

# Improving mental health systems in Africa

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Africa is a vast and diverse continent. The diversity relates not only to geography but also languages, cultures, religions and histories. Notwithstanding the commonalities, to comment on mental health systems across Africa, and how to strengthen them, may seem a presumptuous task. This article simply aims to provide points of departure for discussion and debate, and some possible ways forward – without losing sight of country-specific issues.

## Resources and physical infrastructure

Critical to adequate service delivery are resources. Governments have limitations on the extent of resources that can be provided for health care. There are a multitude of competing areas that need adequate resources, such as education, safety and security, justice, public transport, infrastructure and social services.<sup>1</sup> Each country requires a rational hierarchy of needs, where, for example, very significant overspend on militaries is not unheard of. The range of resources required for an efficient mental healthcare system encompasses both physical infrastructure and personnel.

Psychiatry-specific facilities are necessary, recognising the unique requirements of psychiatric patients whereby co-opted medical wards in hospital settings are simply not adequate. Further, the need for specialist psychiatric hospitals is not about incarceration but about providing an environment that is focused and appropriate for the treatment of psychiatric patients. Neither of the aforementioned types of inpatient facility negates the requirement of community-based services. Likewise, in seeking to manage psychiatric patients as close to their homes as possible through effective community services does not negate, diminish or compensate for inpatient care – which is indeed care in a therapeutic setting.

## Human resources – retention

Personnel is obviously a critical resource. Aside from training inadequate numbers of staff, there is the commonly encountered issue related to loss of trained specialists and medical graduates to developed countries. There are both 'push' and 'pull' factors involved here. Most medical graduates who work in the state sector are acutely aware of the limitations that exist. Given their commitment to patient care, they develop ways of working as best they can within such limitations. However, such working conditions are ultimately disheartening, de-motivating and no doubt contribute to disillusionment and movement out of the sector. While appealing to developed countries to desist from recruitment of locally trained developing world personnel, it is incumbent on developing countries to examine the 'push' factors that drive professionals to leave their country of origin. These 'push' factors make personnel susceptible to the 'pull' factor of apparent stability and better working conditions in developed countries. That being

the case, the African diaspora needs to be fully documented and actively engaged in attempting to create networks that will contribute to patient care and service development in their country of origin. In this way individual practitioners would not be totally lost as a resource.

With regards to non-specialist medical personnel, the active promotion of diplomas in mental health as opposed to specialist fellowships should be a priority. This raises the issue of training, and in this regard one should not ignore the other end of the spectrum – the sub-specialist. There are those who question whether developing world settings can afford to devote resources to such training. A simple example puts that argument in perspective, namely the increasingly youthful demographic of developing world populations, which will lead to an increased demand for child and adolescent psychiatrists. Another example is the impact of HIV/AIDS on the neurological system and the consequent emergence of psychiatric conditions, which will require more neuropsychiatrists; and there are further examples related to forensic psychiatry, old age psychiatry and addiction psychiatry – all sub-specialist disciplines in their own right and all relevant to African countries. Sub-specialists do not only treat selected patients, but also provide the knowledge and clinical experience that serves to train general psychiatrists.

Clearly, medical specialists form the core of psychiatric services, but in developing world settings the inadequate number of specialists highlights the need for and requirement of suitably skilled non-specialists as well as allied mental health professionals such as nurses, occupational therapists, social workers and psychologists. Of all medical disciplines, psychiatry is the one that routinely utilises a multidisciplinary approach, and in so doing provides truly holistic treatment to patients and their families. The extent to which allied professionals are understood to be integral to optimal care cannot be overstated and should be a non-negotiable requirement.

In addition, the possibility of 'task shifting' needs to be more fully implemented with the appropriate skills acquisition by non-medical health workers. It is not uncommon for services to be predominantly staffed by nurses, with psychiatry being no exception. Specialist nursing skills are no less important than specialist medical skills. Further, it is not inconceivable that suitably skilled non-health workers and volunteers might be an option for assisting with both de-stigmatisation and medication adherence through community-based initiatives.

