

Community care for people with mental disorders in developing countries

Problems and possible solutions

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Much of the debate on community care for individuals with mental disorders has focused on issues relevant to industrialised nations. Developing countries also have accepted the need for community care, with the World Health Organization spearheading the crusade to incorporate the mental health component into primary health care (World Health Organization, 1990). Many developing countries have set up model programmes that form the basis of national implementation strategies (Harding *et al*, 1983; World Health Organization, 1984; Wig, 1989). However, the situation on the ground has not changed over the past decade and most programmes have failed to deliver (Wig, 1989; Agarwal, 1991; Gureje & Alem, 2000). The issues with regard to community care for people with mental illnesses in the developing world are complex and differ from those in industrialised societies.

EVALUATION OF MODEL PROJECTS

Community mental health model projects have been evaluated and found to be successful (Harding *et al*, 1983; World Health Organization, 1984; Wig, 1989). However, the evaluation was mainly qualitative, done in the pre-evidence-based era, and would not meet today's standards. In addition, the apparent success of model projects may be due to heightened political, professional and financial commitment and the Hawthorne effect. The absence of these elements in national mental health programmes may explain the inability to implement such plans on a larger scale.

IMPLEMENTATION OF NATIONAL PLANS

The success of the model projects did not result in mental health care being implemented on a national scale. The vast majority of the population are outside these

model programmes and still lack the basic facilities suggested in the national plans. For example, in India the programme is in different stages of implementation in small pockets (22 districts, with an estimated population of 4 million in a country with a population of 1 billion). The evaluation of some of these demonstration projects also has shown a low use of government health care, with major reliance on private health providers (Chisholm *et al*, 2000).

THE REALITY IN DEVELOPING COUNTRIES

The reality in developing countries is responsible for the failure of many national community mental health programmes.

The hierarchy of needs

Conceptually, from the community point of view, mental health concerns are a lower priority in comparison with physical health needs. This is similar to Maslow's hierarchy of individual needs (Costa & McCrae, 2000). The prevalent economic situation tends to push mental health interests into the background and unmet physical needs dominate reality. It can be argued that it would be difficult to overcome mental health problems before the physical needs are satisfied.

Concepts of mental illness

Depression, anxiety and unexplained somatic symptoms are not considered as mental illness in many societies. The varying cultural models of illness (Kleinman, 1980) that attribute such conditions to life events, fate, supernatural causes and physical diseases reduce the demand for mental health care. In addition, the stigma associated with mental disorders results in failure to seek or a delay in seeking appropriate care.

Professional commitment

The deficient demand for mental health care also has a significant impact on the commitment of mental health professionals and the health system. There is an absence of urgency to tackle the problems and a consequent lack of translation of plans into action-oriented programmes (Agarwal, 1991).

Demand and governmental priorities

The insufficient demand from the community for mental health services and the lack of consumer movements have major implications on the supply of mental health services. The consequences include a reduction in the political and administrative will of governments and a lack of financial commitment. In addition, the collapse of communism in the former Soviet Union and in Eastern Europe has resulted in a decline in socialistic orientation and a drift towards market economies in many developing countries. This has resulted in the reduction of resources for mental health care. Globalisation and liberalisation of economies have also had a profound impact on the social fabric of communities (Kleinman & Kleinman, 1999). The consequences include urban migration, overcrowded cities, overburdened infrastructure and rural unemployment and poverty, which have adverse effects on mental health.

The absence of a social welfare net

The community programmes operating in industrialised societies make active use of social welfare services in delivering care and are intrinsic to mental programmes (Thornicroft *et al*, 1998). The complete absence of a social welfare net in most developing countries is a major obstacle to the delivery of mental health care.

The vertical nature of health programmes

Community health programmes in many developing countries are essentially vertical in nature and their organisation reflects the specialist nature of hospital care. Vertical programmes do not fulfil the holistic nature of primary care and tend to break it up into compartments. Even in programmes where these are apparently integrated, the assimilation is superficial, with different vertical programmes competing for the community health worker's time and expertise.

Scope of the programme

The enlarged scope of the mental health programmes (Director General of Health Services, 1982), with emphasis on positive and preventive mental health, is ideal but beyond the scope of the available resources and expertise. The majority of mental health professionals have been trained in disease-oriented systems and lack the required skills. In addition, knowledge and expertise in the prevention of illness and the promotion of mental health at the community level are still in their infancy.

Other factors

Other factors that may interfere with community care include the high levels of civil strife and violence in some societies, political instability and corruption and gender inequality. The abuses perpetrated by psychiatry (i.e. the absence of basic human rights in some state-run mental hospitals) do not add to public confidence in seeking mental health care. Finally, a major psychosocial phenomenon, the 'Matthew effect', has been documented in primary health care: it has been demonstrated that populations with a poor standard of health seem to achieve only meagre improvements, whereas those with good standards seem to show substantial progress (Joseph, 1989). The Matthew effect also seems to influence the community care of people with mental illnesses. Resource allocation is biased in favour of hospital-based strategies, despite their inability to cater for the needs of rural populations. The discrimination against community care hinders the creation of alternative health strategies.

