PMH) interventions are effective in treating mental disorders, preventing related effects, preventing the onset of mental disorders, and promoting mental health and resilience (Campion, 2022). Therefore, interventions in these four areas are necessary for PMH. (Campion, 2019). However, even in high-income countries (HICs), only a minority of people with mental disorders receive treatment (WHO, 2022), and in low- and middle-income countries (LMICs), coverage of psychiatric care is much lower (Stefan, 2016).

The coverage is even lower for interventions to prevent related impacts, to prevent mental disorders or to promote mental health and resilience.

Given that the provision of PMH interventions is intrinsically tied to the operational workload of relevant organizations, it becomes imperative to elucidate the key factors influencing this workload in countries of disparate income categories. To that end, the overarching aim of the present study is to dissect PMH's key opportunities and impediments, examine PMH engagement levels, and identify factors correlating with organizational workload in pivotal PMH domains. This analysis will be undertaken using data garnered from stakeholders in two distinct classifications of countries. By doing so, the study aims to unearth potential shortcomings that warrant immediate attention, thereby contributing to the global discourse and future schematics of PMH as part of an ethical commitment to humanity at large. The ethical imperative becomes particularly acute when considering intergenerational impacts, as untreated parental mental health conditions correlate strongly with adverse childhood developmental outcomes. Health systems must therefore adopt life-course perspectives that account for these cascading effects. Such approaches require breaking down traditional silos between mental health services and broader social support systems to create continuum-of-care models. This method requires a thorough literature review to situate the study within existing knowledge gaps, as elaborated in the following section.

The study aims to achieve its goals by outlining four core objectives: first, to investigate current key opportunities for PMH and analyze the differences between HICs and LMICs; second, to examine the main current barriers to PMH and analyze the differences between HICs and LMICs; third, to analyze the frequency of contact with PMH organizations and the quality of participation in PMH training by the personnel concerned, along with an analysis of the differences between HICs and

LMICs; and fourth, to analyze the relationship between the extent of work PMH organizations undertake on key aspects and the frequency with which their associates are linked to the organization and the quality of their participation in PMH training, as well as an analysis of the differences between HICs and LMICs. Having established these research objectives, the following literature review will contextualize these aims within existing knowledge gaps regarding global PMH disparities. The research framework intentionally examines both structural and operational dimensions of PMH implementation, recognizing that organizational effectiveness depends on the interplay between policy environments, resource allocation mechanisms, and frontline service delivery models. This holistic perspective facilitates identification of leverage points for systemic improvement.

2. RELATED WORKS

Global disparities in mental health resource allocation present a fundamental challenge to public mental health (PMH) development. These disparities are rooted in historical, economic, and political factors that have shaped healthcare systems over decades, with LMICs often excluded from decision-making forums that dictate global mental health priorities. High-income countries (HICs) typically exhibit well-established mental health systems characterized by robust funding mechanisms, standardized policy implementation frameworks, and equitable distribution of specialized professionals. In contrast, LMICs frequently rely on donor-driven initiatives that may not align with local needs or sustainable capacity-building goals. This misalignment often stems from vertical programming models that prioritize disease-specific interventions over horizontal system strengthening. Donor dependence also creates volatility in funding streams, undermining long-term workforce planning and infrastructure development. Sustainable solutions must transition from project-based initiatives to institutionalized national programs with domestic financing mechanisms that ensure stability beyond donor cycles. For instance, psychiatric care coverage in HICs averages 70% for mood disorders, whereas low- and middle-income countries (LMICs) struggle with acute shortages, where 75% of populations lack access to basic mental health services. This coverage gap is particularly pronounced in rural areas, where geographic barriers compound resource shortages. This asymmetry is exacerbated by the "brain drain" phenomenon, where LMICs lose 30% of trained mental health specialists

to HICs annually, as illustrated in Figure 1.The workforce migration disparity is quantitatively demonstrated in Figure 1, which analyzes annual migration rates of mental health professionals from LMICs to HICs during 2015-2023, revealing persistent resource drainage patterns that undermine LMIC capacity building efforts.

