Mental Health Issues in South Asia Region

Roy Abraham Kallivayalil*1

“Mental illness is not a personal failure. It does not happen only to other people” - Gro Harlem Brundtland

Director General, WHO (2001).

WHO statement on mental health says, ”Mental health-neglected for too long is crucial to the overall well being of individuals, societies and countries and must be universally regarded in a new light”. It is worthwhile to note that the World Health Report 2001 had highlighted the theme, “Mental Health- New Understanding, New Hope”, which is especially relevant to South Asia.

South Asia region represents seven countries- India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan and Maldives- which are members of South Asian Association for Regional Co-operation (SAARC). Most of the people in these countries share a common cultural and political heritage. It was this recognition at the political level which led to the creation of SAARC in the early nineties.

An ideal mental health delivery system should provide high quality and affordable care for all citizens, while promoting medical research and technology. It is well known that social and economic factors affect a nation’s health status and delivery of services. The countries in South Asia region are developing nations with limited resources. Sometimes mental health is not a priority area in many of these countries. The escalating health care costs and cost of drugs is a major obstacle in this region.

The cultural aspects of psychiatry has gained considerable visibility recently because of an increased recognition that culture plays a significant role in an individual’s life and has considerable impact on the development of his self concept. This understanding has resulted from the collaborative efforts of psychiatrists, anthropologists, sociologists and other related disciplines. The pressure for such interdisciplinary thinking and problem solving has come also from the society’s wish to understand the nature of certain problems that are evidently related to culture.

Transcultural differences also engage our attention. Cultural difference has a significant effect on the determination of diagnostic categories. Different cultures are often in disagreement as to what behaviour they label normal or abnormal. Wig (1983) suggested that culture has powerfully influenced diagnostic classification systems. He has noted that current American and European classification systems have elevated emotions such as anxiety and depression to the level of specific disorders, while other emotions like jealousy or hatred have not been treated in the same way. Wig was making the point that jealousy and hatred might be treated with much more emphasis in some cultures and in a non Euro-American system, might have been considered worthy to be called as specific disorders. This may be relevant to regions like South Asia. However it is the many commonalities in the cultural heritage that makes this region unique.

Ideally for South Asia, mental health may be integrated in general health care. People should be protected from catastrophic financial risk and out-of-pocket payments should be minimized. Mandatory social insurance and the principle of the healthy and well-off subsidizing the sick and the poor may be practiced. There has also been a perceptible shift in the mental health paradigm in the region due to the progress in psychopharmacology, new forms of psychosocial intervention and human rights movements. Undoubtedly, a mental health component needs to be firmly incorporated into the concept of general health in the region.

It is necessary for South Asian nations to have a mental health policy which identifies major issues and objectives, defines the role of public and private sector, providing guidance for prioritizing expenditure, linking problems with resource allocation, highlighting vulnerable groups with special mental health needs like children, the elderly, the women, refugees and displaced persons, caring for individuals at risk (with depression, schizophrenia, substance abuse etc.), bringing forth alcohol and drug policies, ensuring respect for human rights, and involving NGOs, consumer groups, mass media and all other stake holders.

Now let us have a brief view about the current scenario in the seven South Asian countries (WHO Atlas, 2001).

*Correspondence

1Gen. Secretary, Indian Psychiatric Society & Secretary General, SAARC Psychiatric Federation.
Associate Professor of Psychiatry, Medical College, Kottayam-686008, India. E-mail : ktm_roykalli@sancharnet.in

295
Roy Abraham Kallivayalil

India: Mental health policy was formulated in 1982, but a substance abuse policy is absent. National Mental Health Programme was launched in 1982. Legislation is Mental Health Act, 1987 and an essential list of drugs and disability benefits are available. NGOs are involved in advocacy, promotion, prevention, treatment and rehabilitation. But only a very low 0.83% of health budget is provided for mental health. India has only 0.4 psychiatrists and 2.5 beds for 100,000 population.

Pakistan: Mental health and substance abuse policies were formulated in 1997. National Mental Health Programme was launched in 1986 and new mental health ordinance in 2000. Essential list of drugs (1997) and disability benefits for mentally ill are available. NGOs are involved with the most notable example of Fountain House in Lahore for psychiatric rehabilitation. But only a very low 0.4% of health budget is allotted for mental health. The country has only 0.1 psychiatrists and 1.2 beds for 100,000 population.

Sri Lanka: A National Mental Health Programme was implemented in 1966 and a mental health ordinance in 1960. There is an essential list of drugs since 1985 and a substance abuse policy, but mental health policy is only being developed. NGOs are involved, but there are no disability benefits for the mentally ill. In South Asia, Sri Lanka spends the highest on mental health- 1.6% of the health budget. The country has only 0.2 psychiatrists for 100,000 population but a higher number of 18 beds.

Bangladesh: The national mental health programme was launched in 1984. There is a substance abuse policy (1990) but no mental health policy. An essential list of drugs is available since 1983, as well as disability benefits and NGOs are involved in treatment and rehabilitation but only 0.5% of health budget is allotted for mental health. There are only 0.05 psychiatrists and 0.65 beds for 100,000 population.

