REVIEW ARTICE

COMMUNITY MENTAL HEALTH IN PESHAWAR, THE NEED TO REFORM

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Community mental health is a neglected field in many developing countries including Pakistan. Common mental disorders are high in prevalence, particularly in women. Community mental health services are lacking in Peshawar, which faces a number of challenges owing to sociopolitical instability. The aim of this literature review is to evaluate and interpret current research relevant to community mental health reform, including a review of the evidence regarding community mental health service. A selected review of published literature was undertaken using the PubMed, PsychINFO and Cochrane Database of Systematic Reviews databases. The intervention studies included in this review demonstrate that community based mental health services closely aligned with primary care services have the potential to facilitate improvements in access to care and also improvements in mental health outcomes. It concludes that lack of proper mental health policy and non-integration of mental health in primary health care adversely affects the outcome of mental health progress in community.

INTRODUCTION

LAMIC: Back ground information

In excess of 450 million people mostly living in developing countries suffer mental illness at some stage in their lives.[1] Mental health care remains a neglected issue particularly in Low-and Middle-Income Countries (LAMIC). Mental illness is associated with use of health facilities and significant direct financial cost as well as indirect cost. Under-recognition of Common Mental Disorders (CMD), including depression and anxiety disorders, in primary care is a critical public health problem that has high cost to society related to disability, morbidity, mortality and excessive health care utilisation.[2]

It is estimated that the burden of mental disorders is around 11.1% of the total disease burden in LAMIC.[3] Despite this, less than 1% of the health budget in many countries is spent on resources for mental health.[4] Consequently mental health policies, legislation, community care facilities, and treatments for people with mental illness are not given the priority they deserve. The World Bank Report was a turning point for mental health advocacy as it reported that the depression accounted for 10% of all DALYs in 1996 and that this figure is projected to increase to 15% by the year 2020.[5]

It has been demonstrated that locally available and affordable interventions in community and primary care settings are effective for the treatment of mental disorders in LAMIC. Many mentally ill patients do not receive evidence-based care which leads to increased disability associated with long-term mental illness and increased cost of care.[6]

Pakistan: Background information

The demographics of society in Pakistan are heterogeneous. It is estimated that more than a third of individuals survive below the poverty-line. Another unique feature is the wide cultural and linguistic backgrounds of people living within its four provinces. There is some evidence that prevalence of CMDs may vary across provincial boundaries, influenced by social factors such as population density, poverty, societal violence and terrorism.[7]

In an important review of studies investigating the prevalence of CMD in Pakistan, Mirza and Jenkins found an overall prevalence of 34%. They concluded that community-based estimates of the prevalence of CMDs in Pakistan varied from 10% to 33% for men and 29% to 66% for women.[8] As described by Niaz, women in Pakistan often face domestic violence as well as restriction in equal rights, particularly in rural settings.[9] Other risk factors include being of divorced or widowed status, conflict with in-laws, financial strain and the status of being a housewife rather than employed. This is particularly important as poor maternal mental health is linked with adverse psychological and physical development of children. This effect is compounded in LAMIC where adverse social circumstances may have a transgenerational effect. In a case-control study by Rahman confirmed an association between maternal depression and an increased rate of under-nutrition in infants. The purported mechanism is the reduced capacity of depressed mothers to provide necessary care for their children, negative life events and long-term psychosocial difficulties.[10]

This literature review is aimed to evaluate and interpret current research relevant to community mental health reform, including a review of the evidence regarding community mental health services.

METHOD FOR LITERATURE RETRIEVAL

Relevant literature relating to community mental health programs was identified through a number of database searches. The literature review aimed to identify recent

research; therefore appropriate databases were searched for English language articles. The databases searched included: PubMed, PsychINFO, Cochrane Database of Systematic Reviews, WHO site. The following search terms were employed:

- Community Mental Health in developing countries
- Community Mental Health in Pakistan
- Primary mental health care in Pakistan

The reference lists of relevant articles retrieved through database searches were also scanned in order to identify other important studies for inclusion in the literature review. Findings are qualitatively summarized with emphasis given to intervention studies where available. Studies included in the literature review were those which evaluated interventions designed to improve community/primary mental health care services in the population.

