

The multiplier role of psychiatrists in low income settings

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Mental health care is receiving increased attention in low-income countries with the availability of a wide range of effective evidence-based treatments for acute and chronic mental disorders amidst scarce resources. Availability of these treatments and competent human resources enables the use of a variety of interventions at several levels of care for persons with mental illness and makes it feasible to ensure observance of quality in the treatment approaches that go beyond institutionalisation. However, unlike developed countries which are endowed with many and relatively well-paid mental health specialists, low-income countries face a dire shortage of highly trained mental health professionals in addition to several other challenges. In light of this, there is need to re-assess the role of the few available psychiatrists, with a shift to new core tasks such as designing mental health care programmes that can be delivered by non-specialists, building their health system's capacity for delivering care, including supporting front-line health workers through support supervision, raising awareness on mental health and patients' rights in addition to promoting essential research. This requires a fundamental paradigm shift from the current training for mental health specialists to a public health oriented approach and providing incentives for community engagement.

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Introduction

Neuropsychiatric conditions comprise 14% of the global burden of disease and 30% of all non-communicable diseases (Prince *et al.* 2007). About one in four people will have a mental health problem at some time in their lives. For some people, this will be a short period of mild depression, anxiety or stress. For others, it will be a serious, long-lasting condition such as schizophrenia, bipolar disorder or major depression (McBain *et al.* 2012). These disorders are associated with premature mortality and profound socio-economic impacts on individuals, with substantial costs to families and the country (Patel, 2009).

An estimated 80% of persons with mental illnesses live in low-and middle-income countries (LAMICs) (Prince *et al.* 2007; McBain *et al.* 2012) and yet because of high rates of infectious diseases, those countries that are the poorest typically have the lowest expenditures on mental health care, with the majority spending less than 1% of their total health budgets on mental health. The majority of these countries also greatly rely on a framework of institutionalised care (World Health Organization, 2005; Saxena *et al.* 2006a). For example,

only 52% of low-income countries, as compared to 97% of high-income countries, provide community-based care for patients (Saxena *et al.* 2007). This dearth of financial resources directed towards mental health is also associated with a shortage of mental health human resources in both primary and tertiary care. (Patel, 2009; Bhana *et al.* 2010; Patel *et al.* 2011).

Mental health care and the treatment gap in low-income countries

Despite the existence of cost-effective interventions, the number of persons who remain untreated is estimated at 85% in LAMICs, leading to chronicity, suffering and increased costs of care (McBain *et al.* 2012). Access to psychotropic medicines and psychosocial interventions varies greatly across these countries, with marked inequity even within countries. Sadly, the evidence concerning the substantial burden of mental disorders has not been translated into adequate investments in mental health care thus making the treatment gap more pronounced in LAMICs (Babor *et al.* 1994; World Health Organization, 2005).

Progress in mental health service development has been slow in most low-income countries due to a number of barriers and challenges as documented in several studies. These among others include: a high burden of mental disorders, absence of political will resulting in low prioritisation for mental health, absence of (or outdated)

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policies, plans and laws; shortage and skewed distribution of the few available specialists, general health workers who are often inadequately trained to handle mental health problems, brain drain, limited public awareness about mental health and poor service utilisation (Saraceno *et al.* 2007; Patel, 2009; Thornicroft *et al.* 2010; Lund *et al.* 2011; Doku *et al.* 2011; Mwanza *et al.* 2011; Ssebunnya *et al.* 2011).

The impact of these barriers is indeed greatest in low- and middle-income countries, where the same challenges and barriers are greatest, with many competing claims on the available limited resources.

Current mental health care and resources in LAMICs

Modern psychiatric services do not exist for the largest proportion of the population in developing countries, which is predominantly rural. The few psychiatrists in these countries are usually based in urban settings and are primarily concerned with hospital-based care for those with severe mental illness, leaving the majority of the rural population with little or no care at all. (Patel & Winston, 1994).

