Regional cooperation in South Asia in the field of mental health

Jitendra K. Trivedi[1], Dishanter Goel[1], Roy A. Kallivayalil[2], Mohan Isaac[3], Dhruba M. Shrestha[4], Harish C. Gambheera[5]

[1]Department of Psychiatry, King George Medical University, Lucknow, India
[2]Department of Psychiatry, Medical College, Trichur, India
[3]University of Western Australia, Perth; Fremantle Hospital and Health Services, Fremantle, Australia
[4]Department of Psychiatry, Nepal Medical College, Kathmandu, Nepal
[5]Sri Lankan Psychiatric Association, Colombo, Sri Lanka

The South Asian region accounts for around one fourth of the world population and one fifth of psychiatrically ill patients in the world. The region lacks mental health policies and infrastructure. Issues like community care, trained manpower, patient satisfaction and better legislation have been a focus of attention in recent years. As this region is fast developing, cooperation is needed in the field of mental health to keep pace with the other areas. Cooperation is needed to develop culturally acceptable forms of psychotherapy and new technologies for delivery of mental health services. Another area of potential cooperation is the development of a classification of mental disorders that is more informative in our setting. The development of a mental health programme and its inclusion at various levels of health care delivery has also gained precedence. As most of countries in the area have limited financial resources, the funds are to be used in the most cost-effective manner, and for this a greater collaboration amongst the countries is needed. New research needs to be undertaken in the area especially to meet the local requirements and to understand diseases in a regional perspective, but research cannot be fruitful if regional cooperation is lacking. To enhance the cooperation in mental health, world bodies like the WPA will need to come forward and bring all the countries at a common platform. The WPA has done commendable work in this regard and has always extended support to the regional bodies to uplift the mental health in this region.

Key words: Regional cooperation, South Asia, mental health

(World Psychiatry 2007;6:57-59)

Asia has some of the largest conglomerations of human populations and also the fastest growing economies of the world. About 23% of the world's population lives in the South Asian region, and one fifth of psychiatrically ill patients in the world live in this part of the world. The South Asian Association for Regional Co-operation (SAARC) was formed in December 8, 1985 in Dhaka, Bangladesh. The seven member states are Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. Afghanistan has become a new member since 2005.

Despite vast cultural, religious, geographical and political diversities, the factors influencing mental health remain the same throughout this wide region, as highlighted at the recently concluded Asian summit, where the slogan "One vision, one identity, one community" was launched. Thus, the need to strengthen regional cooperation in the field of mental health has always been felt.

Cooperation is needed to prioritize the mental health needs and delineate the specific mental health problems of the region, to develop a cost-effective strategy in this regard and also to enhance the role of regional psychiatric societies to change the face of mental health in this area.

Cooperation is also needed to develop culturally acceptable forms of psychotherapy and new technologies for delivery of mental health services. Another area of potential cooperation is the development of a classificatory system that is more informative in our setting and the inclusion of a more detailed representation of cultural specific illnesses in the future international classifications of mental disorders.

THE MENTAL HEALTH SITUATION IN THE SOUTH ASIAN REGION

All the seven SAARC countries belong to the low-income group, with a gross national product per capita ranging from US$ 220 (Nepal) to US$ 1,160 (Maldives) per year (1999). The prevalence and problems of mental disorders in all these countries are similar. Estimating a prevalence of 10-12% of mental disorders, the total number of mentally ill people in the region turns out to be 150-200 million.

National mental health policies are present in only four of the countries: India, Pakistan, Nepal and Bhutan. With the exception of India (policy in 1982), all of them have been developed during the late 1990s. The policies still lack comprehensiveness, and countries like India do not have policies in the area of drug and substance control and prevention of abuse. Though mental health legislations are present in some countries, they are old and need amendments. Most countries have national mental health programmes. Some of them have integrated mental health with the general health delivery system, while some have separate mental health programmes. Some countries have a separate budget for mental health activities.