THE WAY FORWARD

Community psychiatry has developed in Western countries in response to a felt need. The economic development took care of physical needs and mental health became a priority. To expect strategies employed in industrialised nations to succeed in developing countries, where the ground realities differ, is naïve. Combating the obstacles to progress is difficult in the short term. In the long term, if the basic needs of the populations are met, mental health care would be a priority and consequently would be adequately delivered. Possible solutions are discussed briefly below.

Shifting the focus

The immediate goal should be restricted to the identification and treatment of priority disorders (e.g. psychoses, depression, epilepsy). This has been attempted in some regions (e.g. Tehran; Mohit, 1998). Programmes that give importance to local systems and values are usually more successful than programmes that neglect realities (Desjarlais *et al*, 1995; Gureje & Alem, 2000). Positive mental health and the primary prevention of mental disorders tend to dilute the emphasis of community care. Focusing on achievable goals would be a useful first step in mental health care delivery. Other specific goals (e.g. life skills education, school mental health programmes, follow-up of subjects at high risk for developing mental illness) (Rahman *et al*, 2000) also can be included when priority illnesses are managed.

Demonstrating the economic advantages of managing mental disorders

Although studies of effectiveness have shown that treating mental disorders makes clinical and economic sense (Thorncroft *et al*, 1998), there is a dearth of studies on the reduction of morbidity, disability and consequent financial costs in developing countries. A recent study has demonstrated that economic analysis of mental health care programmes in low-income countries is technically feasible and can usefully inform policy and service development (Chisholm *et al*, 2000). There is a need to demonstrate the financial advantages of managing mental disorders in the community before governments will support such initiatives on a large scale.

Enhancing skills during basic training

Although empowerment of physicians, nurses and other health workers has been emphasised and various training programmes developed (Harding *et al*, 1983; World Health Organization, 1984, 1990), the basic curriculum of these courses in many developing countries pays lip service to the diagnosis and management of mental disorders. The training programmes do not provide the necessary skills, nor do they transfer the confidence required to treat mental illness. These programmes are conducted in mental health facilities, using patients referred for specialist intervention,

and they employ specialist perspectives. Physicians and health workers are best taught about common presentations and problems in primary care settings using strategies that are locally available and applicable (e.g. ICD-10-PC; World Health Organization, 1996).

Bridging mental health issues with existing public health priorities

Adding a vertical mental health programme to the existing public health programmes has been attempted and found to be unsuccessful. The mental health component needs to be integrated into community health programmes. Removing the subject from the purview of psychiatry altogether and shifting it into the field of community medicine may be a way forward. In the short term, psychiatrists may play a key role in training, but the emphasis should lie in training trainers from community medicine who can, in the longer term, play a key role in training future generations of general health care workers. Such transfer of responsibility from specialist services to primary care in developing countries has been achieved successfully in obstetric and immunisation programmes.

Supporting community health workers

Training courses for health workers have been conducted in many countries (Harding *et al*, 1983; World Health Organization, 1984). However, the health workers usually do not have support in the field, resulting in poor recognition and treatment rates for mental illness. There is a need for training programmes to be followed by the provision of regular supervision in fieldwork. This is best achieved by public health physicians and nurses trained in the management of these disorders.

Partnership with the private health care systems

Most national mental health programmes employ governmental resources for health care delivery. However, resource constraints of governments prevent such programmes from reaching many sections of society. The private sector makes a significant contribution to health care in many developing countries. Two different systems operate: non-governmental organisations (NGOs), which are non-profit-making and are usually based in rural areas; and other

private providers, who operate essentially as businesses and are often based in towns and cities. At present, the participation of the private health sector in most national programmes is negligible. There is a need to involve the private sector, especially NGOs, in the mental health programmes so that the available resources are efficiently utilised. Such cooperation between governments and NGOs in providing antenatal care and immunisation services is well established and can serve as a model.

Partnership with the traditional health sector

In most developing countries traditional medicine is flourishing. It caters to a large population and it manages many common mental disorders (Patel *et al*, 1995). Formal links between systems of medicine can make use of their different approaches, which in many ways complement each other. Training of 'traditional midwives' in obstetric services is well recognised and provides a model for mental health care in the community.

Role of the mass media

The lack of awareness about mental illness, the role of early recognition and the need for treatment result in the absence of demand for mental health services. The mass media, especially radio and television, are especially helpful in educating illiterate populations. This will help also to reduce the stigma related to mental illness and increase the demand for mental health care.

The situation in developing countries is such that any strategy used in isolation will be much less effective than a combination of approaches. All available resources should be harnessed to improve community care for mental disorders.

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CONCLUSIONS

Many developing countries have established national mental health programmes. However, these programmes have not been implemented on a mass scale. The ground reality in developing countries has resulted in the absence of even basic care related to mental illness. Despite their honourable intent, most programmes fall far below their objectives, terminate prematurely or exist only on paper. Without a change in the current emphasis and direction, community care for mental illness in the developing world would remain as good intentions. There is a need for innovative approaches that utilise the available resources in order to ensure that health care reaches the population.

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