
UNIT 1 MENTAL HEALTH SERVICES IN THE COMMUNITY, WITH SPECIAL REFERENCE TO INDIA

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1.0 INTRODUCTION

The World Health Organization (1948) defines health as “a state of complete physical, mental and social well being and not merely an absence of disease or infirmity”. And recently ‘the ability to lead a socially and economically productive life’ has also been included in the above statement. Thus, in addition to being physically and mentally healthy, a person also has to be ‘socially’ healthy. He/she has to be productive in the society. Hence, the role of a person in the community is very much important for his/her overall health status.

From the perspective of mental illness, in the past, asylums were the place where the mentally ill people were kept and treated. Later on, these gave away to mental hospitals. However due to various reasons, it was seen that while a large number of people suffering from mental illness was increasing, the treatment facilities and the availability of specialists in the field of mental health were very less. Even less developed was the availability of treatment for the people with mental illness at the community level. Thus, a branch of Psychiatry relating to the treatment and care of the patient in the community level was the need of the hour. Needless to say, the era of “community mental health” had begun, albeit a bit tediously.

Community mental health, in very broad and simple terms, refers to the care and services provided to persons with mental health problems and their families in community settings. In developing countries such as India, community settings would include a person's home, large joint family setting, a general practitioner's clinic, a government run Primary Health Centre, Community Health Centre or a District Hospital, a non-hospital residential facility such as a Half-Way Home or hostel run by NGO, a private Psychiatrist's office/clinic, a counselling centre or a rehabilitation centre in a community location running day programs and providing a range of other community based services.

1.1 OBJECTIVES

After studying this unit, you will be able to:

- explain the history of community mental health in India;
- describe the different community mental health models that are in use in India;
- discuss why there is a need to treat some mental illnesses in the community;
- be able to identify the common mental illness and treat them in a community setting; and
- explain the present scenario in the field of community mental health in India including the District Mental Health Programme.

1.2 HISTORY OF COMMUNITY MENTAL HEALTH IN INDIA

Mental illnesses have been documented since earlier times. In India, 'Ayurveda' did deal with mental illness and the practice of Psychiatry was known as 'Bhoot Vidya'. Later on during the era of British colonization, mental asylums came into being which eventually gave away to the mental hospitals of the present time.

After India gained its independence, the entire health system underwent a massive revamp following the suggestions of the 'Bhore Committee (1946)'. However in the field of mental health, little progress was made. There was hardly any community based intervention for people with mental illness. Initially family involvement was the only aspect of treatment and care, so far as community involvement was concerned. Such involvement of family members can be traced back to 1920 when cottages were constructed in the Central Institute of Psychiatry, Ranchi (presently) wherein patients would be admitted along with family members. Post-independence, family involvement started in 1950s (Carstairs, 1974; Srinivasa Murthy, 2007; Vidya Sagar, 1973). Mention must be made about Dr. Vidya Sagar who started his innovative 'camp approach' wherein families were also involved in the treatment and care of the mentally ill. He put up tents within the hospital premises and requested the relatives of the patient to stay there and take care of the patient there. This also led to the setting up of general hospital psychiatric beds. 1975 saw the integration of mental health with general health services, which was called as community psychiatry initiative, and was employed to enhance and develop mental health services.

Self Assessment Questions 1

- 1) Describe the contributions of Dr. Vidya Sagar.

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1.3 COMMUNITY MENTAL HEALTH

In certain acute cases of mental illness or its aggravation, hospitalisation is often the rule. Apart from these circumstances, in a number of situation, treatment is possible in the community settings too. This section explores some of the models of community mental health care in our country.

1.3.1 Community Mental Health Models

Integration of mental health into primary health care: Two landmark studies conducted at two different places in India demonstrated that mental health can be integrated with primary health care (Murthy and Wig, 1983; Wig et al, 1981). This in a way led to the development of the National Mental Health Program (NMHP) in 1982. The goal of NMHP was to integrate mental health services into primary care. As a result of initiation of NMHP, the District Mental Health Program (DMHP) was started following the success of Bellary district (in Karnataka). The DMHP is currently implemented in 123 districts and there is a plan to extend it to all the districts in the 12th Five Year Plan. In addition to convenience and feasibility, another guiding principle for integration of mental health into primary health care is the fact that 10 to 25% of those attending primary care have some form of psychiatric disorder (Cohen, 2001; Patel et al, 1998).

