



## ON THE FRONTLINE: A PSYCHIATRIST'S VIEW



Soumitra Pathare

“I have been a psychiatrist for nearly 15 years now. During this time I have been fortunate to get the opportunity to work with people with mental disorders in different countries and cultures such as United Kingdom and India. I have also had the opportunity to observe mental health services in diverse places such as Indonesia, Samoa and Vanuatu.”

“Across countries and cultures, I am amazed by the resilience of people who have mental disorders. [They are] Living with illnesses that are difficult to understand and which affect the very core of our sense of self; battling on a daily basis to live ordinary lives like you and me; trying to live a normal life in a society that will not try to understand their reality and views them with fear and suspicion.”

“I am saddened when I hear and see how mental health services fail to understand the simple desire to work and live a normal life in the community with friends and family. It is highly disappointing to see many mental health services do not perceive their primary role as facilitating the fulfillment of this desire.”

“We (the professionals) frequently fail to understand their need to be in control of their lives and their bodies, just like any of us would want to. We are quick to prescribe solutions but not keen to listen to their voices. We frequently refuse to acknowledge their identity – I hate it when people say so and so is a schizophrenic – as if the illness is their identity.”

“You might wonder why I continue to remain in this profession. Because I also have some memories that I cherish a lot. Seeing the smile and the excitement on the face of a person standing in the checkout queue at the supermarket. For the first time. Someone who had spent the greater part of their adult life in a mental asylum but was now living in their own home. I am proud to have been part of a mental health service that made this smile possible.”

“Mental illness affects people like you and me. Its time we realized this is about us, not about them.”

-- Soumitra Pathare, Psychiatrist, Pune, India

**EXPERT OPINION ON BARRIERS AND FACILITATING FACTORS FOR THE IMPLEMENTATION OF EXISTING MENTAL HEALTH KNOWLEDGE IN MENTAL HEALTH SERVICES**

Psychiatric epidemiology has shown that the aggregated rate of mental disorders is inversely related to socioeconomic status. The disadvantage of the low-income populations is further compounded by their limited capacity to influence decision making processes about issues that affect their lives while their power to lobby is minimal. Briefly stated, the case for action with regard to mental health is affected specifically by the SES-association as well as by general issues related to mental health in all groups.

Large financial institutions with major clout (Inter American Development Bank in the Americas or World Bank, globally) that negotiate grants/or similar with governments/ministries of health seldom raise mental health as a subject.

Strategically, I would select 2 priority areas of action: Primary prevention and poverty-reduction programs in which mental health care plays a significant role, e.g., reduction of risk, of the treatment gap, and of control of alcohol-related problems.

First, training has to take place where people go for services, general hospital, and community settings. Often, medical students and psychiatric residents are trained in mental hospitals. The same goes for nursing students. Second, the curriculum has to be tailored to the issues and the populations alluded to earlier.

Third, the “dinosaurs“ that are often involved in private practice are oblivious to the needs of the poor, constitute poor role models for the young trainees. Importantly, the content of their teaching is often non-relevant for the programs and services that are needed in low and middle income countries.

Leadership cannot be expected from clinicians-turned-by-default-into-administrators/planners. Their views, experience, and training are not compatible with a population-oriented mental health action plans/programs. Perhaps, and this until cadres of public mental health leaders become available, we should rely on public health leaders or other stakeholders (family members) that have the capacity to lead programs. In many cases I would look for leadership outside of the classical mental health field. Perhaps, to make the impact we seek we might need the courage and vision to break the circle.

Working within the confines of the mental health field might not lead us to the changes we wish to obtain. Sadly, I must admit that I found that my own psychiatric colleagues are more comfortable with the status quo than seeking change. Their daily interests are not focused on the excluded, the disfranchised, the poor. Perhaps, in theory, they might feel for their predicament, in practice, this is not expressed. I do not blame them entirely,

perhaps for them the reality is so harsh that they do not see a way out nor see their profession as being part of a meaningful solution. When ideology has been combined with science and praxis (and external support), new developments have taken place, for example, in Rio Negro in Argentina, Santos in Brazil, Lanus in Argentina, Curundu in Panama.

Dr. Itzhak Levav (mental health adviser to Ministry of Health Israel; former WHO Regional Mental Health Adviser Americas Region).

Extracted from “Expert opinion on barriers and facilitating factors for the implementation of existing mental health knowledge in mental health services, World Health Organization, Geneva 2007.