The mental health manpower is grossly inadequate. The number of psychiatrists for one million population ranges from 0.4 in India to 3 in Maldives, and the number of psychiatric nurses from 0.4 in India to 18 in Sri Lanka. The total psychiatric beds per 10,000 population range from 0.065 in Bangladesh to 1.8 in Sri Lanka.

The centralization of mental health delivery system has received a major setback in recent years and the focus has now shifted to community care rather than creating new mental asylums. Many reasons have been identified for the failure of mental asylums in the South Asian region, including ill-treatment of patients, geographical and professional isolation, poor reporting and accounting, bad management, poorly targeted financial resources, lack of staff training and inadequate quality assurance procedures. The concept of community care has brought the focus to individual based care and treatment, wider range of services, coordinated treatment programmes, services closer to home, ambulatory care, and partnership with caregivers.

The mental health issues can be tackled and delivery can be improved through better cooperation among the regional countries. Partnership is needed in areas like research, organizing community care, health education, public awareness through media, publication of data, training programmes, exchanges of faculty/postgraduate trainees, integration with general health care, training primary care physicians, national mental health programmes, teaching psychiatry to undergraduate medical students, general hospital psychiatry, and enlisting cooperation of private sector/non-governmental organizations (NGOs).

MENTAL HEALTH PRIORITIES IN THE SOUTH ASIAN REGION

The government expenditure on mental health in the majority of the SAARC countries is less than 1% of the total national health budget. Most of the people needing treatment have to spend from their own pocket, and most are not covered by insurance schemes. Hence, the majority of poor people do not get adequate treatment, or they prefer alternative forms of treatment which are cheap and affordable, but not effective.

The United Nations Secretary General asked in 2001 all the governments to make mental health a priority, to allocate the resources, develop the policies and implement the reforms needed to address this urgent problem. Similarly, the Director General of the World Health Organization addressed all the member states on the same issue. However, we are yet to see significant changes in this area.

The following mental health priorities have been recommended for this region: including mental health as one of the priorities in the national health system; allocating a separate mental health budget; integrating mental health at all levels of health delivery system; developing district mental health programmes with targets; increasing the number of psychiatrists and other mental health professionals; promoting mental health legislation; ensuring availability of psychotropic and antiepileptic drugs free of cost; supporting families and communities to take care of the mental patients and retain them within the communities for rehabilitation; arranging for social welfare and disability funds for chronically ill mental patients; performing a regular evaluation of the district mental health programmes.

The magnitude of mental health problems is huge, with limited financial and other resources, paucity of skilled mental health professionals and more emphasis on treating communicable diseases. Thus, a cost-effective strategy is necessary for better health care delivery.

This strategy may include the following elements: conceptualization, definition, demarcation and scope of "mental health" and "mental disorder"; proper positioning and marketing of "mental health" and "mental disorder"; exploitation of existing resources; establishment of workable partnerships and collaboration for shared care between various governmental departments, governmental organizations and NGOs, public and private sectors; integration of aspects of basic mental health care into all existing health, education and social welfare programmes of governments and NGOs; in-service training, support and supervision for different categories of personnel; enhancement of "mental health literacy" of general population; development of measurable "goals" and "indicators" for monitoring progress; promotion of innovative programmes of mental health service delivery, training and research.

COOPERATION IN RESEARCH IN MENTAL HEALTH IN SOUTH ASIA

South Asia has been lacking in the field of mental health research mainly due to lack of adequate financial support and infrastructure, and poor collaboration among various health agencies in the region, due to political barriers amongst the countries.

The whole of South Asia faces the problem of "inequalities in health". The majority of people live in rural areas or urban slums with no access to care. New delivery systems are needed to target this large group. Pathways to care should be determined, and traditional sources (e.g., magico-religious healers) should be explored.