Initially it was decided that after brief training of primary health care staff, the mental health cases would be taken up by the staff of Primary Health Centers (PHC). However due to several reasons, like heavy work load of medical and surgical cases, implementation of other mental health programs etc, the government decided to support manpower through the DMHP. Presently, the DMHP has a multi -disciplinary team comprising of Psychiatrist, Clinical Psychologist, social-worker, a nurse and a clerk.

Advantages of integration of mental health into primary health care are:

- a) An alternate treatment facility for people with mental illness that is accessible.
- b) Increase in the number of trained manpower in the field of mental health.
- c) Reduction in stigma as a result of shifting mental health care to the primary care.
- d) Leads to improvement in early detection and treatment.
- e) Results in cost efficiency and savings.
- f) In a way it counterbalances the limitations of mental health resources through the use of community resources.

Treatment through the DMHP was provided for a number of disorders like psychosis, affective disorders, anxiety spectrum disorders, epilepsy, and child mental health problems and so on. Some of the medicines were also provided free of cost to the patients.

Progress and short-comings: During the mid-course evaluation of the DMHPs in 27 districts in 2003 by a team of experts from NIMHANS, it was reported that the program was functioning at different levels of efficiency contributing to different levels of outcome. Many of the DMHP in most states had shown satisfactory progress at various stages of implementation. On the flip side, though there is a provision for the training of community leaders under DMHP, community participation is minimal. There is a need for linkages with the community through the training of ANMs(Auxiliary Nurse Midwifery), ASHA (Accredited Social Health Activist) and PHC (Primary Health centre) level paramedical staff and ensuring involvement of the family members and the community. The services at sub-center, PHC, CHC (Community Health Centre) level also need to be strengthened and made more accessible to the patients.

Satellite Clinics (or Out-reach Clinics): Some teaching hospitals in India have established out-patient treatment services to reach out to patients who cannot reach hospital based facilities. Often such services are provided by professionals (Psychiatrist, Clinical Psychologist, Social Worker, Nurse) from the teaching hospitals, who have additional responsibility of teaching, clinical care of the patients in the hospitals and research. Most such satellite clinic functions once a week. Some Institute also provides once a month treatment.

Ideally, for a satellite clinic to be successful:

- a) It must be located in a health set up like Dispensary, PHCs etc.
- b) It must have referral arrangements to tertiary centers for emergencies.
- c) The community has to be informed regarding whom and where to seek help after clinic hours.
- d) Linkages must be developed with other mental health care facilities in the community.

The advantages of satellite clinics are as follows:

- a) Early diagnosis and treatment of common mental illness in community settings.
- b) Easy accessibility and reduces stigma on the part of the patient.
- c) Patient discharged from tertiary hospital care can be followed up in the satellite clinic, thus reducing the work load of the tertiary care hospital and at the same time benefitting the service users in terms of reduced travel expenses and reduced waiting period for consultation.

Self Help Group (SHG) and Support Groups: Self Help Groups are voluntary, small groups of persons facing similar problems and they come together for a special purpose. They are usually formed by care givers who come together for mutual assistance in handling a common handicap or life-disrupting problem. The indicators and members of such group perceive that that their needs are not addressed by existing government programs and social institutions. Self Help Groups emphasise face-to-face social interactions and the assumption of personal

responsibility by members. They often provide material assistance as well as emotional support; they are frequently cause oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity.” This definition provided by Katz and Blender (1976) is possibly the most comprehensive definition of Self Help Groups.

From the perspective of Clinical Psychiatry, perhaps one of the well known SHG is the Alcoholic Anonymous (AA). It is a group formed by people who have alcohol related problems and who want to quit alcohol. SHGs are involved in solving the practical problems and psychological sorrows of sufferers (Lock, 1986) and are involved in curative, preventive, promotive, palliative and rehabilitative services (Nayar et al, 2004). SHGs are complementary to medical services and not substitutes to medical treatment (Moeller, 1983). A characteristic of SHG is that their members are simultaneous givers and receivers of help.