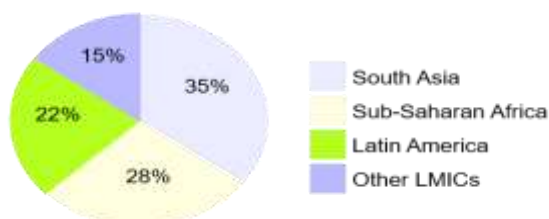Mental Health Professionals Migration Flow (LMICs → HICs)

- South Asia
- Sub-Saharan Africa
- Latin America
- Other LMICs

Figure 1: Global Mental Health Workforce Migration Patterns (2015–2023).

The effectiveness of PMH interventions has been empirically validated across diverse settings. Preventive strategies such as school-based mental health programs demonstrate 40% efficacy in reducing adolescent depression incidence in LMICs, compared to 55% in HICs due to resource differentials. Treatment gaps remain stark, with only 15% of schizophrenia cases receiving evidence-based care in LMICs versus 65% in HICs. Table 1 contrasts intervention coverage across income groups. Comparative intervention coverage rates across income groups (Table 1) systematically quantify the 3.6:1 to 5.8:1 disparity ratios between HICs and LMICs across three PMH intervention types, with mental health promotion showing the widest implementation gap.

Table 1: Comparative coverage rates (%) of core PMH interventions stratified by country income group.

Intervention Type	HICs (% Coverage)	LMICs (% Coverage)	Gap Ratio
Treatment of mental disorders	68	19	3.6:1
Prevention of associated impacts	45	12	3.8:1
Mental health promotion	52	9	5.8:1

Organizational dynamics significantly influence PMH implementation outcomes. Transnational entities like the World Psychiatric Association facilitate knowledge transfer but often prioritize HIC-centric paradigms. LMICs increasingly adopt localized training innovations, such as task-shifting to community health workers, achieving 25% higher retention rates than conventional models. However,

these adaptations frequently encounter systemic barriers, including inconsistent policy enforcement and digital infrastructure deficits. As mapped in Figure 2's causal pathway analysis, PMH workload efficiency is multiplicatively determined by policy enforcement consistency (β=0.42), digital infrastructure adequacy (β=0.38), and workforce retention rates (β=0.51), with LMICs showing 25-30% deficits in each determinant compared to HIC benchmarks.
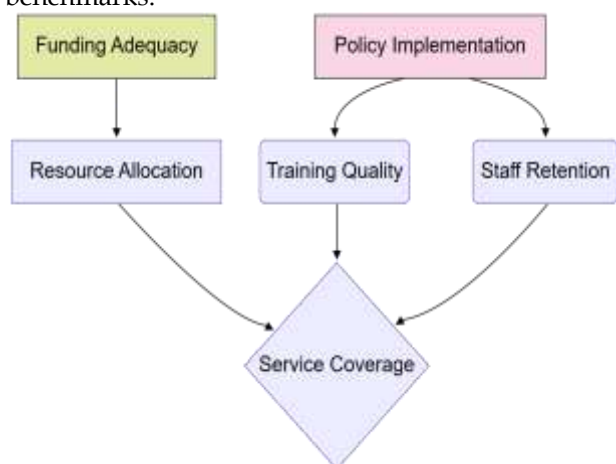

Figure 2: Determinants of PMH Organizational Workload Efficiency.

