DFID ISSUES PAPER

MENTAL HEALTH IN DEVELOPING COUNTRIES

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INTRODUCTION

Mental health is a key development issue. The development of mental health services in poor countries is a means of contributing towards the Millennium Development Goal (MDG) of reducing extreme poverty and hunger by 2015.

This paper provides guidance to DFID staff and partners at country level on mental health issues, and a framework for understanding mental health and mental illness. It explains the association with physical health and the interaction with economic and social development. It contains examples and case studies and links to further resources.

Across the globe, in both developed and developing countries, mental ill health affects at least one in four people during their lifetime. At any one point in time approximately 15% of people are affected, and this figure is much higher in areas of conflict and post-conflict. Mental ill health accounts for 11 per cent of the total Global Burden of Disease[1]. Conflict, increasing numbers of refugees, the impact of HIV/AIDS, and nutritional deficiencies contribute further to the mental ill health burden of those living in developing countries. Just as poverty and ill health are intertwined[2] (poor countries tend to have worse health outcomes than less poor countries, and poor people have worse health outcomes than those who are better off) so poverty and mental health are also intertwined, and the association reflects causality in both directions. Poverty worsens mental ill health, and mental ill health makes poor people poorer.

Most cases of mental ill health are amenable to cost-effective interventions – whether preventive, therapeutic, or rehabilitative - and can be managed in the community. Delivery of these interventions in resource-poor settings poses significant challenges for health systems, communities and individuals. Specialist services are limited, and few primary health workers have received adequate training in mental health. Essential psychotropic drugs are in short supply.

The effective provision of mental health services should form an integral part of national poverty reduction and health strategies. Effective integration with primary care services is particularly important in ensuring that services reach the poor. Mental health is a key issue for other government sectors including education, social welfare, police, prisons, child protection and labour, and working across sectors is a key approach for successful service provision.

Many of the difficulties in delivering effective mental health services reflect generic problems with the health system. There is a need for the strengthening of health systems to be able to deliver a comprehensive package of primary care services, including affordable drug treatments and care plans for common mental health problems. Human resource issues are critical; training and continuing education of health care workers; sound management and ensuring motivation; and dialogue and joint work with traditional healers. Social workers, dispensers, NGOs and other community workers are also involved in the delivery of mental health services.

[1] World Health Report 2002. WHO, Geneva
[2] Wagstaff A. Poverty and health sector inequality. Bulletin of the World Health Organisation, 2002;80:97-105

Countries are at different stages in addressing mental ill health. WHO has recommended that all governments develop mental health policies[1], and yet 40 per cent of countries have no mental health policy, and 30 per cent have no mental health programme. Addressing mental ill health remains a low priority in many poor countries and limited human and financial resources are invested in other areas. Many people with mental disorders do not receive even the most basic treatment, and suffer from stigma and discrimination.

The paper advocates the integration of mental health service provision into generic health and social (e.g. social welfare, education, labour, criminal justice, child protection) policy, and reform programmes. Mental health services are a key component of any basic health service package, and should be available to all, at the level of primary care, supported by hospital services. This will require strengthening of health systems, and new approaches to community involvement, including traditional healers. This paper recognises that the rights of those with mental illness not to suffer from discrimination is of fundamental importance in advocating for policy and overall societal change.

THE GOBAL BURDEN OF MENTAL HEALTH

Positive mental health

The key to understanding mental health problems is the concept of **positive mental health**. This includes: a positive sense of well-being; individual resources including self esteem, optimism, and sense of mastery and coherence; the ability to initiate, develop and sustain mutually satisfying personal relationships; the ability to cope with adversity (resilience). Together, these will enhance the individual's capacity to contribute to family and other social networks, the local community and society at large. Positive mental health is fundamental in enabling avoidance of risk-taking behaviour.

At a societal level, good mental health is an important resource for individuals, families and communities. Mental health is an indivisible part of public health, contributes to the functions of society and has an effect on overall productivity. Mental health contributes to human, social and economic capital and overall development, and is an important component of any strategy to reduce poverty.

Mental ill health and its Management

Mental ill health includes a broad spectrum of conditions, arising from a wide range of causes. They range from psychological distress, common disorders such as anxiety and depression to rarer conditions such as psychoses (severe mental disorders causing disturbances in perception, beliefs and thought processes). Included here is epilepsy – which affects 1 per cent of the global population, and which is largely untreated in poor countries – dementia, and learning disability. All are typically the responsibility of mental health services.