Therapeutic Community (TC): The concept of therapeutic community was initiated by Tom Main in 1946 and popularised by Maxwell Jones. It is a residential facility for a variety of disorders like mental illness, substance abuse and even for prisoners. Based on the principles of social learning theory, TC is a tertiary preventive measure to reduce the impact of maladaptive behaviour and enhancing the rehabilitation efforts through the environmental approach (Carson and Butler, 1992).

The TC believes that people can change and that learning occurs through challenge and action, understanding and showing common human experience. The TC model incorporates elements like active participation, membership feedback, role modeling, collective formats for guiding individual change, open communication, individual and group relationships and a unique technology.

In TC working for those with mental illness, involves continuous risk assessment and management, helping client identify unhealthy aspects of their personality and instilling a sense of responsibility in the client (that the harmony of the community depends on him/her). Some TCs like ‘Aatma Shakti Vidyalaya’, Bengaluru, have additionally incorporated methods of transactional analysis (re-parenting) as part of therapy (Kumar and Srinath, 2009).

Crisis Intervention Team (CIT) and Helpline Services: In a community many a times, a person may have acute psychological distress, for example, a depressed person having repeated thought of suicide or an intoxicated person may have acute psychosis. In such emergency cases certain groups of trained persons are available, especially in the developed nations, who provide immediate care and that too at the affected person’s door step. These people form what is known as ‘Crisis Intervention Team’. In developed nations they are a part of the case management approach wherein any required service including non-pharmacological service is provided at all hours of the day. Such CIT may include Psychiatrist / Psychologist, Paramedics and Psychiatric Nurses.

Helpline services are basically the provision of telephone services to assist and guide people regarding health related issues. Helpline programs related to Psychiatry include Suicide Prevention Helpline, Smoking Cessation Helpline, and Child Helpline etc.

Calls to the help lines are initiated by the client and are available round the clock. Helpline services usually offer counseling (psychological first aid) provided either by trained volunteers or by trained psychotherapists in crisis situation. Some helpline centers also follow-up with clients that have called (call-back) to know if further help is required or direct them to appropriate services. Some of the suicide helpline available in India are: Sneha (Chennai), Aasra (Navi Mumbai), Samaritans Sahara (Kolkata), Aasha (Chandigarh).

Out-patient camps: This unique approach was initiated by teams of Psychiatrists from Pune and Miraj in Maharashtra (Deb Sikdar et al.,1976 and Luketuke et al.,1978). These early camp involved case identification and treatment initiation as out patient service.

The Department of Psychiatry, Government Medical College and Hospital, Chandigarh, have been conducting one day camps within Chandigarh for the past 15 years. The approach was basically used for identification of patients and to encourage them to seek treatment at feasible locations. Basically these camps were ‘awareness-cum-motivation’ camps and intervention was limited to the initiation of treatment.

Some of the limitations of out-patient camps are:

- Post-camp patients frequently needed expert advice and consequently had to travel to the base hospital.
- Arranging free medications was not always possible.
- Prescription would not be renewed due to unavailability of the specialist after the camp.
- Significant man hours were lost in seeing non-psychiatric cases who reported to the camp.

Para-institutional Care (Half Way Home and Day Care Centre): A Half Way Home (HWH) is a rehabilitation facility for individuals such as patient with mental illness or substance abusers, who no longer require the complete facilities of a hospital or other institution, but who are not yet prepared to return to their communities. HWH assist persons who have left highly structured institutions to adjust to society in order to re-enter it and live within its own accepted norms. The intervention provided are those that improve skills, improve interpersonal communication and provide vocational training.

School Mental Health: In India, child and adolescent Psychiatry is not very well developed. With 47% of the population of the country below 19 years of age and an estimated prevalence of 15% of psychiatric issues in their population, the treatment gap is huge for Psychiatric services (Malhotra, 2004).

NIMHANS, Bengaluru developed the School Mental Health Program to overcome these service provision deficits. Their model is an integrated one, using resources already available in the schools. Teachers are trained as ‘master trainers’ who further conduct training for other teachers to be ‘life skill teachers’. It is a participative program focusing on experiential and peer learning. The activities are based on various developmental themes of nutrition, hygiene, academics, inter-personal relationships, substance abuse, gender issues, career and social responsibility (Bharath et al., 2008).