Some potential areas for research collaboration in South Asia have been identified: psychiatric rehabilitation; treatment of major depression; culturally acceptable psychotherapy; delivery of mental health services; epidemiological studies; burden of care; course and outcome of mental disorders; acute psychoses; classificatory systems; psychoeducation; transcultural psychopharmacology.

Individual countries like India have made some significant contributions in psychiatric research. The work of various agencies has been commendable, and the Indian Council of Medical Research, the World Health Organiza-

tion, the Department of Science and Technology of the Indian government, the Indian Council of Scientific and Industrial Research, and the United Nations Children's Fund have been noteworthy among them. Various psychiatric associations have been formed, such as the Asian Federation for Psychiatry and Mental Health (AFPMH) in 1981 (Indonesia, Malaysia, Philippines, Thailand, Singapore, now also Brunei, Laos, Cambodia, Myanmar, Vietnam), the South Asian Forum for Psychiatry and Mental Health (SAFPMH) in 2002 (India, Pakistan, Sri Lanka, Bangladesh, Nepal, Bhutan) and the SAARC Federation of Psychiatry (SFP) in 2004. The global pharmaceutical companies are also targeting India by involving several Indian institutions in various international multicentric studies. Also noteworthy is the contribution of the Indian Psychiatric Society (IPS), as it is the largest ensemble of trained psychiatrists in South Asia and has a major role in coordinating research in the region. The Society has promoted participation of the whole region in its annual conferences, in order to promote a better intra-regional cooperation in research.

THE WPA AND THE DEVELOPMENT OF MENTAL HEALTH SERVICES IN THE SAARC REGION

The WPA may be helpful in the development of mental health services in the SAARC region. One of the prerequisites of this program would be to identify the broad areas that need reorientation and further development. Such areas may vary from country to country in the region. They include: mental health policies, legislations and strategies; standard clinical guidelines; capacity building of mental health workers in certain areas; development of infrastructure and system arrangements; improvement of linkage with outside world; development of knowledge on mental health issues in the region; public awareness and stigma; funding and advocacy; violations of rights of patients.

The development of context specific and standard clinical guidelines that suit the region has been a felt need for a long time. Currently the SAARC countries follow the management models developed in resourceful centers. These models have to be adapted taking into consideration the cultural and socioeconomic characteristics of the region.

Severe shortage of mental health professionals in the region is a main limiting factor in developing mental health services. Therefore, capacity building of mental health workers is one of the important steps in the development of mental health services. Capacity building in specific areas, like rehabilitation, and training in subspecialties like community psychiatry, forensic psychiatry, psychogeriatrics, child and adolescence psychiatry will help in providing quality care.

International conferences co-sponsored by the WPA in the regional countries can be a good measure in capacity building. Further, guidance in the form of educational materials, books and journals, awarding training fellowships and guidance in preparation of curricula for mental health professionals would be essential steps.

WPA advocacy would be quite beneficial in re-orienting the development of mental health services and in promoting continuous professional development. Many of our mental health professionals are isolated in their localities and follow only their own experience due to lack of linkage with the outside world. This of course is very unfair and violates the rights of mentally ill patients.

Most SAARC countries go by the Western statistics in the assessment of mental health disease burden. Regional support and guidance for research activities would help to identify the mental health priorities in the region, and to assess and monitor the trends of mental health disease burden. The establishment of a research fund for the region would be helpful in improving the research capacity of mental health professionals, in identifying research needs, and in organizing and disseminating already existing knowledge in the region.

Providing advocacy to governments to increase awareness about the burden of mental disorders and to combat stigma at every level would immensely help the improvement of mental health care in the region.

The WPA can help SAARC countries to establish strategies that protect the human rights of mentally ill. Poorly developed mental health services in any country violate the patients' right to receive the best available treatment, similarly to other branches of medicine.

The organization and coordination of the above-mentioned array of activities related to the development of mental health services need a focal point. Therefore, it is very much appropriate at this juncture to establish an institution which could be developed to be a centre of excellence on mental health in the SAARC region.