

Sub-specialties in psychiatry in Africa – Intellectual disability

The recognition of psychiatric sub-specialties has been acknowledged and the importance of achieving parity for mental health in medical training, service provision and research stressed.^{1,2} Psychiatry has in the past suffered from relative neglect associated with the stigmatisation of mental illness. Within psychiatry there has been additional neglect and more severe stigmatisation of intellectual disability (ID). It is time to review the history and current status of and the associated challenges facing ID in Africa and to plan for the future. Njenga³ and Adnams⁴ have reviewed the epidemiology, policies and services for children and adults with intellectual disability in Africa and South Africa respectively.

In Europe and North America during the 1800s the solution to the 'problem' of ID was felt to be the establishment of large institutions that admitted people of all ages and aimed at creating self-contained and self-supporting colonies. Residents were segregated from the general public in custodial care so that they could be protected from exploitation. After World War II, there was a substantial shift in emphasis, with the establishment of the principle of normalisation, first proposed in Denmark in 1959. This was based on the questioning of the idea that ID was a static, life-long condition requiring institutionalisation. In contrast, a dynamic approach to service provision, creating an existence as close to normal as possible, in the community was envisaged. The normalisation principle led to the process of deinstitutionalisation. In Africa the practice of custodial care in institutions with subsequent deinstitutionalisation was largely bypassed. Some institutions were established, mainly to cater for a few, largely urban populations, but in villages, most care for people with ID was given by families. Most large South African cities had institutions and these were managed within the Apartheid structure. The process of deinstitutionalisation was introduced during the 1990s and it was proposed that hospital care would be seen as a component of regional and district comprehensive management with treatment in hospital focused on management of psychiatric disorders in ID.⁵ The large scale urban migration taking place in Africa has put strains on families and this factor coupled with a lag in development or implementation of policies and plans, has resulted in a severe shortage of services for people with ID.

In South Africa, since the 1970s, Vera Grover was a driving force in the field of ID. She was for many years on the South African National Council for Mental Health, and a Past President and Honorary Life President of the Council for Mental Health. She was also founder of the Division for Mental Handicap within the National Council and Chair of this Division until 1980. One of her goals was to establish a Chair in Mental Handicap at the University of Cape Town. She achieved this and endowed the first chair in ID at the University of Cape Town in 1990. The decision to locate the Chair in the Department of Psychiatry emphasised the role that psychiatry should play in promoting teaching and research in this area.

The need for a specialised qualification

ID, which has a heterogeneous etiology, from genetic disorders to childhood infectious diseases, affects 2 – 3% of people across the lifespan. Persons with ID have a greater prevalence of both general health and mental health problems than the general population. The recognition of psychopathology or dual diagnosis in people with ID emphasises the need for informed psychiatric treatment. It is reported that between one-third and two-thirds of people with ID in representative community samples have significant degrees of psychopathology⁶ and from 8% to 15%, serious psychiatric disorders.⁷ The diagnosis of psychiatric illness, especially schizophrenia, is difficult particularly in people with severe and profound ID. Psychotropic medications are widely used and frequently misused.⁸ These medications are often prescribed for symptom control rather than for psychiatric disorders. Barbiturates and benzodiazepines are commonly used leading to serious impairment of cognitive function. In many parts of East Africa barbiturates are the only available sedatives and their use, particularly in school going children, impairs their already reduced learning capacity.

Although ID contributes significantly to the global burden of disease, African countries included, throughout Africa specialised health care knowledge, training and service provision has lagged significantly behind that of other health areas, resulting in a further marginalised sector with unmet or poorly met health and other needs. The profile of ID in Africa is unique and cuts across areas of major public health importance, including HIV/AIDS, and in South Africa, substance abuse. Because of the interface between health and mental health in ID, the health care of persons with ID requires comprehensive management of often complex and long term multi-system and multiply disabling conditions, including medical (such as epilepsy), psychiatric and behavioural disorders. This requires knowledge of how medical conditions may affect behaviour and mental health in ID, how psychiatric illness manifests in ID as well as the ability to function in a multi-disciplinary team. It is now recognised that specialised training is required to acquire these skills. Postgraduate programmes for professionals working and studying in the field of intellectual disability have been established in the U.K., Europe, and the USA, with most established programmes having a strong mental health component or falling within the realm of mental health. There is currently one postgraduate ID health and mental health programme offered in South Africa, but no programmes exist in other countries in the African continent. Establishment of post-graduate training programmes would not only address deficits in specialised health care delivery, but would also be a step towards addressing the human rights need of equity in health care for people with ID, as enshrined in the United Nations Convention on the Rights of Disabled Persons, and of which many African

countries, including South Africa, are signatories.

We believe that ID in Africa should move towards a community based, comprehensive, regional approach, where primary care is available to all and referral to tertiary services occurs within an integrated health system. Tertiary mental health care, both inpatient and outpatient, would be required for management of severe psychopathology by a transdisciplinary team. Evidence based management at all levels should take place with patient care provided by trained medical, nursing and other multidisciplinary professional staff. Psychotherapy, supported by psychosocial rehabilitation should be directed towards the re-introduction of the patient back into the family and community when well. Integrated policies and planning, communication and consultation between primary, secondary and tertiary care are essential. This model of care can be achieved through training of sub-specialists in ID who work within a multidisciplinary team.

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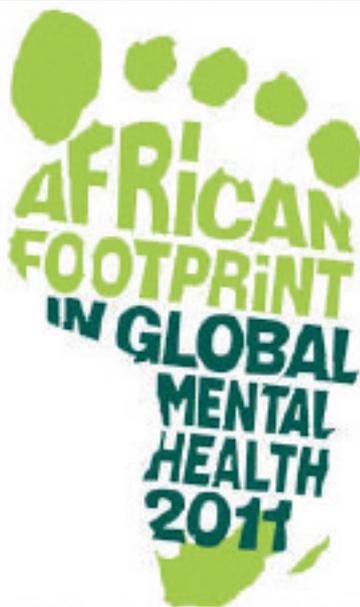
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