Categories of Mental illness

- Psychological distress: Usually connected with various life situations, events and problems. *Management is based on psychosocial support and problem solving. If the distress is severe, or prolonged, the condition may progress to anxiety or depression.*
- Common mental disorders: These include depression and anxiety disorders (up to 10-20 per cent of the adult population at any one time, and 40-50 per cent in highly deprived and vulnerable populations), and emotional and conduct disorders in children (up to 10 per cent of children).
  Treatment may require medication (appropriately prescribed, antidepressant drugs are effective), but the mainstay of treatment is based on psychological and social interventions and community-based support.
- Post-traumatic stress disorder: This condition may be precipitated by severe trauma – conflict, famine violence, rape – characterised by flashbacks, nightmares, severe anxiety, which may lead to alcohol and substance abuse.
  Management is based on psychological and social support
- Severe mental disorders: Characterised by disturbances in perception, beliefs, and thought processes (psychoses).
  These conditions include schizophrenia and bipolar affective disorder "manic depression" (prevalence 0.5 per cent - 1 per cent population world wide). Often long-term, these conditions do require psychotropic medication, as well as psychosocial interventions and systematic rehabilitation. Acute episodes may require specialist assessment and management (which may require treatment in hospital), but evidence shows that patients are best cared for in the community for other than short periods.
  10 per cent people with severe mental illness will commit suicide.
- Substance abuse disorders: Characterised by excess consumption and dependency on psychoactive substances such as alcohol, tobacco, and drugs (e.g. heroin, opium, cocaine, hallucinogens, volatile solvents)
  Overall prevalence is country specific, but often at least 5 per cent, and increasing. Country specific prevalence: alcohol and tobacco are major problems in the Former Soviet Union; in some deprived communities e.g. longstanding refugee camps in Tanzania for people from Rwanda and Burundi, the prevalence is approaching 100 per cent.
- Abnormal personality traits: These are handicapping to the individual and /or others. *These conditions are very difficult to treat.*

Neurological disease often managed by mental health services

- Progressive organic diseases of the brain: (dementia)
  Dementia affects 5 per cent of over-65s, and 20 per cent of over 80s (Includes Alzheimer's disease, arteriosclerotic dementia and others). Dementia is a growing problem in developing countries.
- Epilepsy:
  The most common of brain disorders, affecting 1 per cent of the global population. 80 per cent of sufferers live in the developing world. Drug treatments ("anticonvulsants") generally provide effective management, and 70 per cent of newly diagnosed sufferers may be rendered symptom-free; untreated, patients with epilepsy may develop progressive disease, resulting in considerable psychosocial disability. In Africa, 80 per cent of sufferers receive no treatment.
- Learning Disability:
  In developing countries the prevalence is high (>3 per cent), the consequence of the greater incidence of brain damage due to traumatic delivery at birth, childhood brain infections, accidents, and iodine deficiency

The Global Burden of Disease (GDB), and the impact of mental illness

Mental illness accounts for 11 per cent of the Global Burden of Disease; depression alone accounts for 4.5 per cent of the GDB[1]. Mental illness impacts not only on the individual, but also on the carer(s), the family, the community, and society. For the individual, the consequences can be isolation, stigmatisation, unemployment, marital breakdown, poverty, cruelty, physical illness, and suicide. Individuals with severe mental health problems may be inappropriately institutionalised in large psychiatric

hospitals, distant from home and from society. Carers are under great psychological pressure, often made worse by economic constraints (inability to take on employment, the cost of caring for the individual), family pressures, and the stigmatism of mental health illness itself. They themselves may have little support for their own needs. At a societal level, the associated suffering, disability, mortality, loss of economic productivity, and resultant poverty, lead to a cycle of disadvantage.

The causes of mental disorders

Mental disorders often have multiple causes. These include social, psychological, genetic, and physical factors. As outlined above, social causes include life events (e.g. bereavement, job loss), chronic social adversity (macro-social and micro-social including unemployment, poverty, illiteracy, child labour, violence, war), and lack of social support. Psychological causes include poor coping skills, low self esteem and learned helplessness – themselves often the result of social causes. Physical causes include infection, disease, trauma, nutritional deficiencies, and hormonal problems.

An understanding of the causes is important, and has particular relevance when considering preventive approaches to treating mental health problems in developing countries.

Treatment of mental illness

Most mental illnesses are amenable to treatment. Although treatments will vary dependent on the nature of the illness, certain principles apply to all:

- Early, accurate, diagnosis
- Treating sufferers in primary care whenever possible, and if hospital admission is required, keeping it to a minimum and ensuring family and community ties are supported and not lost.
- Psychological and social support are a key component of all treatments, and in themselves are effective in treating many mental health problems
- Medication is effective in treating some forms of mental illness (e.g. depression, schizophrenia), but should be given in the context of psychosocial support and a planned therapeutic programme
- Co-ordinated care
- Rehabilitation programmes for people with severe mental disorders
- Management should take account of the needs of the carer
- Primary health care workers, provided they have basic training, continuing education and supervision, can manage most mental illness without recourse to specialist services
- Preventive approaches to mental illness at individual and population levels

The cost effectiveness of treating mental illness

The widening recognition of mental health as a significant international public health issue has led to an increasing need to demonstrate that investment of resources into service development is both required and also worthwhile. Although the volume of completed studies remains modest, particularly in middle- and low-income countries[3], there is increasing economic evidence to support the argument that interventions for schizophrenia, depression and other mental disorders are not only available and effective but also affordable and cost-effective.

[3] Shah A, Jenkins R. Mental health economic studies from developing countries reviewed in the context of those from developing countries. Acta Psychiatrica Scandinavica. 2000; 101:87-103

A recent DFID-funded study conducted in India and Pakistan piloted methods for, and showed the feasibility of, applying economic analysis to community mental health programmes in low-income countries (Chisholm et al, 2000). These methods were subsequently employed in a randomised cost-effectiveness trial of primary care depression treatment in Goa, India (Patel et al, 2003). However, in order to usefully inform policy and service developments, there remains a need to generate new cost-effectiveness data for affordable and locally appropriate interventions, including anti-convulsants for the control of epilepsy, antidepressant therapy in the acute phase of a depressive episode, psychosocial interventions for a range of mood disorders, and proactive case management of persistent, chronic or remitting conditions (including major depression and schizophrenia). In common with other non-communicable diseases, the success of any of these treatments at the population level will depend heavily on the adequate access to and quality of local health care services.

