Repackaging Mental Health Programmes in low and middle-income countries

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Conflicts of interest: I do not have any conflicts of interest to declare.

Word count: 2289

References: 14

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Abstract

The World Health Organisation recognised the need to bridge the gap between the enormous burden of mental illness and available services for their management in low and middle-income countries. The WHO suggests that its mhGAP programme, with its emphasis on information, policy and service development, advocacy, and research, is the solution. This article argues the mhGAP is the latest in a series of repackaged solutions. It briefly summarises similar past initiatives and their failures. It also highlights the major barriers to the delivery of mental health services in many LMICs. It argues that the reality in LMICs has to be factored into mental health care delivery for success.

Introduction

The World Health Organisation (WHO) recognised the need to bridge the gap between the enormous burden of mental illness and available services for their management. The WHO mental health Global Action Programme (mhGAP) was endorsed by the 55th World Health Assembly in 2002 and launched in 2008.[1-2] The programme highlights the morbidity, mortality and global burden of disease of people with mental, neurological and substance use disorders. It recognises that the treatment gap is as much as 75% in many low and middle-income countries (LMICs). The four core strategies identified by the program are information, policy and service development, advocacy, and research. The program supports advocacy initiatives and provides normative guidance in improving health systems to deliver care for these disorders. It is specifically aimed at LMICs and advocates partnerships to reinforce and to accelerate efforts and increase investments towards providing services. It provides health planners, policy-makers, and donors with a set of clear and coherent activities and programs.

However, careful readings of these initiatives lead to a *de javu* experience for the more discerning. It suggests that the mhGAP is the latest in a series of repackaged solutions to bridge the huge gap between the burden of mental illness and mental health care delivery. This article briefly summarises similar past initiatives and their failures. It also highlights the major barriers to the delivery of mental health services in many LMICs. It argues that the reality in LMICs has to be factored into mental health care delivery for success.

Past initiatives and failures

The WHO spearheaded the crusade to incorporate the mental health component into primary health care in LMICs in the 1970s.[3] The WHO expert committee reports, their multinational collaborative community care projects in mental health and the Alma Ata Declaration of "Health for all by 2000" formed the platform to launch national mental health programmes in LMICs. Many LMICs set up model programs, which were evaluated and found to be successful. These demonstration projects subsequently formed the basis of national implementation strategies.[4-5] The programmes aimed to establish nodal training centres, train local health professionals for early detection and management, provide outpatient clinical services and facilities for inpatient treatment. It aimed to reduce stigma through mass education and provide data for future planning.

Nevertheless, the success of the model projects did not result in mental health care being implemented on a national scale in many LMIC.[6] The vast majority of the population are outside these programmes and still lack the basic facilities suggested in the national plans. For example, in India, the program is in different stages of implementation in small pockets (122 out of 626 districts). Despite good intentions, the programme failed to deliver. The complete lack of estimates of cost and the absence of provision of budgetary support were important

contributors to its failure.[6,7] Similar situations are reported from many LMICs including South Africa where progressive legislation has been passed without an effective national programme and from Nigeria where action plans were never implemented.[7-8]

The situation on the ground in most LMICs has not changed over the three past decades.[7-9] The national programmes remained on paper while some smaller initiatives, after the initial fanfare, are dysfunctional. Most experts agree that integration with primary care is non-existent in many LMICs. While programmes in some LMICs have ensured wider availability to essential psychotropic medication, their failure to integrate mental health care delivery into primary care has meant limited impact on patient services. The issues with regard to community care of the mentally ill in the developing world are complex and differ from those in industrialized societies.