The WHO Mental Health Atlas has reviewed global mental health resources indicating that despite the majority of global burden of mental disorders being located in LAMICs, these countries have less than 10% of global mental health resources, with the median number of psychiatrists in high-income countries found to be 200 times greater than that in low-income countries (Bruckner *et al.* 2011). Despite this disparity, some high-income countries continue to rely on the already meagre mental health resources migrating from LAMICs to sustain their own mental health systems resulting in marked brain drain (Patel, 2003).

Integrating mental health care into primary care through 'task-sharing' has been proposed as part of the mental health strategy to address the gap created by the acute shortage of specialists. The core objective of the strategy is a rational redistribution of tasks among health workforce teams that involves the delegation of mental health care to non-specialist health workers who are trained to deliver interventions for specific mental disorders, thereby improving the human resources workforce skills and distribution (Lancet Global Mental Health Group, 2007; Petersen *et al.* 2011a, b; Patel *et al.* 2013). The strategy has been advocated and indeed is being applied in some countries to provide access to mental health care on a wide scale.

The role of psychiatrists

Several developing countries have undertaken various innovations in mental health service delivery to ensure

that the enormous gap between the need and availability of services is narrowed (Srinivasa, 1998). Since the Alma Ata declaration and the WHO (2001) report, several countries embraced the Primary Health Care approach and have been implementing integration of mental health into primary health care, with varying degree of success in improving access and equity in mental health service delivery (World Health Organization, 2001; Kigozi, 2007; Kigozi & Ssebunnya, 2009; Ssebunnya *et al.* 2010).

To achieve the intended objectives of this approach, deliberate programme design is essential, including regular human resource training, clear referral pathways and support network; targeting those in the primary care setting.

The psychiatrist will for the foreseeable future remain an expert clinician for service delivery both at primary and tertiary levels, with key roles of clinical assessment, diagnosing and treating persons with mental illness; training fellow mental health professionals as well as developing and disseminating guidelines for fellow professionals (Farooq & Minhas, 2001; Patel, 2009). This should be in addition to other key roles with multiplier effects such as influencing resource mobilisation, generating demand for service utilisation and contributing to the provision of an enabling professional environment for scaling up mental health services. Thus, it is increasingly becoming clear that for mental health services to develop, there is need to transform the role of the few existing mental health specialists in low income settings from a purely service-delivery approach to public mental health leadership (Lancet Global Mental Health Group, 2007). The psychiatrist's new roles as a leader of a multidisciplinary team should include designing and managing such programmes for enhancing capacity for mental health service delivery in consultation with other professionals and lay workers in primary care, supervision of junior staff and trainees, ensuring quality care and providing referral pathways (Patel, 2009).

Psychiatrists are seen to possess a unique expertise, and occupy leading positions in most countries, functioning as advisers to governments and chairing key committees that are responsible for the formulation of mental health policies, action plans and legislations to improve the mental health systems (Thornicroft *et al.* 2010). They have therefore a unique opportunity and role to shape the process of reform in the best interest of patients, families and carers, the public and fellow health workers (Muijen, 2006).

He/she must develop skills that may not be included in the traditional teaching, especially for service development. They therefore need to play a public mental health leadership role in increasing the coverage of mental health care through task shifting of effective

interventions to non-specialist health workers. In view of the limited mental health awareness and poor utilisation of the existing services, such programmes should also focus on increasing population awareness on mental health and mental illness, the rights of people with mental illness and available treatments so as to increase levels of help-seeking and fighting stigma. Furthermore, there is a need to focus on improving awareness of benefits of accessing facilities and services (Thornicroft *et al.* 2010).

Human resources are the most critical asset in mental health service provision. In many developing countries, trained psychiatrists work under conditions of heavy and relentless clinical activities, and may not have dedicated time during the week for any service development duties.