Home Based Community Programs (Domiciliary Care): Mental Health programs that deliver mental health services by case management approach at client's door-step may not be envisioned at least for the next few years. However, many institutions in India have attempted this, albeit on an experimental basis, primarily in limited localities and by providing pharmacological treatment only (Chavan et al., 2010; Pai et al., 1985)

While planning for home based treatment options, it is necessary to adequately train the staff involved. Training should include identification of symptoms, ability to judge worsening /improvement of symptoms, identify treatment related side-effects, motivating patients for compliance and addressing family concerns including stigma associated with mental illness. Patients must be provided with contact number so that there is no delay in treatment seeking, if required.

Telepsychiatry: Telepsychiatry, subsumed under telemedicine, has been in existence for over 50 years. Telepsychiatry involves a host site (where the clinician works) and a remote site (where the patients are seen)

The advantages of telepsychiatry are as follows:

- Improves accessibility of services in rural areas and areas that are far from tertiary care.
- By providing a suitable alternative, and cutting down on travel time, the psychiatrist is able to serve in a more time-efficient way.
- By coordinating with the primary health professional, it provides continuing education to the primary doctor, thus reducing provider isolation

In India, use of telepsychiatry has been reported by some institutions. Schizophrenia Research Foundation (SCARF), Chennai, has reported successful use of this method in collaboration with Indian Space Research Organization (Thara et al., 2008). In recent times, the department of Psychiatry, PGIMER, Chandigarh is also in the process of developing telepsychiatry services.

Faith Healers: Services provided by faith healing groups are neither standardised nor scientific, and vary considerably in the intervention provided. The interventions include blood letting, exorcism, removal of insects from the head, prescribing amulets (*tabiz*), extortion, oblation (*bali*) and many other such procedures.

Though not exactly a model in community Psychiatry, still they may have an important role to play. This group possibly attracts less stigma compared to mental health services and may be regarded as easily accessible.

The World Health Organisation (WHO) has long advocated local level policy of close collaboration between the conventional health system and traditional medicine, particularly between individual health professionals and traditional practitioners.

1.3.2 Need for Treatment of the Mentally Ill in the Community

Though, the acute cases and those patients who have relapsed need treatment in a hospital setting, a large number of patients can be treated in the community.

During the period beginning from 1980s, efforts have been directed to develop and evaluate the community based mental health programs. One of the first such studies was from Chandigarh which examined the utility of a team consisting of a Psychiatric Nurse and Psychiatric Social Worker in providing care in the community for persons suffering from chronic schizophrenia (Suman et al., 1980). This was soon followed by a major research effort which compared home-based care with hospital care (Pai and Kapur, 1982,1983; Pai et al.,1983, 1985). Recent research studies have addressed the situation of persons suffering from schizophrenia and the effectiveness of community level interventions (Chatterji et al., 2003, 2009; Srinivasa Murthy et al., 2004; Thara et al., 2004; Thirthahalli et al., 2009, 2010).

The process of deinstitutionalisation led to increased focus on community based care. Studies started to report on the effectiveness of community psychiatric interventions in both the developed as well as developing nations (Araya et al., 2003; Patel et al., 2003).

The need for treatment in the community was further reinforced by studies which have shown that the cost of providing care in the community is considerably lesser compared to hospital based care (Dauwalder and Ciompi,1995;Hafner and Heiden, 1989; Mitchel et al.,1990; Goldberg, 1995). Most cost advantages are obtained by shortening or even eliminating the initial period of in-patient care (Goldberg,1995). The lower daily cost of living accommodation for deinstitutionalised patients easily offsets the cost of services required for treatment in the community.

Thus, in short we cannot undermine the fact that there is indeed a need for community based treatment of the mentally ill.

1.3.3 Institutional Care versus Community Care

It seems treatment in the community settings have numerous advantages. Studies have reported the cost effectiveness of treatment in community settings (Dauwalder and Ciompi, 1995; Hafner and Heiden, 1989; Mitchel et al.,1990; Goldberg, 1995). Further it has been suggested that a closure of mental hospitals lead to savings which can be infused into developing community care services. These savings more than offset the funds used to expand community services (Kaumis-Gould et al.,1999).

