

Where There Is No Psychiatrist

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2nd Edition
Frontmatter
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*To Abebaw, William and Abraham
To Gauri and Farai*

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Second edition

Vikram Patel and Charlotte Hanlon

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Preface

There is no health without mental health! Even though mental health and physical health go hand in hand, in reality the focus for most health workers is mainly on physical health. In recent years, there has been growing awareness about the burden of mental health problems, from relatively mild and short-lived states of distress, to more severe clinical disorders and disabilities which can last for long periods. Mental health problems are common, occurring in all societies and in all social classes, and across the life course. They are particularly common in certain groups of people, for example, those attending primary health care facilities, people with chronic physical health problems (e.g. HIV, diabetes), pregnant and post-natal women, and people who have been exposed to conflict or violence. All can benefit from interventions which can be delivered by general health workers equipped with the necessary knowledge and skills and, where possible, supported by mental health specialists.

Mental health is a basic aspect of care for all health workers. It is essential that, just as with physical illnesses, the health worker is well informed about how to detect mental health problems and how to help people recover. It is with this goal in mind that this manual has been written.

Who is the manual for?

This manual has been written to meet the needs of the general health worker. This broad term includes anyone who works in a health care or community setting, and is not specially trained to work with persons with mental health problems. Thus, the manual can be used by the community health worker, the primary care nurse, the midwife, the social worker and the family doctor. This diverse group will have different levels of training and skills. However, they all often have in

common a low level of awareness about mental health problems and their treatments.

Where will this manual be most useful?

Given that all societies face similar mental health problems, the manual should be of use anywhere in the world. But the manual has been designed specifically to meet the needs of health workers in low- and middle-income countries and in low-resourced settings of high-income countries. Even though this scope includes nations and societies which are very diverse, there are many features that they share which make this manual applicable to them all. These settings are characterised by relatively few mental health workers and higher levels of social disadvantage. The few mental health specialists who are available are mostly based in cities and spend most of their time caring for those with severe mental disorders in psychiatric institutions or private practices.

The vast majority of common mental health and substance use problems are not seen in specialist settings. Further, most care is restricted to the clinics, with no continuing care in the community, and psychosocial interventions are rarely available. It is obvious that mental health specialists cannot even remotely achieve the goal of providing mental health care for all (and this is true for all settings globally). On the other hand, many countries have large numbers of general health workers and medical practitioners who are at the actual frontline of mental health care.

We have also sought to make this manual applicable in different social and cultural contexts. The theories that underlie psychiatry and other mental health disciplines are deeply rooted in European and North American cultures and in the experiences of mental health specialists working in hospitals. This has had a profound effect on what

mental health problems are called and how they are recognised and managed in the routine care settings in diverse cultural and social contexts. Rather than take a top-down, medical diagnosis-based approach, in this manual we have taken a person-centred, symptom-based approach to mental health care.

The approach taken in this manual

In order to make training on mental health problems practical and useful, there is a need to adopt a more clinically relevant, problem-based approach. The current ICD-10 classification devised by the World Health Organization (which will soon be replaced by ICD-11) is an example of how complicated we have made the diagnosis of mental health problems. Even the primary care version has 24 categories of psychiatric disorder, which are often very difficult to diagnose and distinguish in routine health care. The problem-oriented approach that we have taken in this manual is to begin with clinical presentations which have a mental health component and then to describe how to deal with these problems. The problem-solving-based approach emphasises the experiences of the person with a mental health problem rather than a medical diagnosis. Another approach taken in the manual is to describe the relevant mental health problems as they arise in specific health care contexts. Health workers may often find themselves working in a specialist setting, such as a reproductive health clinic. What are the mental health problems relevant to this setting? These problem- and setting-oriented approaches are two key deviations from the traditional approach to writing manuals on mental health for general health workers.

How does this edition build on the first edition?

The first edition of this manual was written more than 15 years ago. There have been tremendous advances in our knowledge of how mental health problems can be detected and cared for

by general health workers since then. This second edition has been significantly revised in a number of key ways.