## Information technology

A major concern is the availability of adequate information technology. Appropriate resource provision requires accurate data,

in terms of describing services rendered that contribute to defining needs and allocating budget. Fundamentally, it is about having a clear understanding of the cost of psychiatric services. Record-keeping is critical and encompasses not just informing economic decisions but also has both ethical and legal implications. The possibility of electronic record-keeping will allow for more rapid dissemination of patient information between sites, as well as retention of patient information – both of which would contribute to patient care. While the aforementioned relate to institutional requirements, at an individual level the advent of mobile telephone technology with its rapid uptake in Africa, may offer unique opportunities to enhance patient care – for example, medication compliance.

## Medication

The advance of medical science, and neuroscience specifically, has witnessed a proliferation of medications targeting mental illness. Of course, the primary aim is the relief of symptoms, but there is a need also to ensure that this is not at the expense of unwanted and potentially toxic side effects – which might harm the patient directly and/or contribute to non-adherence to medication with consequent inadequate response to treatment. Inherent to the aforementioned are two issues, namely the availability of medication and compliance with prescribed medication. Regarding availability, cost is a significant factor that frequently limits access. While developing world populations often contribute to the testing of new drugs, the eventual cost limits subsequent availability for these same populations. Logistical issues related to medication procurement and supply-chain management are vital components of service delivery; in other words, ensuring that what is indeed purchased actually reaches the intended sites.

Adherence to medication is a perennial issue, and non-adherence frequently contributes to both recurrence of symptoms and relapse of condition. Ensuring adherence is a multifaceted problem, with psycho-education targeting both patients and their support systems being integral to successful treatment. Allocation of resources needs to be cognisant of such requirements, specifically in terms of both training and availability of staff to deliver this component of an intervention.

## Stigma

Most health professionals would instinctively view stigma as a phenomenon affecting individual patients with mental illness, who by virtue of their illness experience isolation, rejection or discrimination within the broader society. While much effort is devoted to inclusion and attempting to convince those without mental illness to have a non-discriminatory understanding of those who do, this remains an ongoing pursuit, even when efforts to legislate against such attitudes are made (not least in the work domain).

Beyond the individual, there is much work needed to confront institutional stigma. Such stigma is quite possibly more iniquitous in that it sees psychiatry as a discipline dismissed by fellow professionals and underfunded by governments. The approach to confronting such stigma would appear to require professionals who are adequately equipped to effectively motivate for change, not only through direct engagement with government individually and through representative bodies but by linking with

non-governmental organisations (NGOs). Two related areas warrant mention: undergraduate training and medical internship training.

There is a need to ensure that adequate and appropriate exposure to psychiatric patients occurs, together with didactic teaching. The curricula of undergraduate medical studies should reflect the importance of mental health as a component of health, which by implication requires not just the promotion of mental health but also the treatment of mental illness. Given the increasing burden of mental illness, it is incumbent on medical graduates to have adequate knowledge and skills in this area. Such skills should be further consolidated through dedicated rotations of psychiatric units during their internship years, leading to independent practice as medical practitioners or further training as specialists.

## Integration

The concept of integration operates at two levels: that of the patient into their community and that of the patient into the health system. Regarding the former, developed countries have actively promoted a policy of deinstitutionalisation with a reduction in both chronic and acute psychiatric beds. The aim was to achieve a return to the community of psychiatric patients. As laudable as these efforts may have been, it is not clear that such an approach has yielded the desired outcome, not least of all where beds have been reduced but sufficient resources have not been allocated for the support and development of community services. In such a situation, the services suffer a double blow. There needs to be a balance, which can most likely be achieved with a truly holistic view of patient needs through the course of their illness – from hospitalisation (acute/longer stay) to community-based care. Whilst there is a need for specialist community services, it is likely that many psychiatric patients could be managed in the primary care setting by non-specialists, provided they are adequately trained and supported. Inherent to the aforementioned is the need to carefully plan for a range of services that provide for a patient's needs at the level required.