A total of 74 articles were found in PubMed, PsychINFO, Cochrane Database of Systematic Reviews and WHO site, when the search terms mentioned above were entered. Only relevant full-text articles and abstracts were reviewed.

Rights of the mentally ill

Mental health legislation reform is one of the cornerstones of community mental health reform. However, in many countries such as Pakistan, mental health legislation reform has not kept pace with social and political changes. Studies conducted in various countries have proven the effectiveness of community health services as compared to institutional care but due to social and cultural differences the same application in Pakistan may be impractical.

The Lunacy Act of 1912, a relic of British India, was not reviewed until 2001, when the Pakistan Mental Health Ordinance came into effect. The Mental Health Ordinance repealed the Lunacy Act and advocated for the care and treatment of individuals with mental illness. It is poignant to note that in Pakistan, the legislation for systematic mental health reform is lacking at policy level. Moreover, the Mental Health Ordinance needs to be enshrined in legislation to facilitate long-term change.

Saxena advocated for the protection of human rights of those with mental disorders. The author argued that existing international human rights laws can be applied to address the human rights abuses experienced by people with mental disorders. Such laws could be used as crude but useful instruments to apply pressure to protect people with mental disorders from abuses of their human rights.[11]

Mental Health and Primary Health Care Evidence from developing world

Integration of community mental health services in primary health care involves the teaching and training of health personnel at all tiers of primary health care and incorporation of mental health sciences in the curricula of health, education, social sciences and law enforcement institutions. In some LAMIC, models of community psychiatry have been developed to provide services to a large population with the approach of incorporating psychiatry into primary care. Nevertheless, it has to be kept in mind that this concept of community psychiatry is starkly different to mental health services in developed countries. The provision of care for people with mental illnesses by specialist community services over a long period of time may not be feasible.[12] The comprehensive mental health service is an ideal model to address the gaps in the current service context.[13]

A key multi-centre study by WHO (2007), the World Mental Health Surveys was conducted. Household surveys were conducted with a total of 84,850 participants in LAMIC, from study sites in developing and developed countries. It assesses prevalence and severity of mental disorders over the preceding 12 months, and use of mental health services. The number of participants receiving treatment was generally lower in developing when compared with developed countries. This study highlights the unmet need for mental health care in LAMIC, and the large gap in service provision between less developed and developed countries.[14]

The famous Lancet series on Global Mental Health concludes with a Call for Action to scale up the coverage of services for mental disorders based on two principles: an evidence-based package of services for core mental disorders and strengthening the protection of the human rights of persons with mental disorders and their families.[15]

A study conducted by Patel described that mental health awareness needs to be integrated into all elements of health and social policy. Integrated mental health policies, applied across disease categories, and to different level of care and types of care setting, will maximize the effectiveness of small mental health services available in most LAMIC.[16]

As far as decentralisation of resources is concerned, as stated by Saraceno *et al* the vested interests of mental health professionals and hospital workers might be one of the most pervasive barriers to decentralization. Primary care workers are already overburdened and there is lack of supervision and specialist support after training. The author elaborates that advocacy for people with mental disorders needs to be substantially improved and expanded.[17]

Evidence from Pakistan

Pakistan is one of the signatories of the Declaration of Alma-Ata. Primary Health Care (PHC) has a focus on mental health among its components. There is general consensus that community mental health services ought to be an essential part of PHC. Although the Millennium Development Goals do not specifically mention Mental

Health, Goal 3 (Promote gender equality and other diseases) can if implemented reduce the incidence of mental illnesses.

There is evidence that engagement of community members can increase the rate of detection of psychiatric cases. A study conducted by Mubbashar reported that by educating faith healers, school teachers and social congregations at mosques, improved rates of detection of mental illness in turn led to the increased utilisation of primary care services.[18]

Naqvi identifies that the lack of political will to improve the plight of individuals with mental illness needs to be considered in its political context, particularly if governments focus their resources on defence spending in response to sustained political instability in Pakistan.[19]

Mental health is often omitted during policy framing for health. Political will is likely to be directly affected by national and international factors such as lobbying by professionals, consumers groups and other advocacy groups, expressions of public opinion and donors political priorities. The policy must specifically mention the provision of medicines and other interventions used for mental disorders and further research on improvement of these interventions. The policy has to encompass a shift from the institutionalised treatment to a community based mental health services program.