- Treatment recommendations have been aligned with the World Health Organization mental health Gap Action Programme (mhGAP) evidence-based guidelines.
- A new section covers core skills for mental health care which are relevant to all health care encounters.
- Expanded chapters provide step-by-step advice on brief counselling and social interventions that general health workers can provide for a range of mental health problems.
- A strengthened focus on the person-centred approach: how to support recovery of the whole person and promote social inclusion.
- Elven flow charts for emergency management of mental health crises.
- Updated and expanded coverage of clinical problems, with new sections on eating disorders, internet addiction, bipolar disorder and autism spectrum disorders.
- The topic of integrating mental health is aligned with the concept of ‘platforms of care’, i.e. the different settings (e.g. health care, schools) for the delivery of mental health interventions.
- An expanded team of experts to ensure that the manual is providing the most relevant and effective advice across more conditions and settings.

How to use this manual

The manual is divided into five parts. It is important that readers familiarise themselves with Part 1 before reading the other parts. This is because much of the rest of the manual requires an understanding of the basic concepts presented in Part 1. Part 5 contains a guide on medications, a glossary of terms for mental health problems and symptoms, and information on local resources. Throughout the manual, use is made of crossreferencing with other sections. External resources used in writing the manual are listed in Part 5.

A final word

We have tried to communicate complex issues in everyday language, with the goal of being able to demonstrate the diversity of mental health problems and their prevention and management in routine care settings in an accessible style. Inevitably, some readers may find the manual too simple, while others may find it too complex.

We only hope that most find it easy to use in their day-to-day work. We welcome comments on how to improve the manual and ensure that future editions can reach out to more users around the world.

*Vikram Patel and Charlotte Hanlon
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Foreword

If the numbers of us who will one day experience one of the conditions classed under the broad rubric of mental illness are substantial, and a majority of families are likely to be affected, then the truly staggering number is how few in need will receive much in the way of help from professionals trained to provide it. *Where There Is No Psychiatrist* summarises this grim maths, as do hundreds of studies of communities, counties, countries, and continents. That's one reason the book deserves ubiquity more than any others that have come along in recent years. (Even Antarctica's tiny and snowed-in population could use a shelf-full of copies.)

But *Where There Is No Psychiatrist* is anything but grim, and for three reasons.

First, it is, like its earlier edition, an admirably concise overview of what might be done to respond to common mental disorders, and also to the even more common disorders of everyday life: disturbing behaviour, prolonged sadness and grief, addiction, abuse. This doesn't sound like a cheerful list, and it's not, but the reason the book isn't grim is that it underlines just how much can be done to ease suffering, fear, and stigma. Not all, perhaps not even most, of the afflictions classed as mental illness require pharmaceutical interventions, and this new edition has been updated to reflect the best evidence gathered over the past few decades about both pharmacotherapy and non-pharmaceutical interventions. *Where There Is No Psychiatrist* not only avoids jargon, it also eschews the partisan debates that have riven academic psychiatry for a century, in part by drawing on evidence and experience from around the world. The fact that both authors are psychiatrists and social scientists is clear in these pages, as in their other work, but this book is not promoting cultural competence so much as cultural humility. (A watered-down *Diagnostic and Statistical Manual of Mental Disorders* this is not.)

In an inviting, rather than a hectoring, tone, this volume serves to remind the reader that social context shapes symptoms, illness experience, and outcomes. Although these are well-recognised facts in American and European psychiatry, clinic- or hospital-based practitioners often forget that one person's serious mental illness causes social suffering within families and social networks. Here, too, this manual is a model of pragmatism and inviting erudition, since the authors' own experience has shown that acknowledging this daunting fact, and working with community health workers and households, is one way to improve outcomes even if formally trained clinicians remain office-bound. It is not too much to ask that this be required reading for their fellow psychiatrists, who are likely to learn a good deal about psychopharmacology and proper case management, too.