Evaluation of evidence

The WHO community psychiatry programmes of the past and its present avatar, the mhGAP, have many similarities. Both identified the high burden of disease, acknowledged the shortage of trained mental health professionals and accepted the need to integrate mental health care through the primary health care system. However, they differed widely on the nature of the evidence used to argue for the respective programmes. The evidence for implementing national mental health programmes three decades ago were based on demonstration projects and model programs of the WHO which were implemented in many LMICs. Their evaluation was mainly qualitative, done in the pre-evidence based era, and would not meet today's standards.[7]

Recent attempts at evaluation of the magnitude of the burden of mental illness and the best available evidence for its treatment employ methodology that is much more sophisticated. These

have been reported in many articles including series in the Lancet and PLoS Medicine.[10-11] They have summarised the best available scientific and epidemiologic evidence, which have employed systematic sampling and objective assessment strategies, randomized controlled trials, systematic reviews, meta-analysis and statistical modelling. Nevertheless, the evidence of successful interventions is often based on "small" projects, which work well in ideal third world settings, and which are projected as solutions for national programmes in LMICs. Governments are again being exhorted to implement the integration of mental health care into the primary care delivery system.

Although the recent compilation of evidence meets much stricter scientific criteria, they fail to acknowledge the ground reality of the primary care delivery system in LMICs. The cynics would argue that these new initiatives are essentially older plans with slicker packaging. They would contend that these newer plans are also doomed to failure.

Flawed assumptions

International leaders and agencies based in the first world and their co-opted colleagues working in LMICs do not seem to have understood the ground reality under which the new programme has to operate. Lack of general health infrastructure, over burdened and inefficient health care delivery systems, scarcity of trained health and mental health professionals, burden of infectious and physical diseases and limited funding are rarely factored as is the magnitude of the scaling up that is required.

Poor infrastructure, overburdened systems: The primary health care delivery system in the public sector in most LMICs is poor. It is not efficient even for managing the many physical health problems faced in LMICs. This is particularly true in primary care and at the

community level. Although recent inputs in some countries have increased the infrastructure, physical resources and personnel, decades of neglect, the overburdened system and the poor discipline and morale of the health professionals make the inclusion of mental health care provision into primary care difficult.[8,9] The integration of mental health into primary health care delivery is only possible with well-established, functional and efficient systems.

Specific mental health programmes, with their limited aims, are often shown to be successful when employed in project mode but fail to produce results when rolled out on a larger scale. The political and administrative leadership, financial commitments, the increased human resources, supervision and monitoring, which ensured the success of the pilot and research projects, are missing in the national and expanded programmes.[7] While such national programmes are certainly better than no programme, their impact on improving access and availability of clinical services is very limited. The West ensured development by providing a basic minimum standard of living and of health for all its citizens, and yet international financial institutions insist that LMICs focus on specific problems rather than on improving the general public health infrastructure. In addition, the migration of trained health personnel to more affluent countries is a double whammy for LMICs: cost of training and brain drain.

Inappropriate training: The complete lack of training to manage common psychiatric conditions seen in general medical settings is a major lacuna in the curriculum in many LMICs. Most training programmes employ tertiary care and specialist perspectives and jargon, which are inappropriate for primary care settings. For example, most psychiatric classifications used in training physicians sub-classify common mental disorders into depression, anxiety and somatisation, etc,[12] despite the fact that the recognition of these syndromes is difficult in primary care practice in LMICs.[13] The inability to recognise

classical psychiatric syndromes by primary care physicians and nurses make them unable to choose from the many different management protocols. This often results in the dismissal of the patients complaints as unimportant or management using vitamins and benzodiazepines.

The lack of ability to diagnose and manage psychiatric presentations in primary care has spawned many short courses for physicians and nurses. However, these transfer knowledge, rather than skill and confidence making it difficult for physicians to translate the knowledge gained for use in their primary care practice.

Professional apathy: It is no secret that the majority of psychiatrists and their professional associations in LMICs are indifferent to empowering general physicians.[8] The community psychiatry movement always had second-class status within the discipline. Psychiatrists prefer the safety of specialist institutions rather than moving out into the community. They favour referrals and consultations to transferring expertise to primary care professionals. For example, the community psychiatry movement was led in India, in the 1970s and 1980s, by many national institutes and centres of excellence across the country. However, the very ideas of decentralisation and empowerment gradually lost ground and are all but abandoned by these centres, resulting in a leadership vacuum. In addition, the concentration of trained mental health personnel in urban LMIC centres make the delivery of care and the supervision of community psychiatry programmes deficient.[8] Mental health professionals are also divided based on their disciplinary perspectives (e.g. psychiatry, psychology, nursing, social work) weakening the cause.