Comprehensive Mental Health Services Evidence from Pakistan

The evidence based in Pakistan is scant, yet several studies have demonstrated the effectiveness of community based interventions.

A cross-sectional study conducted by Mirza with the main objective of study the perceived effectiveness of different types of treatments. Five different types of primary mental health care providers were consulted by the participants. These included General practitioners (GP), religious healers (Maulvis, Peers, Fakirs), Hakims, Homoeopathic and faith healers (Aamil, Sanyasis). The treatments provided by GPs were regarded most highly by the patients (56%) as compared to other practitioners including religious/ faith healers, Hakims and other practitioners (20%).[20]

A study undertaken by Saeed that compared the two sub-districts in Punjab showed that there was an increase in the detection of mental disorders and prescription of psychotropic drugs in primary care settings in the sub-district where an intervention of community mental health project was implemented. Improvements was also noted in general health parameters including an increased use of primary care services by men, an increased use of antenatal care, as well as increased immunisation coverage.[21]

A study by James *et al* in Pakistan and India explored the relationship between the availability of public community-based mental health care and factors affecting the demand for, access to and use of such health care by those for whom such program are targeted. A total of 795 adults (aged 16–65 years) in the Bangalore and 948 in Rawalpindi were screened using the Self Report Questionnaire. The results of the study showed an increase in the utilisation of integrated primary health care. In Bangalore 17% of participants had contacted a government primary care provider in the month preceding baseline assessment. This rose to 25% at the three month follow up assessment point. By comparison, in the integrated care locality 37% had being in contact with a government primary care provider and this rose to 43% at the three months follow-up assessment. The results in the Rawalpindi site showed that two-thirds of subjects at base-line had had contact with a government primary care worker in the non-integrated site compared to a quarter of subjects in the integrated locality. After three months, the contact rates with government primary care providers rose to 88% and 52% respectively.[22]

A randomised controlled trial conducted by Ali demonstrated the effectiveness of counselling delivered by minimally trained counsellors for people suffering from anxiety and depression.[23] Aga Khan University Anxiety and Depression Scale (AKUADS) was used. This scale has been validated in an urban squatter settlement of Karachi.[24] The questionnaire has 25 items, 13 psychological and 12 somatic, which increases its reliability for use as a screening instrument.[25] A significant reduction was demonstrated in the mean AKUADS scores between the intervention and control groups, demonstrating that counselling can be effective for CMDs with relatively minor input in terms of capacity building.

A randomised trial conducted by Rahman investigated the effectiveness of a school mental-health program. The investigators chose two secondary schools for boys and two for girls and the intervention group students received a 4-month program of mental-health education. A questionnaire containing 19 statements to assess awareness of mental health issues was administered. In the intervention group there was a significant improvement in the mean score of responses of school children, their parents, friends and neighbours, indicating an improved awareness of mental health issues.[26]

Mental Health Services Reform Challenges

The evidence regarding the effectiveness of specific approaches to specific mental disorders in primary care and community settings is growing. There are many variables that will profoundly influence the effectiveness of mental health interventions. These include markedly different priorities in public health, varying levels of risk factors (such as violence,

terrorism), the heterogeneous nature of primary health care provision and the availability of health resources.

For community health programs to be effective, it is essential that there should be inter-sectoral collaboration. Other departments beside health including social welfare, education, NGOs and law enforcing agencies should also be involved, and their role in this program be clearly defined. As described by Minas there is a need for collaboration between a range of stakeholders for this to take place, including mental health policy makers, academics, practitioners and various non-government organisations with the goal of providing evidence-based mental health care in LAMIC.[27] Adverse social circumstances that are common to other LAMIC include poverty, malnutrition, unrestricted urbanisation and loss of protective family networks, may influence the risk of mental illness in the general population, including families and even children.[28] As demonstrated in a household survey of the Indian Kashmir community, exposure to torture and violence is endemic. In the study, a third of respondents reported significant psychological distress and had considered suicide. In particular, women were noted to have higher levels of psychological distress than men. Furthermore, for both men and women, higher levels of psychological distress were associated with poor self-rated health and poor social functioning including being unable to work.[29] This finding is also generalisable to that of other communities affected by violence.