A second and related reason this manual on a gruelling topic isn't grim is that it dispenses with the social fiction that psychiatrists alone are fighting a lonely and hopeless battle for individuals with mental illness. *Where There Is No Psychiatrist* validates the efforts of the many others who wage a lonely battle – sometimes lonely because they enjoy little in the way of material or moral support from credentialled health professionals. Barefoot doctors, medicine men and women, traditional healers of every stripe, diviners, clerics, concerned citizen activists, community health workers, home health aides, allied health professionals, and above all family members – all have faced the dilemmas addressed squarely in this useful and inspiring book. What people in distress and their families are after is effective care and expert mercy. Since they so rarely find these, they are usually obliged to manage on their own,

with the help of a diverse group of caregivers and diagnosticians classed under the term ‘traditional healers’. It is in part this professional abandonment, rather than some inherent cruelty native to poor families living in the clinical desert, that leads them to lock-up or chain family members who suffer psychosis or other disturbances frightening to them and to their neighbours.

And that is why this book should be in the hands, or on the screens, of millions of people asking the questions that serious mental illness invariably sparks among those affected most directly: What is happening to my child, parent or friend? What is likely to happen next? What can be done? Is this incurable? Where does it come from? Who can help my son, daughter, parent or friend? What is the best treatment? How will we pay for it? Admittedly, other questions rise to the fore, including the famous, ‘Is this person a danger to self or others?’ That important query leads, often, to efforts to restrain or extrude the erratic or violent, a minority of those afflicted with mental disorder. But those who live in places where there are no psychiatrists know that many more people, especially family members, are likely to ask the most common question: What can I do to help?

Patel and Hanlon did not call their book *Where We Need No Psychiatrist*. But the guild mentality of credentialled health professionals does not help. The problem the manual addresses – how to help people facing the world’s most prevalent condition, major mental illness – has not, however, been addressed squarely by the medical profession, including those who specialise in providing mental health services. In what are these days termed resource-poor settings, they cannot, because there are so few of them. Nurse practitioners and others with the power to prescribe cannot help in rural areas, since they are not present there either. (The desire to proliferate a series of books with titles like *Where There Is No Nurse Practitioner* is unlikely to improve matters much for the rural poor, or for the urban poor locked out of nearby services by user fees, co-pays, and the usurious cost of branded pharmaceuticals.)

Nor are social workers, psychologists or other credentialled professionals around to address a long list of eminently addressable afflictions that one encounters in places like rural Haiti, where I

have had the good fortune to work since 1983. If they had been there once, they were gone by then, when there were more Haitian psychiatrists in the city of Montreal, for example, than in all of Haiti. We need more of them, but how long do we think it will take to see enough psychiatrists able and willing to address the mental health problems of the poor and underserved? Even at a more rapid clip than now registered, even optimists respond in terms of centuries. To extend this metaphor, the entire world is a clinical desert when we take the trouble, as Patel and Hanlon and their colleagues do, to survey it from the point of view of the poor who suffer major mental illness and families who suffer along with them.

The fact that *Where There Is No Psychiatrist* can help us water the clinical desert is the third reason it is an uplifting volume and pragmatic guide to action. Although colonial-era distinctions regarding aetiology continue to hold sway today – the bright line between communicable and non-communicable illnesses remains problematic and unquestioned – aetiology of affliction is not always as important as its chronicity, associated stigma, access to community-based care and insurance, and social suffering. In the rural reaches of Haiti and Rwanda, where (along with Harvard teaching hospitals) I have spent much of my professional career, diabetes, hypertension, HIV disease, tuberculosis, and severe asthma join major mental illness as a series of afflictions of varied aetiology but similar and grim outcomes without the sort of interventions Patel and Hanlon advocate in this manual. These were, until recently, clinical deserts, but are much less so now than 20 years ago. This is in part because of the recognition that community-based care in such settings is not only feasible but is the highest standard of care, even where there are infectious disease doctors, endocrinologists, pulmonologists, and the like on hand. As far as AIDS goes, some of the outcomes in Haiti and Rwanda are far better than in American cities.

The problems addressed in *Where There Is No Psychiatrist* are not seen only in rural backwaters, nor with chronic disease alone. If parts of Chicago,

the third largest city in the USA, can reasonably be called a ‘trauma desert’ due to the lack of a trauma centre, imagine what it is like for someone with acute psychosis in the vast and uneven metropolis that is Calcutta in India. This implementation gap is profound when we leave the affluent world for places of poverty.