A final word on integration must, within an African context, make mention of traditional healers. It is increasingly acknowledged that while medical models provide for care of the patient's disease (as understood by the medical practitioner), one needs to be aware of the patient's experience of their illness, which in some cases will see them consult outside of the accepted medical structures. There is a need to integrate this reality into any understanding of what constitutes the package of care, and to actively engage to ensure optimal intervention.

## Legislation and advocacy

Mental health legislation exists in many African countries. The aim should be to ensure that all African countries have the appropriate legislation as part of a continent-wide move to provide for a highly vulnerable section of the population. While laws may be passed and policies drawn up to target the unique circumstances of those suffering with a mental illness, they are meaningless without appropriate resources to both implement and monitor.

Part of medical professionalism involves advocacy which, in short, places an obligation on health professionals to actively engage with

decision-makers in motivating for the provision of adequate patient care. Medical professionals need to be suitably skilled in the art of negotiating a better deal for the patients they serve. Such interaction should, however, not be an individual pursuit, but involve collective approaches that are channelled through representative bodies of health professionals. The realm of advocacy is often pursued by NGOs, who without fear of recrimination and often with greater resources than individual medical staff or professional organisations, can actively engage with government. The Treatment Action Campaign that forced the South African Government through the country's constitutional court to ensure availability of antiretroviral drugs for HIV-infected sufferers of AIDs is an illustration of a successful action of this nature.

## Professional networks

On an international level, the discipline of psychiatry is well served by the World Psychiatric Association (WPA). However, it is important that beyond having zonal WPA representatives in Africa, that as a continent there is a representative organisation that provides active support to professionals within individual African countries as well as assists them in promoting African issues beyond WPA structures. The African Association of Psychiatrists and Allied Professionals (AAPAP) is one such organisation. However, it is no small task to create a critical level of momentum and credibility that would enable such an association to play the role it should and can play. Through the *African Journal of Psychiatry*,<sup>2</sup> in existence since August 2007, the promotion of psychiatry in Africa has provided a platform for African psychiatrists to convey research that is locally relevant. In addition, it has given international psychiatrists a window into African psychiatry that may indeed inform their practice. A 2011 publication, *Contemporary Psychiatry in Africa: A review of theory, practice and research*,<sup>3</sup> brought together a group of African psychiatrists in writing chapters that provided a status quo of African psychiatry on a range of conditions and issues, which together with peer review from psychiatrists outside of Africa created a truly international collaborative effort. The development of African researchers and the creation of indigenous knowledge are critical to informing local practice and developing services that are appropriate for Africa.

## Conclusion

The issues raised are not exhaustive. Additional areas of focus could have included the physical: for example, the non-psychiatric medical requirements of psychiatric patients, more detail on substance abuse, as well as factors that contribute to mental illness, such as the family, societal change, bullying in schools, urbanisation, etc. Notwithstanding such omissions, the content highlights a range of issues and provides some insight into their relevance – each topic could easily be the subject of further and more detailed discussion. However, the aim here has been to highlight one specific point – in pursuit of better psychiatric and related services in Africa, there are many aspects to consider, and that such consideration must adopt an inclusive approach incorporating the multitude of factors. Herein lies the challenge.

## Endnotes

- 1 One facet of leadership concerns African social and political elites' choices about their own medical care. Something as straightforward as encouraging politicians and elected officials to use the state medical system for themselves and their dependents could reap benefits. When citizens at all income levels use state-funded care, this preserves incentives for the state to maintain adequate levels of funding.
- 2 For more information, see [www.ajop.co.za](http://www.ajop.co.za).
- 3 Acrodile Publishing Limited, [www.acrodile.co.ke](http://www.acrodile.co.ke).

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