In a cross-sectional study conducted at the Aga Khan University Hospital, Khan *et al* demonstrated that anxiety disorders were highly prevalent. Consistent with the findings of other studies, females were more than twice as likely to be represented amongst this group.[13]

The acute shortage of mental health professionals and the relatively low levels of awareness about mental disorders imply that primary health care will remain the single largest sector for mental health care in LAMIC. The increased cost of specialist care makes it difficult for the middle and poor income group to regularly access this resource. Patel advocate for an alternative approach whereby community health workers, who may include trained lay persons, play a key role in identifying individuals with mental illness and linking them with primary care services. Improving the provision of ongoing medication is a core component of community care that is focused on the promotion of relapse prevention and recovery.[30]

It is also necessary not only to train physicians but also allied health care staff in diagnosing and treating CMD. Primary health care sector is poorly developed with a weak referral chain across the primary, secondary and tertiary care services. Most patients' by-pass the primary care services and access directly mental health services at tertiary care levels. The main reason for this process is the poor quality of services offered at the primary care centres.[31]

The involvement of traditional faith healers in community mental health reform in Peshawar is also critical. It is widely perceived by members of the community, and reinforced by the beliefs of traditional faith healers, that mental illness is caused by supernatural forces such as spirit possession or testing by God. Religious healers are usually the first group of practitioners sought by families of the mentally ill. Pakistani people have strong faith in religious healers and the Quaranic texts used by them, which places these healers in a powerful position to help people solve their psychosocial problems.[32] The traditional healers use talisman and gave them to the families of the patients. The public perception of the importance of traditional faith healers as the first line of treatment is also based on the fact that there is a lack of mental literacy in general public. Hence, further efforts are needed not only to improve the mental health literacy of the general public and also to educate traditional faith healers in order to improve their knowledge and beliefs about mental disorders that may facilitate their recognition, treatment or referral.[33]

Priority Areas in Peshawar

The Sarhad Psychiatric Hospital, Peshawar built during the British colonial rule in 1854 is situated within the premises of the Central Jail of Peshawar. The hospital has both outpatient and inpatient facilities. It provides electroconvulsive therapy and psychotropic medications. The male ward is separate from the female ward premises. Care is rudimentary and violent patients are often chained. Khyber Teaching Hospital and Lady Reading Hospital are tertiary care hospitals both having outpatient and inpatient facilities. Peshawar has a network of primary health care centres.

In Peshawar traditional faith healers in a village by the name of Achini are widely known amongst people, for providing treatment to mentally ill individuals. However the treatment is not often inhumane. Patients are physically restrained and chained to the wall. Patients typically live in squalid conditions without access to appropriate pharmacological and psychosocial treatments.

Anecdotally, the number of individuals with mental illness is increasing due to the precarious social, economic and terrorism situation in the district. There is also an increasing availability of illicit drugs.[34] The already overburdened and poorly financed public health system is unable to tackle this scale of mental health morbidity in the community. However in reality no such comprehensive mental health program has been implemented. The private sector provides mental care but high costs make these services inaccessible to all members of the community. The poor who are unable to

afford such care are hence likely to either go to the public sector or traditional faith healers.

CONCLUSIONS

In Pakistan lack of proper mental health policy adversely affects the integration of care delivered by government health care professionals for patients with mental illnesses. In this regard it is the duty of all integral stakeholders to advocate for the formation of a proper and comprehensive National Mental Health policy.

Mental health services needs to be integrated into the overall primary health care system. And a prevalence study would indeed provide a more accurate picture of the burden of mental illnesses in Peshawar. Research is also needed to determine the impact of mental health literacy on the approaches of traditional faith healers.

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