Studies have shown that maintenance costs may also be less in the community care settings. For example, a study by Dawlder and Ciompi (1995) over a ten year period has shown that direct daily costs for community based social psychiatric care were about half that of in-patient treatment over the whole period. The WHO-Choice program found that treatment of severe mental disorders in the community care settings costs 35 to 50 per cent less than hospital based care in developing countries (Chisholm D,2005,Chisolm D et al., 2008)

Recent studies have tried to integrate cost of care with out-come, in either monetary or non-monetary terms. Cost-benefit analysis (using monetary terms in outcome) has shown that added benefits are clearly more than added costs (Weisbroad et al.,1980). Studies measuring outcomes on other domains have also shown that care in the community is more cost effective than hospital based care (Dickey et al.,1997; Weisbroad et al.,1980). Also most of the studies have

expressed improved outcomes in terms of improved satisfaction with services as perceived by patients and their care-givers (Hoult and Reynolds,1994).

Some recent studies have also evaluated other outcomes like symptoms and social adjustment and have found positive outcomes (Knapp et al, 1998; Reinhartz et al.,2000). WHO-Choice program also replicated the findings that community based treatment for severe mental disorders is more cost-effective compared to hospital based care, with cost-effectiveness ratios estimated to be 25-40 per cent lower (Chisholm et al., 2000). Even in acutely ill people (where hospital based care is considered to be more effective), residential crisis program have been tried and found to be cost-effective compared to hospital based care (Fenton et al., 2002). The residential crisis programs had near-equivalent effectiveness and reduced cost of services.

Though it seems that community care has several advantages, even then, all is not so straight forward. The Health Evidence Network (HEN) synthesis report on community mental health mentions: There is no compelling argument or scientific evidence that favours a mental health care model focused on hospital care alone. On the other hand, there is also no specific evidence that community services alone can provide satisfactory comprehensive care. Available evidence and accumulated clinical experience in many countries support a balanced care model that includes elements of both hospital and community care. Nevertheless, local communities may have strong views on developing such mental health services in their midst.

Self Assessment Questions 2

- 1) Who initiated the concept of “Therapeutic Community”? Describe the Concept

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- 2) Name the district whose success in integration of mental health with primary care led to the commencement of the District Mental Health Programme in India?

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3) Name a self-help group formed by people who have alcohol related problems and who want to quit alcohol.

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4) What do you understand by “helpline” services in Psychiatry?

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1.4 COMMUNITY MENTAL HEALTH IN INDIA

The story of community mental health in India is very different from the West. In India persons with mental disorders traditionally have always been treated in the community. Such persons were generally taken care of by the family, the larger community and traditional healers. Asylums, which later became mental hospitals, were opened in India, initially by the British East India Company and later by the country’s colonial rulers, primarily for British soldiers and British nationals who suffered from mental disorders. More mental hospitals were also built after India’s independence. Bold reforms involving the family members of those admitted to the hospital were initiated as early as the mid 1950s and 1960s in mental hospitals at Amritsar and Agra and certain centers, as Vellore. During the late 1970s and 80s, the Community Mental Health Unit at NIMHANS developed an approach and strategy for integrating basic mental health care with the existing general health care services in India. Initially it was tried in various PHCs in Karnataka state and later it was expanded to the whole district, in Bellary district of Karnataka. The overall strategy which evolved after 5 years of trial in Bellary came to be known as the ‘Bellary Model’ of District Mental Health Program (DMHP) and was adopted by the Ministry of Health and Family Welfare, Government of India for staggered country wide implementation as a fully centrally funded program (Issac, 2011; Srinivasa Murthy, 2011). Thus the era of community mental health had slowly begun in India.

1.4.1 Present Scenario

In 1982, India was one of the first countries in the developing world to formulate a National Mental Health Programme (NMHP). But budgetary allocation for the NMHP was made only since 1996-97, during the ninth (1997-02), tenth (2002-07) and the eleventh (2007-12) Five Year Plan by the Government of India.