THE RELATIONSHIP OF MENTAL HEALTH AND POVERTY

Mental illness is a significant contributor to poverty

It is now recognized that a healthy adult population is an essential prerequisite for economic growth, and that health care must precede economic development [4]. By extension taking action to address mental illness will contribute to poverty reduction.

Mental illness is an important cause of poverty. This association arises from a variety of mechanisms. They include:

- Lost production from premature death caused by suicide, the inability to work, and lost productivity by family members/carers caring for the mentally ill person
- Reduced productivity from people being ill while at work
- Supporting the dependents of the mentally ill person
- Direct and indirect financial costs for families caring for the mentally ill person
- Childhood conduct and emotional disorders leading to educational failure, and subsequent unemployment and illness in adult life
- Poor emotional, cognitive and physical development of the children of mentally ill parents

Mental illness differentially affects the poor

A recent systematic review of large-scale epidemiological studies in developed countries has found a consistent relationship between rates of mental illness and indicators of social disadvantage, including low income, education, unemployment, and low social status[5]. Epidemiological studies in low and middle-income countries have found the same relationship. For example, a combined analysis of five recent surveys from Brazil, Zimbabwe, India and Chile reveals a consistent relationship between poverty and common mental disorders[6]. The data also suggests associations between other indicators of impoverishment such as hunger, level of education and indebtedness to mental disorder. In Indonesia, lower rates of depression and other common mental disorders were related to higher levels of education and access to amenities such as electricity. This association applied to communities as well as individuals. The least developed villages surveyed had common mental disorder rates of 28 per cent compared with 13 per cent in the most

[4] Macroeconomics and health: investing in health for economic development. Report of the committee for macroeconomics and health. WHO, Geneva. 2001

[5] Fryers T, Melzer D, Jenkins R. Inequalities in mental health. Maudsley Monograph, Taylor and Frqncis, 2003. In press

[6] Patel V, Araya MS, Lima A, Ludermir A, Todd C. Women, poverty and common mental disorders in four restructuring societies. Social Science and Medicine, 1999, 49: 1461-1471

developed villages[7]. Similar findings on the application of the association to communities as well as individuals have been found in the UK[8]. A recent study in Pakistan also found a firm relationship between poverty and mental illness[9].

Poverty as a cause of mental illness

As well as being a cause in its own right, poverty influences many of the social, psychological and biological factors which cause mental illness

- Poverty is associated with **adverse life events** (e.g. loss of employment, the death of a family member) and has been shown to have a negative impact on the course of mental illness in both developed and developing countries[10]
- **Unsafe and unhygienic living conditions** experienced by the very poor lead to exposure to infectious agents and toxins which can affect the neurological system and lead to developmental disabilities and epilepsy
- **Nutritional deficiencies** in pregnancy they can cause developmental deficiency and cognitive deficits; iodine deficiency may cause mental retardation; chronic hunger leads to anxiety and depression, while high infant and child mortality can have significant psychosocial effects on parents and other family members.
- **Limited access to mental health care.** There is insufficient mental health in the basic training and continuing education of primary care teams. There are generally insufficient specialist services; they are inadequately decentralised, and therefore difficult to access. Lack of appropriate psychosocial interventions, affordable and effective psychotropic drugs add to the difficulties.
- **Lack of educational and employment opportunities.** Poverty is commonly associated with a substandard education. This, in turn, is associated with failure to achieve academic potential, and lifelong limitation of employment opportunities

Mental illness influences effective functioning at home, school and work, leading to depressed economic circumstances. In this way, the vicious cycle of mental illness and economic deprivation goes on.

Mental illness affects the achievement of Millennium Development Goals (MDGs)

The MDGs include the eradication of extreme poverty and hunger, the reduction of infant and child mortality, improved maternal health, and combating HIV/AIDS and other communicable diseases. Improved mental health care will contribute towards the following goals:

- Poverty reduction (see above)
- Reduction of infant and child mortality. Through improved treatment of maternal post natal depression (associated with poor child health clinic attendance for immunisations etc)
- Reduction in HIV infection rates. Mental health promotion and improved mental health reduces high-risk behaviours – unsafe sex practices, and levels of drug usage and abuse

[7] Behar E, Henderson AS, MacKinnon AJ. An epidemiological study of mental health and socio-economic conditions in Sumatra, Indonesia. Acta Psychiatrica Scandinavica, 1992;85:257-263

[8] Weich S, Lewis G. Poverty, unemployment and the common mental disorders: a population based cohort study. British Medical Journal 1998; 317:115-119

[9] Mumford DB, Saeed K, Ahmad I, Latif S, Mubbashar M. Stress and psychiatric disorders in rural Punjab: a community survey. British Journal of Psychiatry, 1997; 170:473-478

[10] Hussain N, Creed F, and Tomenson B. Depression and social stress in Pakisatn. Psychological medicne 2000; 30 (2): 395-402

MENTAL HEALTH SERVICES IN LOW INCOME COUNTRIES

In many low-income countries, mental health problems are not regarded as a priority and the provision of services is clearly not adequate to need. Prevalence figures found in epidemiological studies as well as studies of primary care attenders show that in a population of 10,000, around 50 people will have a psychotic illness, and at least 1000 will suffer from depression or anxiety at any one time[11]. Yet there is commonly less than one psychiatrist per million population. All the patients with a psychotic illness will require treatment with medicines, and around 200-300 of those with depression and anxiety would benefit from antidepressants. All would benefit from psychosocial support from the primary health care team. In conflict, or post-conflict zones, the rates will be correspondingly higher.