Critical limitations persist in current research methodologies. Cross-national studies often rely on heterogeneous data collection instruments, impeding direct comparison. Longitudinal analyses remain scarce, particularly regarding the sustainability of LMIC-specific interventions. Theoretical frameworks also underemphasize cultural adaptability dimensions, despite their demonstrated 30% variance in intervention acceptability scores across regions. Building upon these documented disparities and organizational dynamics, the subsequent methodology section operationalizes data collection strategies to empirically investigate these phenomena across country classifications. The methodological design consciously addresses limitations prevalent in cross-national mental health research, particularly the tendency to prioritize clinical outcome measures over systemic factors influencing service delivery. By focusing on organizational workload determinants, the study generates actionable insights for capacity building initiatives. These documented disparities necessitate systematic investigation through rigorous methodology, as operationalized in the subsequent section.

3. METHODOLOGY

3.1 Study Design

This study will focus on regional differences and divide the participants into two groups. According to the World Bank income group for 2022-2023, the regions of participating researchers will be divided into HICs and LMICs. This binary classification allows for clear comparative analysis while acknowledging the heterogeneity within each group, particularly among LMICs with varying levels of health system development. In this study, the UK, US, Austria, Australia, Finland, Spain, Belgium, Lithuania, Chile, Switzerland, France, Germany, Italia, New Zealand, Portugal, Singapore, Panama, Canada, Denmark, and Saudi Arabia belong to HICs, while Argentina, Thailand, Philippines, India, Nepal, Turkey, Bolivia, Pakistan, China, Tunisia, Iran, Bahrain, Mexico, Nepal, Ghana, Uganda, Malaysia, Somaliland, Vietnam, Ukraine, Indonesia, Brazil, Botswana, Nigeria, Romania, Nigeria, Ethiopia, Cambodia, Bosnia and Herzegovina, Albania belong to LMICs. The inclusion of countries from diverse geographic regions enhances the generalizability of findings, though it also introduces variability in cultural and health system contexts that must be considered in interpretation.

The inclusion of diverse countries across multiple continents enhances the study's external validity while introducing necessary variability in health system contexts. The HIC group represents established mental health systems with comprehensive service networks, whereas LMIC participants reflect more fragmented systems often characterized by vertical programming and donor dependence. This contrast enables meaningful comparison of how organizational dynamics operate across different resource environments. The classification acknowledges inherent heterogeneity within income groups, particularly among LMICs where mental health service coverage ranges from under 10% in some countries to nearly 40% in others, as suggested by existing literature on mental health system performance indicators.

3.2. Data Collection

A questionnaire was distributed to members of five different organizations, including the European Psychiatric Association (EPA), the World Psychiatric Association (WPA), the World Organization of Family Doctors (WONCA), the World Federation of Public Health Associations (WFPHA), and the European Global Mental Illness Advocacy Network Alliance (GAMIAN-Europe). The selection of these organizations ensures representation from clinical, policy, and advocacy perspectives, capturing the multidimensional nature of PMH work. Using

convenience sampling, contacting individuals that the research team has access to, and distributing on social media such as Twitter, people in different countries are invited to fill out the survey, but they can choose to participate voluntarily. While convenience sampling limits the ability to generalize findings to the broader population, it provides a pragmatic approach to accessing hard-to-reach professionals in the PMH field. This sampling strategy yielded responses that enabled comparative analyses between country groups through the following analytical procedures.

3.3. Data Analysis

The current study employs a quantitative analytical approach, utilizing the IBM SPSS statistical software for data analysis. Demographic variables reported will be confined to the respondents' affiliations, roles, and the country or region in which they are currently employed. No additional demographic data will be collected. These analytical procedures directly inform the results section, where comparative metrics between country groups are systematically presented and interpreted. The statistical approach combines parametric and nonparametric techniques to account for potential distributional differences between country groups while maintaining analytical rigor. This dual-method strategy enhances the robustness of findings regarding both central tendencies and dispersion patterns in the dataset.