One illustration of the ‘know-do’ gap – and the cost of ignoring the obstacles posed by a lack of insurance and a lack of community-based care – comes from a Kenyan colleague, a neurologist reporting not from a rural village far from a medical centre (and far from paved roads, electricity, a reliable pharmacy, to say nothing of physicians) but from a neurology clinic in Kenya’s capital. Nairobi, a bustling city replete with traffic jams and tall buildings, does boast the amenities of a modern city for those who can afford them. In a series of patients already diagnosed with epilepsy and for whom anti-seizure medications had been prescribed and, by report, dispensed, our colleague found that none of these patients had therapeutic levels of anti-seizure medication, and in no instance was a suprathreshold level registered. They were underdosed, if dosed at all. Most patients in this referral clinic had no trace of such agents in their peripheral blood: this among patients already diagnosed and living in, or able to present to, a big-city subspecialty clinic in East Africa’s most sophisticated city. For some decades now, similar studies were published in analyses of adherence to antihypertensive and antituberculous regimens in countries rich and poor.

Even though we know how to diagnose and treat epilepsy and chronic mental illness (and most other chronic afflictions), if we refuse to apply the lessons of *Where There Is No Psychiatrist* to the delivery of therapy in settings of poverty, a know-do gap can occur. Working with local partners to develop health care systems able to manage both acute and chronic disease suggests that we can improve delivery systems in ways that help bring about sharp declines in mortality and morbidity. It is also true that some experience in such settings might plausibly inform the transformation of American health care, which is increasingly deemed urgent. Whether this is termed ‘reverse’ or ‘frugal’ innovation, *Where There Is No Psychiatrist* advances the case both for optimism

and for greater investments in understanding and improving health care delivery. Although some of the best examples involve introducing and then improving care for chronic infectious disease, it is clear from this manual that this approach has implications across the globe and for other chronic afflictions (often classed as non-communicable) and sequelae increasingly recognised as the leading causes of premature death and disability in settings rich and poor.

The earthquake that levelled much of Haiti’s capital city in 2010 remains one of the most personally traumatic events of my life. But everyone who has worked in the clinical desert has stories of trauma. I refer not just to that experienced in war or in allegedly natural disasters like earthquakes or tsunamis. I refer to the experience of not having a book like this one when faced with patients, friends and colleagues who fall ill with psychosis, depression, or who are stricken with delirium or confusion. What too often follows is our own confusion about what to do.

If I may be permitted to illustrate from painful personal experience in rural Haiti, I will close with a story that might have been a lot less grim if we had had the advice laid out in *Where There Is No Psychiatrist* available to us. In our first few years of a health survey conducted in Haiti’s Central Plateau the late 1980s, we lost three of our close friends and co-workers. That was almost half the team working on the survey. All of them were just as enthusiastic as I was about introducing health services to this region; not one lived to see 30.

Acephie died of cerebral malaria, misdiagnosed as a psychotic break. She perished sitting in a psychiatrist’s waiting room. That meant she had travelled hours to the capital city, since that is the only place where there was one. Michelet was felled by typhoid fever, complicated by severe neurological symptoms, which were attributed by his family to sorcery after a short course of antimalarials failed to drop his fever. His illness was then complicated by an ileal perforation: microbes ate through his small intestine. He was taken too late to the operating room, and died in a busy referral hospital – again in far-off Port-au-Prince

– writhing in pain and fear while waiting for surgery. Marie-Thérèse, who everyone called Ti Tap, had classic bipolar disorder. When in a prolonged manic phase, she was sexually abused several times and was soon pregnant. She died of puerperal sepsis days after delivering a baby boy. The disease has been rare in places like Boston ever since doctors and midwives learned to wash their hands properly before and after each delivery, and almost never registered in such settings after the advent of modern infection control and antibiotics. In every sense, three pre-modern, premature deaths.

There is no health without mental health, and it is the job of all of us to ease the suffering caused by mental illness, which tops the list of causes of excess morbidity in most studies of the global burden of disease. It is the job of all of us to fight for the dignity of those afflicted, and against stigma, by altering the course and consequences of these common disorders. To close, allow me to note that it is hard to imagine the words, life-saving and book in the same sentence. But it is no hyperbole to argue that you will be reading one of these rare treasures upon turning the page.

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