Finances and delivery: The exhortation to increase the mental health budget is laudable. However, the very low current spending implies that even a doubling of the budget will have

very limited impact on mental health care delivery. For example, the median mental health expenditure in low-income countries is 1% of the total health budget, which in itself is very low in actual terms.[6] The doubling of the current budget would result in a very meagre availability funds for mental health care. The ring fencing of such monies in LMICs for use in stand-alone mental health programmes or it employment for integration with primary health care will have limited impact on mental health care delivery. This is particularly true due to the dysfunctional nature of existing primary care systems and directly empowering primary health care delivery systems will pay better dividends.

While the finances for mental health care have improved over the past few decades in many LMICs, their utilization leaves much to be desired. For example, the funding increased from Rs.280 million (US$ 6.2 million) during the Ninth Plan to over Rs. 4000 million (US$ 100 million) in the Eleventh plan for India.[6] However, only a small fraction of the monies allocated in the national 5-year plans have been utilized. The failure to have a clear and workable plan to integrate mental health into primary care and to move psychiatric services from mental hospital to the community has resulted in a return of the allocated funds.[14]

Advocacy and technical inputs: Current attempts to revive community psychiatry programs at national and international levels are more about mental health advocacy and less about technical inputs and guidance. The technology to translate psychiatric research evidence into primary care practice, with its poor infrastructure, staffing and morale, does not exist in poor countries. The idealism of the original primary health care movement, without technical contribution for scaling-up, meant that implementation at the national level was problematic, patchy and unproductive. The situation has not changed since.

The way forward

The repeated failures of such programs beg the question "Why do national and international leaders and agencies regularly repackage and reintroduce failed programs?" The answers seem to suggest that they mistake activity for accomplishment and advocacy for technical leadership and solutions. The goal of mental health for all, a socialistic ideal struggling in today's capitalistic world, demands a reappraisal of the issues.

Restructuring medical and nursing education: Basic medical and nursing education needs to be skill-based to produce competent practitioners. The current specialty-based medical education has become a knowledge-based information transmission system. The specialist and western-based curriculum makes the need to master common regional diseases and national health priorities much less important. Consequently, basic doctors, without practical training, are forced to specialise in order to practice medicine. The curriculum needs to be restructured to focus on the essential competencies required.

Revamping psychiatric training: The current elaborate psychiatric diagnostic systems and management, essentially watered down tertiary approaches, are irrelevant and impractical in primary care and general practice. The recognition and management of psychiatric presentations should be based on the reality of primary care rather than specialist perceptions. The identification of common clinical presentations (rather than specific diagnosis) and simple management protocols (rather than elaborate and separate routines) are mandatory.[13]

Revitalising primary care: The strengthening of the general health infrastructure, to improve primary health care delivery, is mandatory for the effective integration of mental health into primary care practice. The availability of effective and affordable treatments and improved

national finances has not closed the gap between mental health need and services in most LMICs. The major challenge is to transform overburdened, underfunded and demoralised primary care systems. The focus of mental health care delivery should shift from attempting to incorporate mental health care into an impoverished system to strengthening and empowering primary health care in general. Only robust primary health care systems can meet the challenge of delivering mental health care to communities.

Renewing political pressure: Leadership from politicians, administrators, health and mental health professionals is crucial. Educating the population about mental illness using the mass media will reduce stigma and increase the demand for services. A "HIV/AIDS model" of activism, where users, families, interest groups, health professionals and scientists come together with the single aim of service provision, is required for transformation. Slick documents, scintillating launches, stirring speeches and shallow programs, which repackage failed strategies, are no substitute for hard technical inputs for translating research evidence into primary care practice.

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