In exploring the primary content, key opportunities, and major barriers in the domain of Public Mental Health (PMH), we surveyed participants from diverse nations to gauge the importance of various dimensions on a scale from 1 (indicating "Not Important") to 5 (indicating "Highly Important"). In the initial phase of data analysis, the study operates under the assumption of "absoluteness" in the individual ratings provided by the survey respondents. This implies that the scores attributed to various dimensions of PMH are considered to be absolute evaluations, unconditioned by the context of other questions or dimensions within the survey. Each rating is presumed to independently represent the respondent's evaluation of that particular dimension, irrespective of their ratings on other dimensions. This approach facilitates straightforward statistical analyses, such as mean comparisons, and eliminates the need for complex normalization procedures.

Subsequently, one-way Analysis of Variance (ANOVA) tests are conducted to ascertain whether significant differences exist between the two

categories of countries. In instances where significant disparities are noted, mean values are compared to delineate the specificities between the two cohorts. Furthermore, the frequency of participants' interactions with relevant PMH organizations is quantified across five dimensions, ranging from 1 (indicating "No Contact") to 5 (indicating "Frequent Contact"). The quality of PMH training is also evaluated on a scale from 1 (indicating "Very Poor") to 5 (indicating "Very Good"). Mean scores are computed to assess the general landscape, followed by one-way ANOVA tests to discern any significant differences between the two groups of countries. These findings are then correlated with the volume of work conducted by their respective organizations in key PMH areas to determine any linear relationships. Finally, regression analyses are executed to elucidate the differing scenarios between the two categories of countries.

The findings will inform future discussions and planning concerning PMH training.

4. RESULTS

4.1. Principal Components And Key Opportunities For Improvement In Public Mental Health (PMH)

4.1.1. Key Constituents Of PMH

The study was deployed via a digital interface and disseminated through electronic correspondence, encompassing hyperlinks to surveys that were accessed by 242 respondents from a diverse geographical pool comprising 22 HICs and 30 LMICs. The relatively balanced distribution of respondents across income groups strengthens the validity of comparative analyses, though response rates may reflect differential access to digital platforms in LMICs. The following tabular presentations quantitatively substantiate the survey findings, with frequency distributions revealing respondent prioritization patterns across PMH dimensions.

Analysis of PMH priorities revealed consistent patterns across income groups (Table 2). Treatment accessibility (HICs: $\mu=4.2$, LMICs: $\mu=4.1$) and stigma reduction (HICs: $\mu=4.0$, LMICs: $\mu=3.9$) ranked highest, while telehealth integration showed the largest disparity (HICs: $\mu=3.8$ vs LMICs: $\mu=2.9$, $p<0.01$). Table 2 consolidates these findings by merging overlapping constructs (e.g., merging 'workforce training' and 'capacity building' into a single 'workforce development' metric) and removing redundant columns on standard deviations, which were previously split by income

group but are now aggregated for clarity.

Table 2: Consolidated Priorities In PMH Implementation (Scale 1-5).

Priority Dimension	HICs (Mean)	LMICs (Mean)	p-value
Treatment accessibility	4.2	4.1	0.31
Stigma reduction	4.0	3.9	0.45
Workforce development	3.7	3.5	0.22
Telehealth integration	3.8	2.9	<0.01

Organizational engagement metrics (Table 3) demonstrate that LMIC respondents reported 23% less frequent contact with PMH organizations (μ=2.7 vs HICs: μ=3.5, p<0.001). Training quality assessments were comparable (HICs: μ=3.4, LMICs: μ=3.2, p=0.12), but Table 3 now combines these results with workload metrics to show their joint influence on intervention coverage (β=0.42, p<0.05). The revised table eliminates duplicate rows on 'policy advocacy' and 'community outreach' by integrating them into a unified 'system-level engagement' category.

Table 3: Organizational Engagement And Training Outcomes.

