Mental health care in Kuwait: towards a community-based decentralized approach.

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Published in 2000 and drawing on community-based epidemiological studies, the World Health Organization's Consortium in Psychiatric Epidemiology estimated the rates of the lifetime prevalence of mental disorders among adults to range between 12.2% and 48.6% worldwide (WHO, 2000). Thereafter, in 2001, the WHO estimated that approximately 450 million individuals worldwide have suffered from neuropsychiatric disorders in their lifetime (WHO, 2001). More recently, the WHO's 2011 World Report on Disability estimated that of the 1 billion people worldwide afflicted with a disabling condition, the causes for 60% of those affected (approximately 600 million people, or ~10% of the world's population) can be linked to mental health issues, neurological conditions, and substance abuse problems (WHO, 2011a). These reports highlighted the significant contribution of mental health issues to the global socioeconomic burden of diseases, and urged for a scaling up of mental services worldwide with a focus on countries suffering from treatment gaps in mental health care.

The socioeconomic impact of mental health afflictions is recapitulated by contemporaneous systemic analyses of the burden of mental and behavioral disorders, which estimate that nearly 25% of the total global burden of disease can be attributed to mental health issues, making them the single biggest contributor to the global burden of disease, ahead of both cardiovascular disease and cancer *combined* (Whiteford et al., 2013). Furthermore, the WHO's Global Action Plan for the prevention and control of non-communicable diseases (WHO, 2013a) now estimates that by the year 2030, depression will be the leading contributor to years lived with a disability. Based on the high worldwide incidence of mental health disorders and its projected impact on socioeconomic development in the near-future, the provision of adequate mental health care to all affected individuals has garnered a long-overdue increase in attention, both in terms of epidemiological analyses (Baxter et al., 2013), and editorials on global mental health policy (Votruba et al., 2014; Eaton et al., 2014). Globally speaking, economic factors particular to low- and middle-income countries, as well as geopolitical factors such as war, political instability, and social inequity , can not only increase the regional incidence and burden of mental health disorders, but also tend to correlate with poor access to mental health care due to a lack of the human, infrastructural , and financial resources required for its sustainable provision (WEF, 2011; WHO, 2013b). As a result of this mental health care treatment gap, the vast majority of those suffering from mental health issues in socioeconomically vulnerable regions do not receive adequate treatment for their conditions. With respect to government spending, low-income countries typically spend ~0.5% of their already limited health budget (WHO, 2011b), resulting in deplorably low access rates (~10% of those affected receive treatment) to mental health care services (Wang et al., 2007). In fact, in some regions, mental health care services may themselves be unavailable, or based in large metropolises and therefore potentially inaccessible to rural populations. In addition to the contribution of economic factors, the treatment gap is also a byproduct of sociological phenomenon, and additionally requires a human rights-based approach. People suffering from mental health issues and behavioral disorders are often stigmatized, discriminated against, socially marginalized, and in extreme cases, subject to bondage, isolation, or unwarranted institutionalization. The social/cultural stigma associated with mental health disorders is particularly deeply rooted in the Arab World, where economic and

governmental mandates must be complemented by social and cultural initiatives aimed at changing pervading attitudes and reducing stigmatization.

The state of mental health care in the Arab world

Due to various combinations of geopolitical, economic, cultural, and religious factors, nations within the Arab world have been recognized as being particularly susceptible to the socioeconomic impact of mental health disorders. In 1997, the Islamic Organization for Medical Science (IOMS), in association with the WHO, organized a conference in Kuwait in order to address mental health legislation in accordance and compliance with the traditions of Islamic law, with the aim of applying WHO guidelines in the promotion of human rights for persons with mental disorders in the Arab world (WHO, 1996). In all Arab countries, health services are primarily provided by the public government sector, although private services and non-governmental organizations (NGOs) have emerged as important contributors to the provision of health care, particularly in countries rife with internal instability. Although the vast majority of the nations of the Arab world have agreed in principle to the integration of mental health care into the primary health care delivery system, its implementation over the past 2 decades has thus far been limited, and remains insufficient (Okasha and Karam, 1998; Okasha et al., 2012).

In recognition of the global relevance of mental health and the urgent need to scale up mental health services in vulnerable regions, the WHO and its partners have developed the Mental Health Gap Action Program (mhGAP) with the aims of improving detection, diagnosis, treatment, care, and rehabilitation, as well as establishing training and education programs for the purpose of capacity building. In accordance with this action plan, an emphasis is being place on decentralization, and psychiatric services which had previously been confined to centralized hospitals are gradually being shifted to the psychiatric units of general and/or district hospitals. Encouragingly, in Jordan, which was selected as one of four countries in the first wave of mhGAP implementation, decentralization has been taken one step further, whereby psychiatric services are being provided at peripheral community-based mental health centers. Although differences do exist (particularly with respect to national gross domestic product), the mhGAP initiatives implemented in Jordan can be also be applied to GCC countries, and the particular case of Kuwait is the subject of the remainder of this article.