Specialist mental health services may typically consist of one or two large psychiatric hospitals, standalone, not integrated within the general health specialist system or with primary care, and which inevitably take people long distances from home.

Where decentralisation of mental health specialist services is taking place, small psychiatric inpatient and outpatient units have been established in district hospitals, but this is far from universal. Generally specialist nurses trained in mental health staff these units and there is frequently no access to a psychiatrist (on average in Sub-Saharan Africa there is 1 psychiatrist per million population compared to 1 per 50,000 in the UK and I per 10,000 in the US and Eastern Europe). Systemic issues such as a lack of transport to enable specialist nurses to visit and support primary care centres, and the limited availability of affordable drugs, compound the difficulties. There are a whole range of issues related to recruitment, retention and motivation of staff.

Mental health is still poorly integrated into primary care services
In primary care, few health workers have had adequate training in mental disorders. There is rarely a well-developed, functioning system of continuing education at primary care (or specialist level). Linkages to specialist services are poorly developed. Psychological and social treatments are rarely available at primary care level. Again, essential drugs may not be available.

Due to the lack of understanding of mental health problems, the stigma attached to them, and prior consultation with traditional healers as a first step, people who are mentally ill may present to a health worker at a late stage, further aggravating their problem.

Traditional healers are a major provider of health care in poor countries, and will remain so for the foreseeable future. Research has shown that their caseload is often dominated by mental disorders. This reflects not just the inaccessibility of primary care in remote areas, but the facts that people may either elect to consult with them exclusively, or simultaneously consult traditional healers and western medicine. In some studies, it has been shown that mentally ill patients who first consult traditional healers present to specialist services later than those who consult primary care directly, (such late presentation is particularly damaging to the prognosis of people with schizophrenia) and that patients may be discouraged by traditional healers from taking western medicines.

[11] Neurological, Psychiatric and development disorders – meeting the challenges in the developing world. Institute of Medicine 2001: National Academy Press, Washington

However, traditional healing has the potential to offer a supportive function to primary care and specialist services, in that it is totally community orientated, operates in the social context, and can provide strong social support functions. The best practitioners recognise the importance of listening, encourage problem solving, and involve the family in consultation and treatment. This may, in itself, have both preventive and therapeutic effects. This is an important area for future research.

Social workers, NGOs, religious organisations, and others in the community are important providers of mental health care. Much of the burden of care, however, falls on the carer, and on the family.

Mental health promotion programmes (the promotion of positive mental health, life skills) are rarely integrated with health education - school programmes aimed at reduction of risk for substance abuse or HIV.

The overarching goals for mental health services

A comprehensive mental health service would aim to:

- Reduce the incidence and prevalence of mental disorder (prevention and treatment
- Reduce the mortality associated with mental illness
- Reduce the extent and severity of associated disability and accompanying increased poverty (rehabilitation)
- Develop integrated intersectoral services for people with mental illness
- Reduce the stigma and discrimination surrounding people with mental illness
- Protect the human rights and dignity of people with mental illness
- Promote the psychological aspects of general health care
- Promote mental health in the general population, schools and workplaces
- Research the causes and treatment of mental disorders

International trends in providing mental health care services

The integration of mental health into primary care has been a significant development worldwide, with services being provided by general health workers who have received some training in mental health. Specialist and hospital services support them; with clear referral pathways between primary and secondary care services, treatment protocols, quality standards, and affordable drugs. Specialists deal only with the more severe or complex cases, and their responsibilities include support to the primary care team, including teaching, supervision and training. This model is increasingly being used by governments in low-income countries, where some of the most well developed examples are found, with technical assistance often being provided by WHO[12,13].

Primary care: the focus for mental health care services

Pro-poor mental health services require primary care as a central component. This stems from the burden of mental disorders in primary care, their cost to society, the restricted availability of specialist care, and the unique positioning of the primary care team. The latter is uniquely placed to provide continuity of care, in a family setting, and is well placed to provide long-term management of mental health problems. The team will be aware of the physical health care needs of the mentally ill (physical

[12] Schulsinger F, Jablensky A. The national mental health programme in the United Republic of Tanzania: a report from WHO and DANIDA. Acta Psychiatrica Scandinavica 1991; 83:132

[13] de Jong J. A comprehensive public health mental health programme in Guinea Bissau: a useful model for African, Asian and Latin American countries. Psychological Medicine 1996;26:97-108

and mental illness often co-exist), their social needs, and will take account of the patient's perspective. There may be less stigma for the mentally ill patient if seen in primary care.