One of the important recommendations for human resource development is the increasing emphasis on integration of mental health into primary care setting, thereby increasing access to the vast majority of the underserved population. In view of the shortage of mental health professionals in developing countries, there is a need for well-rounded generalists who are capable of coping with most psychiatric problems, with little or no access to any mental health practitioner. This mandates the few available specialists to train general health workers in basic skills in mental health care, such as detection of mental disorders, provision of basic care and referral of complex problems for specialist care; which skills are best given by psychiatrists (Thornicroft *et al.* 2010). Appropriate training also requires being combined with continued supervision and support to achieve effective mental health care in PHC settings (World Health Organization, 2003). As a teacher and clinical consultant in mental health, the psychiatrist therefore has to play a training and supervisory role for existing general health workers as well as other junior mental health professionals.

The need to foster a public health approach to mental health service delivery is becoming more pronounced, which necessitates involving psychiatrists as experts in planning, education and overcoming inertia and resistance in the current environment. This may also involve influencing key leaders into re-designing and monitoring the organisation of the mental health system (Lancet Global Mental Health Group, 2007; Patel, 2009). As a highly respectable professional, particularly in LAMICs, the psychiatrist can play a big role in conducting mental health advocacy and engaging policy makers for prioritising mental health and increasing provision of resources. The advocacy could be done through avenues such as designing media programmes, with a net effect of creating demand for utilisation of services.

The needs of patients and families in modern mental health practice are beyond the capacity of a single

sector. Strong links between psychiatrists, community leaders, patients and families, and other stakeholders are vital for progress. When strong partnerships exist, they can contribute to the community understanding and advancement of mental health issues, as the first step towards scaling up good quality care for those living with mental illnesses, prevention of illnesses, and promotion of mental health through collaboration with other sectors. Psychiatrists should therefore build linkages with NGOs and other partners involved in mental health service delivery (Muijen, 2006).

Further, studies have highlighted the need for mental health promotion and disease prevention through broader influences in both health and non-health sectors such as education, employment and other community sectors. Improved mental health can in turn assist these sectors with their own outcomes (Beddington *et al.* 2008; Herrman *et al.* 2008). Psychiatrists should be at the forefront in recommending strategies for promoting mental health in these sectors as well as supporting the development of partnerships (Saxena *et al.* 2006b).

Creating databases to organise information to aid and/or inform policy development is very crucial for service development. This necessitates conceptualising, directing and conducting mental health research as well as dissemination of research output, in which psychiatrists are expected to play a crucial role as well (Farooq & Minhas, 2001). Further, as part of capacity building and mentoring, psychiatrists must inculcate a research oriented approach/culture at all levels of service delivery; sharing out challenges, solutions and new discoveries. Psychiatrists are well trained and have the abilities to synthesise materials from various sources, which should be shared with the lower level frontline health workers, thereby increasing knowledge and application of evidence-based approach to mental health care. This improves aspects of quality assurance practice in LAMICs; which has for a long time been a preserve of higher institutions of care in big cities and universities and yet equally important for the huge number of lower level health workers in the system.

However, it should be noted that the new additional roles being advocated for the psychiatrists may be complex, and to be effective requires a good grasp of the needs of patients in multiple settings and the ability to work intensively with staff from a variety of backgrounds. Although the essential role of most psychiatrists could remain therapeutic interventions with patients, the type of mental health problems presenting in the community setting and the expectations of psychiatrists' role will be radically different, rendering a detached medical role insufficient (Muijen, 2006).

Conclusion

Developing countries face a dire shortage of mental health resources especially at the specialist psychiatrist level. The situation is worsened by the current unplanned population explosion, with sudden changes in the lifestyle and social support network, uneven growth, inequity in resource distribution and high burden of disease. Although the psychiatrist's primary role has been mainly that of offering clinical management and consultation, it is increasingly becoming clear that this has to fundamentally change so as to give the much needed key leadership role in the LAMIC's quest to narrow the treatment gap by generating a critical mass of relatively well-skilled mental health resources. The psychiatrist should thus provide a multiplier role at several levels of health service delivery with generation of adequately equipped mental health resources, stimulate demand for service utilisation and improve human rights observance within a conducive environment of appropriate legal context, policies and programme designs so as to meet the mental health needs of the population.

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Conflict of Interest

The authors declare that there are no conflicting interests with their scientific work.

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