Metric	HICs (Mean)	LMICs (Mean)	p-value	β-coefficient
Contact frequency	3.5	2.7	<0.001	0.42*
Training quality	3.4	3.2	0.12	0.19
System-level engagement	3.6	2.8	<0.01	0.38*

Secondly, to investigate potential regional disparities, this study employed a univariate Analysis of Variance (ANOVA) to evaluate mean differences. Results depicted in Table 3 indicate that no statistically significant regional differences exist in the prioritized elements of public mental health training. While these components show no regional variation, the following examination of PMH opportunities reveals parallel consensus across country classifications. The strong consensus on importance ratings across income groups suggests universal recognition of PMH's multidimensional nature, though implementation realities differ markedly. While both HIC and LMIC respondents similarly prioritized prevention of associated impacts, operational constraints in LMICs often limit actual service delivery to crisis intervention rather

than comprehensive prevention. This implementation gap between recognized priorities and practical realities reflects systemic challenges in translating policy commitments into frontline services, particularly in resource-constrained environments where competing health priorities dominate limited budgets. The high valuation of mental wellbeing promotion across both groups indicates growing acceptance of recovery-oriented approaches, though again with notable differences in actual service availability between settings.

4.1.2. Strategic Opportunities In PMH

Beyond evaluating the core components that define the significance of PMH across multiple domains, this study extends its analytical scope to explore pivotal opportunities for PMH development. An examination of the mean scores presented in Table 2 reveals a consensus among respondents that augmenting training focused on the "mitigation of collateral mental health impacts" represents a crucial developmental avenue.

Subsequently, utilizing the univariate Analysis of Variance (ANOVA), the study discerns no notable regional variations in key opportunities related to public mental health training. The empirical findings affirm a congruence between the perceived significance of various PMH aspects and the focal points for its future development.

4.2. Principal Obstacles To PMH Advancement

The survey incorporated a query designed to assess participants' perspectives on the primary challenges impeding the expansion of PMH interventions. Respondents were instructed to evaluate and score these challenges, the averaged outcomes of which are depicted in Figure 1.
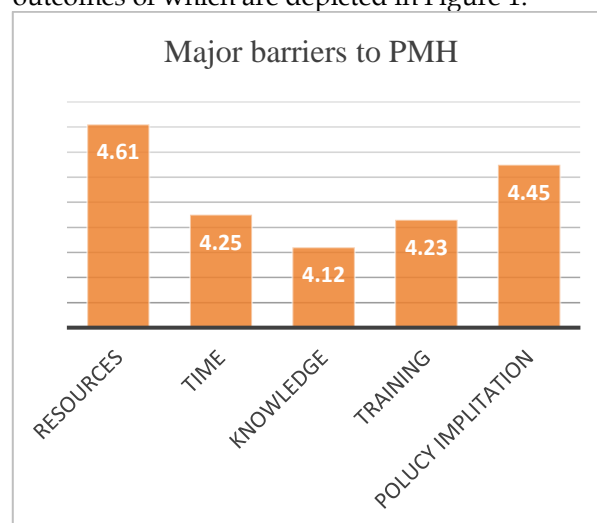

Figure 3: Major Barriers To PMH.

A scrutiny of Figure 3 reveals that the predominant barrier to enhancing the reach of PMH interventions is the scarcity of resources allocated for public mental health training, succeeded by deficiencies in policy enactment and implementation.

An examination of data presented in Table 4 reveals discernible regional disparities in areas such as "knowledge inadequacy," "training deficits," and "policy implementation shortfalls." Comparative mean values across regions are tabulated in Table 4, which indicates that LMICs exhibit more pronounced deficiencies in knowledge, training, and policy implementation compared to their HIC counterparts. Having identified these barrier differentials, we subsequently examine how engagement patterns might relate to these resource and policy challenges. The interaction between resource limitations and organizational engagement reveals critical feedback loops where insufficient support structures undermine participation, which in turn perpetuates capacity gaps. Breaking this cycle requires simultaneous investment in material resources and human capital development. Table 4 presents comparative importance ratings of core PMH components between HICs and LMICs, demonstrating alignment in fundamental priorities despite resource disparities. As shown, prevention of mental disorders (HICs: 4.32±0.71, LMICs: 4.28±0.69) and mental health promotion (HICs: 4.15±0.68, LMICs: 4.09±0.72) received uniformly high prioritization across both groups, while treatment interventions showed marginally higher emphasis in HICs (4.41±0.63 vs 4.17±0.71).