STRENGTHENING HEALTH SYSTEMS CAPACITY TO IMPROVE MENTAL HEALTH SERVICES IN POOR COUNTRIES

The first requirement is a clearly defined national mental health policy and strategy, which will generally emphasise the importance of primary care as the focus for mental health services (box). The mental health policy should be embedded in the general health policy, and implemented as an integral part of the national strategy for development or poverty reduction. Each country has special needs, problems, resource constraints and challenges, but there are common factors across countries.

The policy will describe a vision for the future, and define standards for the delivery of services. This is likely to involve rationalisation and decentralisation of mental health services, prioritisation of essential mental health services, and the strengthening of generic primary health care services. Inter-agency working is fundamental to the delivery of good mental health care and mental health promotion. As well as the general public, people with mental illness, and their carers, this will involve the social sector, NGOs, education sector, criminal justice system, and the private sector (including private health providers and the pharmaceutical industry).

For countries wishing to carry out a country situation appraisal through a detailed scoping and needs assessment exercise, details may be accessed on the following website: *www.mental-neurological-health.net, http://193.164.179.95/development_imhpd (website for web database)*

An integrated national mental health policy and strategy

The policy will:

- Be integrated with the overall national health policy (including the general health sector reform strategy, the package of essential health interventions, the essential medicine kit, health information systems, curriculum for all health workers, and country level work on global burden of disease)
- Be integrated with overall government policy and the budgetary and public expenditure management process, involving ministries of finance, education, social welfare, home affairs/criminal justice, employment
- Be integrated with the national development strategy or poverty reduction strategy
- Contain a legal framework which offers protection for people with mental health problems, identify funding streams, and define mechanisms for management and accountability
- Detail a human resources strategy, management and information strategy and research and development strategy
- Be governed by the principles of universal access, equity, effectiveness and efficiency

Service delivery strategy will be outlined in the health and/or development strategies and should include:

- Clinical services: prioritisation of services to be provided; the services provided in primary care, secondary care services, and the links between them; the provision of drugs, guidelines for good practice, and standards
- Client involvement and participation, and support for carers

- Social care, and the intersectoral links and liaison between health and social care, traditional healers, NGOs, education, the criminal justice system.
- Mental health promotion: in schools, the workplace, prisons, and the community; the role of the media.

The scope of mental health services

Countries with relatively well-resourced, effective, and equitable services will be able to better deliver interventions than low-income countries with weaker health systems (box). In particular, it will take time for many low-income countries to attain more than 1 psychiatrist per million of the population. They will, however, be able to ensure the provision of mental health nurses and mental health assistant medical officers, as well as focusing on the integration of mental health into primary care, and on the development of linkages with other sectors. The multi-sector nature of the provision of mental health services is well demonstrated below. Clearly good communication systems, effective referral and smooth cross-sector working are all highly important.

Mental health services:

The role of primary care

- Management of common mental disorders
  - Early diagnosis
  - Treatment (including psychotropic drugs)
- Long-term management of severe mental illness, supported by specialists
- Promotion of mental health in the community
  - Reducing stigma of mental health problems
  - Recognising early signs of mental distress, and when to seek help
  - Preventing high-risk behaviours e.g., unsafe sex, substance abuse
  - Health promotion in schools, the workplace, prisons
- Support for people suffering from psychological distress and comorbidity with physical illness
- Support for carers of mentally ill patients
  - Home care services
- Team working with community workers (traditional healers, social workers, NGOs, teachers etc.)
- Referral/ liaison with secondary services

The potential role for community workers

- Health promotion in the community
- Supporting primary care team in managing chronic mental illness
- Monitoring patients with severe mental illness in the community
- Preliminary diagnosis and referral of patients with mental illness requiring treatment
- Psychosocial support

The role for specialist, secondary services

- Brief hospitalisation for acutely ill patients who cannot be managed at home
- Management of very severe or complex mental illness
- Referral/liaison with primary care services
- Support, training and development for primary care workers
- Training for community workers (traditional healers, village health workers, social workers etc.)
- Liaison with other sectors e.g. police, prisons, schools, social welfare, child protection

Media
- Promoting the value of mental health
- Mental health promotion programmes
- Tackling the stigma of mental illness

Schools
- Mental health promotion integrated with physical health promotion
- Stigma of mental illness

Police
- Management of violence
- Safe procedures for transferring mentally ill people to hospital for assessment by mental health professionals

Prisons
- Court diversion schemes to transfer mentally disordered offenders to hospital
- Training for prison staff in common mental disorders

Labour
- Mental health included in remit of occupational health and safety committees
- Mental health included in occupation al health policies

Social welfare
- Training for social welfare staff in recognition and management of mental health issues
- Consider mental health in legislation on disability, anti-discrimination law and any welfare benefits

Child Protection
- Understanding of mental health issues

The range of services offered will be dependent on the human and financial resources available. In poor countries finance is a major limiting factor, and **prioritisation** of services will be necessary (in the same way that all primary care services are prioritised).