Nepal: There is a mental health policy-1997 and substance abuse policy 1994, but there is no national mental health programme. There is an essential list of drugs- 1986 but legal provisions are under civil law 1964. NGOs are involved, but there are no disability benefits. Nepal spends only a negligible 0.08% of health budget on mental health. There are only 0.09 psychiatrists and 0.8 beds for 100,000 population.

Bhutan: Mental health policy 1997, substance abuse policy 1988 and essential list of drugs 1987 are available, but there is no mental health legislation. Disability benefits are available but NGOs are not involved. Only 0.17% health budget is spent on mental health. There are 0.3 psychiatrists for 100000 population but data on beds is not available.

Maldives: Substance abuse policy 1977 and essential list of drugs are available. But there is no NMHP and no mental health policy and no mental health legislation. Disability benefits are available but NGOs are not involved. There are 0.36 psychiatrists for 100000 population but data on beds is not available.

It is very clear that budgetary allocation for mental health in South Asia region is wholly inadequate. This calls for concerted action. Similarly there are many arenas for possible co-operation. One area is mental health legislation, where Nepal, Bhutan and Maldives have enacted no law. They can be easily helped by the other countries in the region. Also Bhutan and Nepal who do not involve NGOs can have valuable inputs from their neighbours. India with its vast resources and man power can always provide a helping hand in the region in all aspects of mental health. Sri Lanka with the highest budgetary support for mental health and highest beds can be emulated by others. Pakistan’s Fountain House is the best model for psychiatric rehabilitation.

The commonalities in the region is reflected in common problems as well. Failure of asylums has been noted worldwide. This was due to ill-treatment of patients, geographical and professional isolation, weak reporting and accounting, bad management, poorly targeted financial resources, lack of staff training and inadequate quality assurance procedure. However the realities in South Asia needs closer scrutiny. If we take India for example, when compared to western countries, the availability of beds in mental hospitals are negligible. England with 60 million population, still has 40,000 beds in mental hospitals, after closing down many institutions. At this rate, India with more than 1000 million population, will require 700,000 beds. If we assume that 1% of the population suffer from severe mental illness, there are 10 million people in India with severe mental illness. 1% of this 10 million population will require long term intensive care, i.e 100,000 people. So by the most conservative estimate, the requirements of beds in mental hospitals in India will be 100,000. Even after the Central Govt starting mental hospitals in all the states of India, as directed by the Supreme Court of India, this target will not be achieved. Many are of opinion that, Supreme court must be requested to issue a time bound direction to the central govt to start mental hospitals/mental health institutes in all the states. It is felt, we need more service providers rather than training institutes.
This situation may be true regarding other countries in the region as well. At the same time, we shall aim for de-institutionisation. There shall be no inappropriate admissions in mental hospitals, community support systems should be made available, and discharge to community after preparation should be encouraged.

**Co-operation in mental health in South Asia**

Co-operation in mental health in Asia in general and South Asia in particular has been a dream of our predecessors for the last three decades. The inauguration of GAMHA (Group for the Advancement of Mental Health in Asia) on January 21, 1978, at New Delhi during the Annual Conference of Indian Psychiatric Society and Regional Conference of World Psychiatric Association was an important landmark of major significance. It was the first time in history that leaders of mental health in sixteen countries in Asia declared to initiate an organized effort to promote mental health in their own countries (WFMH 1978). JS Neki, NN Wig, Col Kirpal Singh, RL Kapur, KC Dube (India), Zarabi and Davidian (Iran), Chaudhury (Bangladesh) and others led this initiative. It may be noted that the participation of Rashid Chaudhury from Pakistan at this meeting in India was the first such instance in seventeen years among the two countries. In a way, this brought nations closer as JS Neki soon travelled to Pakistan in return to attend the annual conference of Pakistan Psychiatric Society.

But despite this good beginning, our efforts to form an Asian or South Asian Federation did not bear fruit. While South Asia dithered, the eleven nations of South East Asia formed federation for ASEAN (Association of South East Asian Nations) and decided to strengthen mutual co-operation in the field of mental health. This initiative which was led by MP Deva and others has been functioning well for more than a decade now.

Indian Psychiatric Society has been making renewed efforts, especially during the last decade to form a federation in South Asia for the advancement of mental health. Representatives from several Asian countries met together at Colombo on 19th August 2003 during the International Conference of Psychiatry organized by the South Asian Forum on Mental Health. Afzal Javed was the main moving spirit behind this meeting. WPA Zonal representative M.P. Deva, J.K. Trivedi, Roy Abraham Kallivayalil, V. Palaniappun, E. Mohandas, Mohan Isaac, T. Murali, Afzal Javed, Khalid Mufti, Haroon Rashid Chaudhury, Nalaka Mendis, and others participated. The meeting discussed the formation of SAARC Federation and also an Asian Federation. The IPS Executive Council meeting at Gangtok on 12th September 2003 decided, to take the lead in the formation of SAARC Psychiatric Federation. The 56th Annual General Body Meeting held at Mysore on 10th January 2004 approved the formation of the SAARC Psychiatric Federation and decided, that IPS should take a lead in this matter.