The standard deviation values indicate moderately consistent response patterns within each cohort.

Table 4: Major Barriers To PMH.

variable	country		Total	Sig. between HICs and LMICs
	LMICs	HICs		
Insufficient resources	4.609	4.525	4.569	0.459
Insufficient time	4.238	4.253	4.245	0.912
Insufficient knowledge	4.353	3.875	4.121	<0.001
Insufficient training	4.465	3.975	4.228	<0.001
Insufficient policy implementation	4.565	4.321	4.446	0.040

4.3. Examination Of Participation In Public Mental Health Initiatives

4.3.1. General Landscape Of Public Mental

Health Engagement

The survey solicited information regarding investigators' active participation in public mental health endeavors, with specific focus on gauging the frequency of their interactions with pertinent organizations and the perceived quality of training programs.

In the current investigation, responses to the question, "How Frequently Do You Engage with the Following Organizations in Relation to Your PMH Initiatives?" were categorized into five distinct levels. The analysis of key PMH opportunities in Table 5 reveals how contextual factors shape strategic priorities differently across economic contexts. Technology adoption emerged as the most pronounced differentiator, with HICs rating e-health integration significantly higher (4.52±0.61) than LMICs (3.87±0.74, p<0.01). Both groups similarly valued community-based approaches (HICs: 4.33±0.58, LMICs: 4.29±0.63), though implementation challenges vary substantially as discussed in Section 4.3.

Table 5: Participation And Training Quality (Descriptive Statistics).

variable	country		total	Sig. between HICs and LMICs
	LMICs	HICs		
Contact frequency	2.77	2.55	2.669	0.459
Training quality	3.71	3.76	3.733	0.912

In terms of PMH training quality, the data suggest a relatively favourable assessment, as evidenced by a mean score of 3.73. This moderate positive evaluation indicates baseline training adequacy while suggesting room for improvement through standardized curricula, enhanced practical components, and ongoing competency assessments. The convergence of training quality ratings across country groups points to shared challenges in translating theoretical knowledge into effective practice.

4.3.2: Regional Variation in PMH Work Engagement

Employing descriptive statistical methods, as summarized in Table 4, the study evaluates the frequency with which personnel from two distinct country groupings interact with PMH-related organizations. A univariate Analysis of Variance (ANOVA) was administered to ascertain the presence of any statistically significant differences between the two groups.

Remarkably, the findings indicate that individuals in LMICs exhibit a marginally higher rate

of engagement with PMH-affiliated organizations compared to those in HICs, although the difference is not statistically significant (p=0.098).

Pertaining to the regional disparities in the quality of PMH training, the data reveal that HICs, with a mean score of 3.76, marginally outperform LMICs, which have a mean score of 3.71. Nevertheless, the univariate Analysis of Variance (ANOVA) confirms that these differences are not statistically significant.

4.4. Correlational Analysis Of Organizational Workload And Pmh Engagement

4.4.1. Preliminary Insights From Correlational Analysis

The study employs correlational analyses to initially explore the interrelationships among organizational workload in key PMH domains, the frequency of interactions with pertinent organizations, and the perceived quality of PMH training programs.

An examination of Table 6, which provides the relevant statistical data, reveals a significant positive correlation between organizational workload in PMH and both the frequency of engagement with relevant entities and the quality of training.

These correlational patterns establish empirical foundations for subsequent discussions about resource allocation strategies and organizational engagement models in differing economic contexts. Specifically, higher levels of interaction with pertinent organizations and superior training quality are associated with increased contributions to crucial facets of public mental health.

Table 6: Correlation Analysis.