The NMHP is now accepted as a relative low-cost, high yield public health intervention which is a doable as shown in states such as Kerala and Gujarat

(Goel, 2011). The country is also on the threshold of seeing a new National Mental Health Care Plan with specific reference to NMHP and DMHP, with specific strategies and activities to implement the priority areas of action identified in the National Mental Health care policy and an estimate of financial resources required to implement the plan by April, 2002 according to the 'Terms of Reference' of the Policy Group (Government of India-MOHFW, 2011).

In addition on 30th August, 2011, a Memorandum of Understanding (MoU) was signed between the Ministry of Health and Family Welfare, Government of India and the University of Melbourne, to effectively develop Community Mental Health in India. Four centers were selected to develop a tribal model, model for rural area, urban model and an extended outreach model. The selected institutes for these four models are Central Institute of Psychiatry and Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS) (Jharkhand; Eastern region; tribal model), Ahmedabad Mental Hospital (Gujarat; Western region; model for rural area), Department of Psychiatry, Government Medical College and Hospital (Chandigarh; Northern region; urban model) and Madurai Medical College (Tamil Nadu; Southern region; extended outreach model). The project is likely to start in the first quarter of the year 2013.

1.4.2 DMHP and its Role in Community Mental Health

The DMHP was conceptualised to understand the feasibility of providing basic mental health care for the entire district. The experience with respect to integration of mental health care in primary health care before this was largely confined to the population reached through primary health centres. The DMHP was pilot-tested to understand the feasibility of Mental Health care programme on a public health platform in the district of Bellary, Karnataka, covering a population of 1.5 million people. The effectiveness of the DMHP in Bellary resulted in the implementation of this model in several states in the country.

Currently, over 125 districts implement the DMHP with financial assistance from the Ministry of Health, Government of India.

Aims and objectives of DMHP: The aim of the DMHP is to extend mental health services to persons suffering from mental disorders in the district through the existing health care personnel and institutions. The mental health services should cater to the need of persons with psychosis, depression, neurosis, mental retardation and childhood mental health problems, substance use disorders and epilepsy. The trained PHC personnel are to be provided support and supervision on a regular basis to empower them to provide holistic care to the population. The progress of DMHP is to be monitored by developing systemic mechanisms like review meetings, on-the-job training to refine skills, and improved coordination between the agencies to facilitate implementation of the DMHP.

The specific objectives of DMHP are as follows:

- a) To develop and implement a decentralised training program in mental health for all categories of health personnel appropriate to their levels of functioning with the least disruption to the ongoing general health care activities.
- b) To provide a range of essential drugs (anti-psychotics, both oral and parenteral; anti-depressant; anti-convulsants; minor tranquilizers) for the management of persons with mental disorders.

- c) To develop a system of simple recording and reporting of case by health care personnel.
- d) To monitor the effect of service programs in terms of treatment utilisation and outcomes with treatment.

It was envisioned that the DMHP would be launched in all the states of the country after training the Psychiatrist/Program Officer and other members of the team in the philosophy of decentralised care within the district as in any other National programme. The district mental health team consisting of the psychiatrist will conduct training programs for the primary health care personnel to provide essential mental health care for the entire population of the district through primary health care services in an integrated manner.

However DMHP probably didn't progress as smoothly as it was supposed to. Several authors have looked into the lacunae of the DMHP and have offered corrective suggestions (Goel, 2011; Isaac, 2011; Jacob, 2011; Patel, 2011, Srinivasa Murthy, 2011). Most experts believe that the DMHP has failed to "integrate mental health care delivery into primary care due to a wide variety of administrative, managerial and technical reasons". However, experts observe "...the programme has ensured wider availability of essential psychotropic medication..." (Jacob, 2010), the DMHP is "essentially a psychiatrist led outpatient clinic in district hospitals" (Patel, 2011) and "major gains have been made....". The country can soon expect a "radical revision and re-hand of the dysfunctional NMHP" and a "re-written" DMHP for the 12th Five Year Plan (2012-2017) in independent India's first mental health policy as in early 2011, the Ministry of Health and Family Welfare, Government of India, constituted a mental health policy group comprising diverse stakeholders (Patel, 2011).

Role of DMHP in Community Mental Health: Though the DMHP had several hurdles on its way, it did contribute to community mental health.