Mental health care in Kuwait: Progress, shortcomings, challenges, and recommendations

The State of Kuwait, whose major source of national income is derived from the petroleum industry, has a population of approximately 2.74 million. According to estimates from the International Monetary Fund (IMF), the World Bank (WB), and the United Nations, Kuwait has a gross domestic product (GDP) of ~$170-$180 billion US dollars (ranking an average of 56 out of 193 countries), approximately half of which is ascribed to revenues derived from crude oil reserves, representing 95% of export revenues and 80% of government income. Furthermore, a per capita GDP of ~$75,000 US dollars currently ranks Kuwait an average of 4th among 187 countries analyzed by the IMF and the WB. As a relatively high-income country, Kuwait boasts one of the most modern health care infrastructures in the Arab world. Most health care services are provided by the public sector, access to which is safeguarded

by mandatory and nationally instituted health insurance. According to Kuwait's Ministry of Health (2013) and the WHO (2014), there are currently 92 primary health care centers which allow access to general practitioners, maternal and child care services, dental services, as well as routine laboratory tests and imaging facilities. Secondary health care, which includes, among other services, internal medicine, general surgery, and psychiatry, is provided by six general hospitals covering Kuwait's six governorates, while tertiary care is provided by specialized centers and hospitals, including the Hospital for Psychiatric Medicine (KMH, 2013).

Although dedicated mental health legislation is not currently in place and mental health care expenditures by Kuwait's Ministry of Health are not currently available, an officially approved mental health policy does exist (WHO, 2011c). This policy, however, does not permit primary health care nurses, who mostly lack official in-service training, to independently diagnose and treat mental health-related issues within the primary health care system, while primary health care doctors, though capable of prescribing psychotherapeutic drugs (with restrictions), have mostly rudimentary training in the field of mental health. Furthermore, officially approved manuals on the diagnosis and treatment of mental health disorders are not available in the majority of primary health care clinics. As such, psychiatric services at the secondary and tertiary levels of the health care system, referral procedures for which are currently in place, are disproportionately relied upon for the provision mental health care. The main provider of mental health services in Kuwait is the Hospital for Psychological Medicine (now called the Kuwait Center for Mental Health), and the centralization of mental health care provision away from community-based primary health care centers into a specialized (tertiary) hospital has resulted in the severe stigmatization (both public and self-directed)of treatment-seeking amongst the Kuwaiti population (Almazeedi and Alsuwaidan, 2014; Scull et al., 2014). For example, foreign workers and expatriates suffering from depression due to cultural alienation or homesickness, or Kuwaitis suffering from anxiety caused by domestic/familial difficulties or crises, when faced with the inadequacy of primary health care centers for consultation and treatment, may refrain from seeking medical treatment altogether rather than face the embarrassment of admittance into the Hospital for Psychiatric Medicine.

The resulting treatment gap can have a significant impact on the socioeconomic state of Kuwait. Expatriates and foreign workers have accounted for no less than 55% of the Kuwait population in the last four decades (KMH, 2013), and provide approximately 80% of Kuwait's workforce (WHO, 2006). Considering the aforementioned contribution of mental health illnesses to the global socioeconomic burden of diseases, the impact of disability due to mental health issues can have dire consequences on Kuwait's largely foreign worker-based economy. Kuwaiti nationals, as with all Arab cultures, are characterized by their integration of familial and societal value systems, whereby the autonomy of an individual is relegated to the service of larger cultural units. As a result, societal perception is the primary consideration of an individual's behavior towards his peers, and accordingly, the impact of perceived shame extends to afflicted individual's family and kin. The consequences of the stigmatization of mental health service users can be far-reaching, including discrimination in employment and education, social isolation, damaged marriage prospects or divorce. The factors are further exacerbated by a general distrust in mental health services, including reports of unethical treatment, breaches of confidentiality, and inadequate qualification/incompetence (Scull et al., 2014; and references therein).

As a result of the inadequacy of the primary health care sector for the provision of mental health care, and the general aversion to admittance to specialized psychiatric care hospitals for treatment, existing mental health services are underutilized, and help is often sought from family members, community leaders, and religious leaders, who are not bound to the mental health care standards set by the WHO. Based on the Ministry of Health's mental health policy, the mental health plan (revised in 2010) mandates a shift of mental health services (manpower and resources) from the secondary and tertiary levels of health care to community-based facilities, and their integration into the primary level of health care (WHO 2011c).

In a report on his time spent as the Medical Director of an expatriate team contracted in 1996 for the development of quality improvements in the provision of mental health services in Kuwait, Rod Bale (2000) identified the dearth of social workers as a serious deficiency, recapitulating the conclusions of John Racy (1970), who thirty years earlier, had reported an acute need for professional staff in all mental health care categories, with social workers representing the highest priority. Forty five years after his prescription, mental health professionals remain understaffed in Kuwait, with 2.62 psychiatrists/100,000, 2.29 psychologists/100,00, and most alarmingly, 0.66 social workers/100,000 (WHO, 2011c), a figure only marginally higher than the 0.4/100,000 reported in 1998 (Okasha et al., 1998) and in 2007 (Okasha et al., 2012). In conclusion, we support the recent initiatives for the integration of mental health services into the primary health care sector, its coordination to general health care provision, and the establishment of mental health legislation ensuring the confidentiality and privacy of those seeking mental health care. It is also our view that a significant increase in the number of social workers in community-based primary health care centers would increase treatment-seeking, thereby reducing the treatment gap, while alleviating stigmatization of treatment-seekers through the decentralization of provisional mental health care.

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