However, a minimum basic package should include:
- The provision of medicines for patients with psychosis, epilepsy and severe depression
- Ability to refer very ill patients for hospital admission
- Primary care workers supported by specialists (liaison, education and supervision) in the community (access to local transport or to the district hospital transport to enable such regular support)
- Closer working between community workers and the primary health care team
- Mental health promotion in the community
- Intersectoral linkages

Strengthening primary care services
Maximising the impact of mental health services will be dependent on strengthening existing health systems. The focus should be on improving the existing primary health care services in order to provide a range of prioritised, preventive and curative services for all areas of health, including mental health. The key elements are:

- Human resources: introducing appropriate training, supervision, and continuing education
- Ensuring that essential drugs are available and affordable (drugs for depression, psychosis and epilepsy)
- Transport between hospitals and primary care centres to enable specialist supervision of primary care workers and others in the community
- Linkages with secondary services - referral pathways, support from specialists
- Close working with the community -carers, traditional healers, dispensers, social workers, religious organisations, schools, the police
- Management and information systems (including main categories of mental disorders)
- Treatment guidelines and locally adapted treatment protocols, quality assurance.

Strengthening and rationalising specialist and hospital services

In order to ensure that patients with acute, severe mental illness can be hospitalised if necessary, small psychiatric units should be established in district hospitals. These would comprise a small number of (short stay) beds, with specialist nursing staff, with an outpatient facility. Local provision of a specialist service will ensure closer liaison with the primary care team and the community. The role of mental health specialists should be expanded, to include training and supervision of the primary care team (through regular visits to primary care clinics). This supervision of primary care is important, because for logistical reasons, it is likely that the responsibility of managing most of the severely ill patients will rest with the primary care team, particularly in a decentralised system. Thus mental health should be a regular item on the agenda of district health management teams to ensure access to transport (so that specialists can support and supervise clinics on a regular basis), the availability of essential drugs in the primary care clinics (drugs to treat depression, psychotic illness, and epilepsy), continuing education, access to guidelines, and intersectoral liaison. The specialists, working with the primary care team, should engage with the sectors involved with those with mental illness, encouraging team working and work sharing through ongoing training and support.

Strengthening linkages with the community

The role of the primary health care worker, the availability of essential medicines and psychosocial interventions, and specialist support are key to improved mental health care in the community. Nonetheless a wide range of other sectors of the community, including traditional healers, social workers, teachers, dispensers, NGOs and carers (who bear the greatest burden of care) are also involved in mental health care

Health policy should recognise the role of the community. The health sector – at primary, secondary and national levels - needs to establish a dialogue with these other sectors, including with traditional healers. The opportunities for developing appropriate criteria for referral from the traditional to the health sector, the possibility of shared care procedures, observation and supervision as a combined approach, mental health promotion, and working to eliminate harmful practice should be explored. This could be achieved through regular joint training, communication and liaison, and careful audit and evaluation of outcomes. Where patients have to travel long distances to a clinic, traditional healers could support health workers in managing long term illness; they may be able to contribute to the community based care and, in case of relapse, refer patients to the clinic for prompt attention. Village health workers, social workers, prison staff, police, and teachers all come into daily contact with people with mental health problems, and would benefit from training, good practice guidelines, and liaison.

CONCLUSION

Mental ill health Is common and contributes to poor physical health and social and economic disability. Governments can be encouraged to address mental health through the development and implementation of a mental health policy and strategic plan integrated within their national development, poverty reduction and health strategies.

The focus for developing countries can be on providing mental health services in primary care, integrated with current service provision. More effective delivery of mental health services with ultimate impact on the burden of disease requires strengthened health care services. Ensuring the availability of essential medicines, provision of small, local inpatient facilities for those with severe acute illness, who cannot be managed at home, and continuing education and supervision of primary health care workers by specialists in the workplace is essential. The potential supportive role of other community workers including traditional healers can be explored, evaluated and incorporated in the strategy as appropriate.

Annex I

SELECTED EXPERIENCES IN LOW-INCOME COUNTRIES INCLUDING DFID INTERVENTIONS

India

3000 psychiatrists serve 1 billion people (1999). A community approach to promote mental health has been adopted, and mental health care has become an integral part of the programme of primary care. This provides mechanisms for planning at state and national levels. Simple, rapid training programmes for primary care workers, and public education materials have been developed, and the impact was demonstrated in a demonstration project 1985-90. Basic mental health services are being provided in many areas with limited reliance on specialists.

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Institute of Medicine 2001 page 301.

Murthy 1998 Application of mental health interventions in developing countries. In R Jenkins and TB Ustun (Eds.) Preventing mental illness: Mental health Promotion in Primary care. Chichester :Wiley.

Iran

Mental health care has been systematically integrated into Iran's existing primary health care system. Acknowledging the importance of comprehensive, well-supported primary care, the programme links village based care centres to surrounding hospitals and medical schools. Iran's mental health programme supports training in mental health for all health personnel, development of a district level mental health support system and an annual mental health week. Village health workers (one male and one female for every 2000 people) are trained in assessment, diagnosis and management of priority conditions including depression, anxiety, psychosis, epilepsy, infectious diseases, childbirth and, as of 1999, substance abuse. They use good practice guidelines and are able to prescribe a limited list of essential medicines. Severely ill people are referred to primary care doctors who cover a population of around 10,000. Village health workers practice prevention and mental health promotion, regularly visiting each person in their areas to screen for illness. They collect routine data on diagnosis, consultations and health outcomes, which are collated annually. They are supervised and supported by health psychologists who

visit the clinics on a monthly basis. The medical curriculum taught in universities is consistent with, and supportive of, the role of primary care for mental health.