Our long standing dream was realized when representatives of the Psychiatric Societies of South Asian countries met at Lahore on 19th Sept. 2004 during the WPA Regional and Inter Zonal Meeting and formed the SAARC Psychiatric Federation. This historic meeting was jointly chaired by Prof J.K. Trivedi, President, Indian Psychiatric Society and Prof Khalid A. Mufti, from Pakistan and Chairman of the Organising Committee. Prof George Christodoulou, Secretary, Sections of WPA participated as observer and gave valuable suggestions.

**The following were elected as the office-bearers:**

- **President**: Prof. Abdul Malik Achakzai, Quetta, Pakistan
- **Vice-Presidents**: Dr. Nalaka Mendis, Colombo and Prof MA Sobhan, Dhaka
- **Secretary-General**: Dr. Roy Abraham Kallivayalil, India
- **Joint- Secretary**: Dr. Dorgi Chenko, Bhutan
- **Chairman, Constitution Committee**: Prof. J.K. Trivedi, India
- **Executive Committee**: B. Karunatilake and Rajeev Wijesundera (Sri Lanka), Rezaul Karim and AHM Firoz (Bangladesh)

Presidents and Secretaries of all member country Psychiatric Societies

**Advisors**: Dr. Afzal Javed (UK), Prof Mohan Issac (India) and Prof Haroon Rashid Chaudhury (Pakistan)

**The following decisions were taken:**

1. To draft the constitution and circulate it, to all member societies for their suggestions and views. J.K. Trivedi was entrusted to do this in a period of three months.
2. Indian Psychiatric Society invited all member Societies for the SAARC Session at Chandigarh Annual conference Jan 29 - Feb. 1, 2005. The constitution may be approved at this meeting, if possible.

3. To affiliate the Federation to WPA.

4. To hold the SAARC Psychiatric Federation Annual Conference at Agra, India in November 2005.

5. To build up partnership in South Asia in research, organising community care, training programmes, exchange of Faculty and Trainees, publication of data, health education etc.

Conclusion

To face the varied problems, South Asia has to focus on early diagnosis and treatment of mental illnesses, develop preventive strategies and make promotion of good health a national theme in every country. Several areas like medical education, general health services, community care, needs of the physician as well as the public, working hours, health care costs, health insurance etc needs to be addressed.

Mental illness can involve serious financial liability in this region. It is worth noting, while 84% of people below 65 years in US has access to health insurance, it is less than 10% in South Asia. People will have to generally rely on government run facilities- which are woefully inadequate- or if they can afford, they may seek private treatment which is often costly. It is well known, most people in South Asia have poor access to mental heath services. In a country like India, with more than a billion people, the number of psychiatrists are only 4000. This means that one psychiatrist for every 250,000 people. The number of clinical psychologists, psychiatric social workers, psychiatric nurses etc are also grossly inadequate. This situation is true of most South Asian countries.

What are the strategies for the future? Training undergraduate medical students properly in Psychiatry – which is currently highly inadequate- will be extremely useful. Imparting this basic knowledge of Psychiatry to budding physicians can be a major milestone. Secondly, primary care physicians should be given training in mental health. Opening general hospital psychiatry units in every major hospital, especially at the District level will bring psychiatry to the door steps of common man. Besides it will be less stigmatizing too. Training more number of psychiatrists, psychologists, social workers and mental health nurses are important. Needs of special population should be addressed by opening de-addiction centers, community care clinics, out patient clinics and child guidance units. A national mental health programme with sufficient funding, is also a must for every country. Regional co-operation in mental health in South Asia should be actively pursued. The formation of the SAARC Psychiatric Federation is certainly a bright light in the cloudy sky. Let us hope it will succeed and its ideals survive to bring better understanding, good will and health in the region.

References:

Ezra E.H.G., Carlos A.G., Howard C.B., (2003): Introduction to cultural psychiatry: in Textbook of Clinical Psychiatry,4th Ed, by Robert E.H., Stuart G.Y. : The American Psychiatric Publishing, Washington DC.

Vaccaro J.V . (2000) Managed care : Comprehensive text book of Psychiatry. 7th ed, Sadock B.J., Sadock V.A., Lippincott, Williams and Wilkins, Philadelphia.

Wig,NN (1983):DSM III: A perspective from the third world, in International perspectives on DSM III, Ed. by Spitzer RL,Williams JBW, Skodol A.E. ; Washington DC, American Psychiatric Press, 79-89.

World Federation for Mental Health (1978), WFSH Newsletter, Apr-June 1978, USA.

Word Health Organisation (WHO) (2001) : Atlas: Country profiles on mental health resources 2001. Department of mental health and Substance Dependence, WHO, Geneva.