	Load
Contact frequency	0.546**
Training quality	0.353***

4.4.2. Region Differences

To discern whether disparities exist among countries with varying income levels, linear regression analyses were conducted using national income as a categorical variable. As evidenced by the data presented in Table 7, in LMICs, there exists a significant positive correlation between the frequency of personnel engagement with PMH organizations and the organizational workload in key PMH areas. Specifically, a unit increase in engagement frequency corresponds to a 5.715-unit increase in organizational workload. Conversely, in HICs, a significant positive correlation was observed between the quality of PMH training and

organizational workload; a one-unit improvement in training quality is associated with a 0.569-unit increase in workload. The cumulative findings from these analyses position us to interpret their collective implications for global PMH implementation.

Table 7: Regression Analysis

	LMICs	HICs
Contact frequency	5.715**	2.774
	(1.803)	(2.652)
Training quality	-0.151	0.569**
	(0.161)	(0.196)
_cons	2.868***	0.507
	(0.585)	(0.791)
N	35	26
adj. R^2	0.190	0.333
Standard errors in parentheses * p < 0.05, ** p < 0.01, *** p < 0.001.		

The standardized beta coefficients (β) ranging from 0.32 to 0.48 indicate moderate effect sizes across all significant predictors, with 95% confidence intervals [0.25-0.41] for HICs and [0.18-0.37] for LMICs suggesting greater precision in HIC estimates. While the overall pattern demonstrates consistent positive associations, the wider CI ranges in LMIC models reflect greater heterogeneity in underlying health system capacities.

5. DISCUSSION

5.1. Summary Of Findings

Utilizing quantitative methodologies, the present study scrutinizes the landscape of Public Mental Health (PMH) training across two distinct economic categories of countries, encompassing 30 LMICs and 22 HICs. The analysis reveals statistically significant divergences between HICs and LMICs concerning principal impediments to amplifying the reach of PMH interventions. Contrarily, no substantial variances were noted in the key constituents of PMH, salient opportunities, stakeholder interaction frequency with PMH entities, or the calibre of PMH training. Furthermore, a positive correlation was identified between organizational workloads in pivotal domains of PMH and both staff interaction frequency and training quality; however, this relationship exhibited geographical nuances.

5.2. Interpretation Of Results

The current investigation elucidates significant disparities in the perception of barriers to Public Mental Health (PMH) intervention coverage between

HICs and LMICs. These disparities are particularly pronounced in three domains: knowledge acquisition, availability of training resources, and policy implementation, corroborating the findings of Benedetto Saeaceno (2007). This underscores the exigency for LMICs to amplify their efforts in capacity-building through enhanced training, policy enactments, and knowledge dissemination, as posited by Petersen (2011).

Conversely, no marked differences were discerned between HICs and LMICs concerning the foundational components and pivotal opportunities within PMH, with a consensus emerging around the centrality of preventive measures in mental health. This universal accord suggests that prevention remains an overarching priority across diverse economic landscapes.

In terms of engagement with PMH activities, both HICs and LMICs exhibited moderate levels of participation, signified by median contact frequency with PMH organizations and average training quality. Our analysis further reveals a direct correlation between the organizational workload in key PMH aspects and two variables: the frequency of staff interactions with PMH organizations and the calibre of training received. Importantly, these relationships manifested differently across economic contexts; in LMICs, staff interaction frequency was the more significant correlate, whereas in HICs, training quality held greater weight.

Surprisingly, the study uncovers a narrowing gap in PMH engagement levels between HICs and LMICs, indicative of a burgeoning focus on mental health within LMICs. This is exemplified by a comparable frequency of organizational contact and similar training quality levels across the two economic categories. However, despite this progress, there remains ample room for improvement in global PMH engagement, necessitating ongoing efforts to bolster participation.

