The global response to mental illness

First line care facilities and support for providers have to be improved

EDITORS—Thornicroft and Maingay highlight the inadequacy of international responses to mental illness. In low income countries the burden of mental illness is amplified by financial insecurity, poverty, and partition of families, if not by violence and war. Prevention in mental health is intimately linked with overall human development. Individual care is also necessary. In some societies religious or traditional healers still provide culturally relevant and socially acceptable responses to problems labelled as mental illness. Nevertheless, mental suffering is manifest among users of modern medical services, where it goes largely unrecognised.

Besides poor availability of drugs, human resources are of utmost importance in understanding the apparent neglect of mental health problems. Doctors and nurses in low income countries are often described as rude to their patients, partly because they have low salaries and poor professional perspectives, which affects their morale, self confidence, and dedication. Some have problems similar to those of their patients—for example, domestic violence or living with HIV. Some are not prepared to face the emotional burden of listening to patients' suffering. Adequate professional support is unusual, and dealing with emotions is seldom valued by the organisational culture.

If health care in low income countries is to be oriented towards more biopsychosocial approaches, efforts have to include improving first line care facilities and support for providers. Well functioning first line facilities are crucial to integrate mental health programmes accessible to the population. This does not rule out specialised services, but these tend to remain concentrated in cities and are often of limited accessibility financially. In the case of mental health services, stigmatisation furthermore limits their acceptability to potential users.

The integration of mental health programmes in first line care facilities should of course not be detrimental to the comprehensive character of the service delivered. The purpose is not to divert available resources to serve a specific programme but to take advantage of the existing relations between a service and a community to widen the scope of responses provided locally. Health care in low income countries is increasingly thought of as a series of vertical programmes, so the need for access to regular health care is crucial, and specific programmes must strengthen general services rather than weaken them. Indeed, mental health programmes may improve first line care. Concerns for mental health are likely to promote listening skills, to foster patient centred care, and to broaden the professional identities of care providers, currently focused on biomedical issues. This could be an important step on the way to quality general practice adapted to social and cultural contexts.

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Focus on mental health means new opportunities for developing countries

After the Gujarat earthquake

EDITOR—The global resources for mental health raise two issues. Crisis results from the low priority given to and the limited resources for mental health care. However, the focus on mental health by the World Health Organization offers a new opportunity for developing countries to organise mental health using current knowledge.

Developing countries have four advantages: most ill people live in the community and are cared for by family members; families continue to feel directly responsible for care and support, which is an advantage in organising services; the lack of an extensive mental health infrastructure (specialists, specialist beds, different professionalists, etc) means that services can be organised using community resources; and greater acceptance of patients by the community allows for easier community involvement in mental health care.

Mental health care has been integrated with primary health care in India and Iran. In India, initiatives began in 1975 and led to the development of a district mental health model (1-2 million population). This model has now been implemented in 25 districts and is expected to be extended to 100 districts in the next five years (about 150 million population). In Sri Lanka, the amount of training in psychiatry for undergraduates (two full months) has increased and psychiatry is now an examination subject in the final year. The family movement is taking shape in developing countries, and this is fostering new partnerships. Massive disasters such as the Gujarat earthquake and the Orissa supercyclone have led to the development of a community based psychosocial care with community volunteers. Similar developments are occurring in many countries of Asia, Africa, and South America.

The development of mental health care faces special challenges in developing countries. These are the need for mental health professionals to shift from a clinical to a public health focus; the development of training materials, case records, information systems, and treatment guidelines; the development of support programmes for families; the passing of legislation to protect the rights of mentally ill people and increase access to mental health care; and the availability of adequate numbers of mental health professionals to support, supervise, and guide the new initiatives.

In conclusion, the global situation is a challenge to professionals to think innovatively.

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Discontinuation of thioridazine

Risks must be balanced

EDITOR—Until the Committee on the Safety of Medicines restricted the use of thioridazine in 2000, it was the most widely used antipsychotic drug in the United Kingdom, with 50 million years of safe use by patients worldwide. In Scotland in 1999, were 250 808 were prescriptions dispensed in primary care (hospital data not available, but the safety committee reports that it was the most widely used antipsychotic drug in hospitals too). This dropped to 39 177 in 2001, according to information from the Primary Care Information Unit in Scotland.

Is thioridazine safer, cheaper, and more effective than alternative antipsychotic drug treatments for anxiety, agitation, mania, and hypomania? We do not have enough evidence to answer this because thioridazine has been widely used for 30 years—before the days of rigorous randomised controlled trials. Lack of evidence is not evidence of no benefit. Conversely, there is only evidence of a handful of adverse cardiac events, some of which may not have been directly caused by thioridazine or may have been due to combination with other drugs. Although the reported cardiac deaths are lamentable, it