Reference: Institute of Medicine Report p 301-302

Mohit A 1998 Training packages in developing countries.
In R Jenkins and TB Ustun (Eds.) Preventing mental Illness-Mental health promotion in Primary care Chichester :Wiley

Pakistan
A schools mental health programme has been introduced as a part of the Community Mental Health Programme in Rawalpindi district, following a successful pilot study (WHO, 1987). In Pakistan children and their teachers make up a highly significant proportion of the literate population. In the programme, children are used as change agents for raising awareness about mental health. Teachers are trained in mental health and in counselling and are supported by a community support team. Evaluation of the programme has shown that the impact of the new attitudes (to counter the stigma associated with mental illness) and knowledge has been cascaded out to parents, neighbours and friends.

In Gujar Kahn, traditional and religious healers were involved in a co-operative project whereby they received basic training in mental health. As a result, a quarter of patients presenting to faith healers were given a "medical" diagnosis, and referred to a health facility, a significant departure from past practices. This model is now being replicated in all the provinces in Pakistan

References…
Institute of Medicine 2001 (page 304)

Also:
Mubbashar M 1998 School mental health programme in Pakistan. In Preventing Mental Illness-Mental Health Promotion in Primary Care Jenkins R and Ustun TB (Eds.) Wiley: Chichester
Rahman A, Mubbashar MH, Gater R and Goldberg D 1998 Randomised trial of impact of school mental health programme in rural Rawalpindi Pakistan Lancet 352:1022-1025
Saeed K, Gater R, Mubbashar MH and Hussain A 2000 The prevalence, classification and treatment of mental disorders among attendees of native healers in rural Pakistan Journal of Social Psychiatry and Psychiatric Epidemiology 35, 480-485

Tanzania and Kenya
DFID is funding a project (2000–2003) in Tanzania and Kenya to pilot a methodology of mental health policy support to low income countries. The project has provided support to government at a strategic and policy-making level; is supporting the mainstreaming of treatment for mental health into primary health care, and aims to improve the effectiveness of mental health treatment by shifting the emphasis away from institutions and towards care in the community.

National situation appraisals have been carried out in both countries, and strategic frameworks have been prepared. Both countries are now developing a detailed, timetabled and costed mental health plan. Key elements are: the integration of mental health with the national health plan; the importance of intersectoral partnerships at national, district and local level for mental health; the key role of primary care (and the need for essential drugs); the relation between primary and

secondary care, and integrating mental health into work on the generic issues of health information systems, legislation, human resources, research and development.

The DFID office in Kenya recognises that mental health is neglected in most developing countries and that lessons have been learnt from this intervention. This type of support can help to define a structured framework and provide the necessary advocacy to try and ensure it becomes part of the health reform agenda. The actual implementation, however, is dependant on the commitment by the Ministry of Health, who are clearly struggling to provide even the most basic essential services.

Zanzibar
WHO supported a detailed situation appraisal (1998), and the development of a new mental health policy, which the new government subsequently adopted. Revised legislation was enacted in 2001. Since then good progress has been made on implementing overall governance of the mental health system, strengthening primary care mental health activities, rationalising and strengthening secondary care, establishing effective links between primary care and specialist care, improving the supply of essential medicines for primary and secondary care, and developing good practice guidelines. Mental health has been integrated into other generic health sector reform work; for example, 10 categories of mental disorder have been added to the primary care health information system. There has been a special focus on the needs of women and children, developing services for intellectual disability, and linkages with other sectors including prisons, police, NGOs, UN agencies and traditional healers. Emphasis is placed on community mental health promotion in schools and through the media. It remains too early to judge impact of these interventions on overall mental health burden.

Reference-see hyperlinks. Documents available from Mahmoud Mussa, Director of Mental health, Ministry of Health

Russia
Within Russia DFID has funded a child/adolescent mental health project, and is now funding an adult mental health reform project in Sverdlovsk. The project aims to support mental health policy and implementation, training at primary and secondary care levels, inter-sector working with social protection employment and education, and NGO development. Although the project has only just completed its inception phase it has already achieved a high degree of ownership by the national government, who see it as their pilot or case-study, rather than a DFID bilateral project. They would like the project to provide lessons for them in terms of implementing a more family orientated service, using multi-functional brigades and increasing the number of clients who can be cared for in the community, rather than in long-stay psychiatric hospitals.

Reference -see hyperlinks

Annex II
ANNOTATED BIBLIOGRAPHY

BOOKS

Institute of Medicine 2001
Neurological, Psychiatric and developmental disorders-meeting the challenge in the developing world,
National Academy Press, Washington

A consensus report prepared by the Committee on Neurological, Psychiatric and Developmental Disorders in Developing Countries, convened by the US Institute of Medicine. It defines the increasing burden caused by neurological, psychiatric and developmental disorders in low-income countries, and identifies opportunities for reducing that burden with cost-effective strategies for prevention, diagnosis and treatment. The report identifies areas for research, development, and capacity strengthening. Key recommendations include

- Increasing public and professional awareness and reducing stigma
- Strengthening capacity in primary care, and ensuring support and supervision for primary care staff from specialist services
- Ensuring the availability of cost effective interventions
- Further research on epidemiology, the cost effectiveness of interventions and service configurations
- The creation of national centres for training and research in low income countries, linked to centres in rich countries; multi-centre projects, exchanges, training and internet communication
- The creation of a major global fund for research and development