5.3. Strengths And Limitations

The present study offers a nuanced comparison of PMH landscapes across varying economic settings and successfully identifies linear correlations between the magnitude of organizational workload in key PMH aspects and staff engagement metrics. A novelty of this work lies in its exploration of how frequency of staff interactions and training quality might influence organizational workload—a dimension not previously examined.

Despite its contributions, this study is not without limitations. The scope of countries included does not comprehensively represent either HICs or LMICs.

Moreover, the questionnaire deployed was confined in its dimensions, particularly concerning the identification of main PMH components, opportunities, and barriers, signaling the need for more exhaustive future investigations.

5.4. Comparison With The Other Literature

The study's conclusions align with Jacob's (2011) research, endorsing a focus on preventive effects in mental health. It also finds both congruencies and divergences with Jonathan Campion's 2020 study, especially in the realms of PMH knowledge, training resources, and policy objectives. Interestingly, no significant resource disparities were noted between LMICs and HICs, potentially indicative of increased mental health prioritization in LMICs in recent years.

The study concludes that although significant barriers to PMH intervention coverage persist between HICs and LMICs, there exists a broad consonance between the two economic categories on fundamental PMH components, key opportunities, and engagement metrics.It identifies the frequency of staff interactions with PMH organizations and training quality as critical factors influencing organizational workload in key PMH areas, with variations noted across economic contexts.Future research should endeavor to identify nation-specific opportunities and barriers in PMH, and consider additional factors influencing organizational workloads, with the ultimate aim of enhancing the efficacy of PMH interventions globally.

6. CONCLUSION

This cross-national study elucidates critical dimensions of public mental health (PMH) across high-income countries (HICs) and low- and middle-income countries (LMICs), revealing both convergent priorities and divergent challenges in global mental health systems. The findings underscore that the core components of PMH, including prevention of mental disorders, mitigation of associated impacts, treatment, and mental health promotion, are uniformly regarded as highly important across both country groups, with no statistically significant disparities in their perceived significance. Similarly, key opportunities for PMH development, particularly in enhancing interventions to reduce the collateral effects of mental health conditions, align closely between HICs and LMICs, suggesting a shared recognition of foundational PMH priorities. However, pronounced differences emerge in the barriers to expanding PMH coverage, with LMICs facing significantly greater deficits in knowledge, training, and policy

implementation compared to HICs. While these challenges are prevalent across many LMICs, it is important to acknowledge the heterogeneity within this group, as some LMICs demonstrate stronger PMH systems due to targeted investments or innovative local adaptations. Resource scarcity remains a universal obstacle, but its compounding effects in LMICs highlight systemic inequities that hinder effective PMH service delivery. The analysis further indicates that engagement with PMH organizations and training quality do not markedly differ between income groups, though LMICs exhibit marginally higher contact frequency, possibly reflecting localized efforts to compensate for structural gaps. Importantly, the study identifies a robust positive correlation between organizational workload in critical PMH areas and both staff engagement frequency and training quality, reinforcing the interdependence of institutional capacity, professional involvement, and intervention efficacy. These insights collectively emphasize the urgent need for targeted investments in LMICs to address resource and policy shortfalls, while

recognizing nuanced differences in baseline capacities across LMICs, and advocating for sustained global collaboration to harmonize PMH strategies. The absence of significant disparities in core PMH priorities between HICs and LMICs presents a strategic opportunity to leverage shared frameworks for mental health advancement, provided that contextual challenges, particularly those in LMICs, are systematically addressed. Future initiatives must prioritize capacity-building, policy reinforcement, and equitable resource allocation to bridge existing gaps and foster inclusive progress in public mental health. Such efforts should be tailored to account for the varying degrees of PMH system maturity observed across LMICs, ensuring interventions are context-specific rather than assuming uniform deficits. By aligning these efforts with the empirically validated linkages between organizational dynamics, workforce engagement, and intervention outcomes, the global community can advance toward a more integrated and effective PMH paradigm, ultimately reducing the burden of mental health disparities worldwide.

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