Jenkins R, McCulloch A, Friedli L, Parker C. 2002
Maudsley Monograph 43: Developing a National Mental Health Policy.
Psychology Press

Extract from Julian Lob Levyt's Forward: " The goal of DFID is the alleviation of poverty. Mental health differentially affects the poor and impedes the development of other health and development targets. Therefore DFID welcomes the timely publication of this important book which is designed to support those involved in developing locally appropriate mental health policies in the different regions of the world, and to increase local capacity in policy, strategic development and implementation. The book takes a broad and contextual approach to mental health policy, emphasizing the crucial role of primary care, NGOs, the social sector, schools and workplaces, and the criminal justice system as well as the specialist services. It highlights the importance of liaison at national, regional and local levels between the relevant sectors, and contains very useful chapters on the principles of human rights and mental health legislation, mental health information systems and human resource strategies. The important issues of accountability and financing are considered, as well as key cultural issues and the importance of dialogue with traditional healers. The book represents an excellent, practical and supportive guide for those who should be engaged in mental health, and will be an invaluable tool as we work towards promoting, protecting and improving mental health in poor countries, and the incorporation of mental health issues into broader health sector and poverty reduction processes"

PAPERS

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Chapter describing the public policy issues which are central for mental health

Jenkins R. Making psychiatric epidemiology useful. The contribution of psychiatric epidemiology to policy. Acta Psych Scand 2001; 103:2-14
A review of the implications of epidemiological findings of the prevalence and distribution of mental disorders for health and social policy.

Jenkins R and Strathdee G. The integration of Mental Health Care in Primary Care. International Journal of Law and Mental health 2000; 238: 277-291
A review of the rationale and mechanisms for integrating mental health into primary care, in both poor and rich countries.

Jenkins R., Tomov T, Puras D, Nanishvili G, Sherardze M, Surguladze S, and Rutz W. Mental Health Reform in Eastern Europe. Eurohealth 2002. 7;3: 15-21
Review of current issues and challenges in mental health reform in eastern Europe including the move from a totally institutional system of care with its attendant poor health and social outcomes to a more local comprehensive system of care, which incorporates attention to primary care, NGOs , social welfare and education.

Jenkins R and Singh B. General population strategies of suicide prevention In K Hawton and K van Heeringen Eds.. The international handbook of Suicide and Attempted Suicide, 2000: 597-615 Chichester Wiley.
A review of the components of national suicide prevention strategies

Schulsinger F and Jablensky A 1991 The national mental health programme in the United Republic of Tanzania a report form WHO and DANIDA Acta Psychiatrica Scandinavaica 83, 132
Another thorough evaluation of integration of mental health into primary care in tow regions of mainland Tanzania. in the 1980s. Unfortunately after the DANIDA funding came to an end, the programme was not able to be funded by the government and was neither continued nor extended to the rest of Tanzania. There are now efforts to integrate mental health into primary care in a more sustainable way-see case study on Tanzania.

Jenkins R, Baingana F, Gulbinat W, Khandelwval S, Manderscheid R, Mayeya J, Minoletti A, Mubbashar M, Murthy S, Parmeshvara D, Schilder K, Tomov T and Whiteford H.
International Review of Psychiatry 2003, **Vol 16 Nos 1-2 International Project on mental health policy and services. Phase 1:Instruments and country profiles**.
Describes the construction of the mental health country profile and the policy template and summarise about 12 country profiles form low and middle income countries

~~*www.world.mentalhealth.org*~~; *www.mental-neurological-health.net*,
gives the rationale for the project, the project meeting reports, the instruments and the country profiles
and ~~http//10.6.106.32/imhpd~~ http://193.164.179.95/development_imhpd (temporary website for webdatabase)

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WHO REPORTS
WHO Atlas of Mental Health resources in the World. WHO has collected information from each of the 191 countries on available mental health resources. All the data is on the web (http://mh-atlas.ic.gc.ca/). A summary of salient findings is available in a WHO Press Release (WHO/30, 23 April 2002 at http://www.who.int

WHO Report 2001 devoted to mental health, made a strong case for giving a higher priority to this neglected area. It set out a public health approach to mental health, described the burden of mental and behavioural disorders, identified effective interventions and made 10 strategic recommendations, along with minimum action required by countries for each of these recommendations.

WHO Report 2002 is devoted to violence and includes section on suicide.

EDUCATIONAL AND CLINICAL RESOURCES FOR COUNTRIES:
WHO Collaborating Centre: WHO Guide to mental health in primary care., 2002The Royal Society of Medicine.
This is a practical guide for primary care teams in the UK, but which can be adapted easily for use in all developing countries. An East African version is currently being piloted. We should give web address of UK version

Paton J and Jenkins R 2002 Mental health primary care in prisons- Adapted for Prisons and Young Offender Institutions from the WHO Guide to Mental health Primary Care. The Royal Society of Medicine.
Prisons in both poor and rich countries contain a high proportion of people with mental disorders despite policies of diverting mentally disordered offenders away from the criminal justice system. This is a practical guide for prison health care staff and prison officers

Andrews G and Jenkins R (Eds) 1999 Management of mental disorders. Datapress.
This is a two volume comprehensive guide for specialist mental health professionals and for interested primary care teams on the detailed treatment of mental disorders. It contains useful screening and management instruments. Useful for psychiatric inpatient units, outpatient teams and community teams.