- a) *Manpower development:* The DMHP helped in increasing manpower pertaining to mental health. Overall 55% of health personnel confirmed that they had received training and more than half of the health personnel (54.7%) were satisfied with the training programme.
- b) *Availability of drugs:* 25% of the districts reported a regular inflow of drugs. The rest of the districts faced difficulties in maintaining regular availability. However 80% of the beneficiaries across districts also indicated that they received at least some medicines from the health centers.
- c) *Access to treatment facilities:* About 61% of the beneficiaries accessed the district hospital as their first point of contact. The percentage of patients accessing CHCs (12.7%) and PHCs (11.5%) were found to be low. Again 18% of the total respondents confirmed that they were referred to the district level for treatment.
- d) *Awareness about mental illness and its treatment:* In the DMHP districts, 86.9% of the community members contacted knew about mental illness which is higher than in non-DMHP districts (74.7%). Awareness about the type of mental illness namely psychosis, neurosis, epilepsy etc were found to be significantly higher in the DMHP districts compared to non-DMHP districts. More than half of the respondents from the DMHP districts agreed that proper

medication and counseling could help in the treatment of mentally ill people, against only 30% in non-DMHP districts. 70% of the respondents in the DMHP districts also recommend treatment at a hospital.

Thus, it can be seen that right from promoting awareness about mental illness to its treatment, the DMHP had played a wide role in the community.

1.4.3 Role of Village Panchayat, “Sarpanch”, Municipal Councillors etc. towards Promotion of Positive Mental Health

The Public Health Agency of Canada (PHAC) definition looks at five potential components of positive mental health. These are:

- a) Ability to enjoy life.
- b) Dealing with life’s challenges.
- c) Emotional well being.
- d) Spiritual well being.
- e) Social connections and respect for culture, equity, social justice and personal dignity.

In a community its leaders and representatives like the ‘Village Panchayat’, ‘Sarpanch’ (in rural area) Municipal Councilors (urban area) etc. have a wider role in promotion of positive mental health, so that all these five components are well received by the community. These leaders often have a larger say in the key decisions related to the development of the community as a unit. The people also look up to them for various purposes, both personal as well as non-personal. These leaders have often contributed in promotion and coordination of various health related activities. These representatives are a part of community resources, which are helpful not only in sensitizing the community about psychiatric illness, but also encourage community participation in therapeutic process.

In Indian context mention may be made here about the formation of the Mental Health Association at Raipur Rani (in 1978). This was formed by the community members of the villages in Raipur Rani Block in Ambala district of Haryana. The aim of this association was to support the service activity, educate the public to accept the modern treatment, rehabilitation of those recovering from illness and impress the state machinery for the needed service. This association has been functioning in a limited way during last two to three years. The village leaders have been meeting periodically and sharing their experience as well as supporting certain activities.

In the camp method of treatment carried out by the Department of Psychiatry, Government Medical College, Chandigarh, often the leaders like ‘Sarpanch’ and Municipal Councilors not only extend their cooperation in organization of these camps, but they were also instrumental in motivating the local people to attend these camps for treatment of mental illness. In fact the first camp by the Department was conducted by invitation from community leaders of village Palsora in Chandigarh (Chavan and Arun, 1999). This was soon to be followed by many such camps in a number of places in Chandigarh.

Self Assessment Questions 3

1) Describe the ‘Bellary Model’ of District Mental Health Program (DMHP).

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2) Explain the aim of DMHP.

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1.5 RESEARCH IN COMMUNITY MENTAL HEALTH

Academic research that takes place outside the laboratory is becoming an increasingly important force in addressing and helping communities resolve local programmes. Academic researchers use different terms to describe this kind of inquiry, including applied research partnership. In community research some of the principal methods used are:

- a) **A case-by-case phase(Natural observation method):** Here the researcher collects detailed information from case to case to provide basic facts in many areas.
- b) **The Experimental Design:** The experimental design uses appropriate control and statistical tests of significance to provide results with a greater degree of certainty.
- c) **The Survey Method:** It is a systematic investigation, whether by questionnaire, interview or reading of the records and analysis of the characteristics of large group of individuals or agencies or institutions who have been randomly selected from a larger population with given characteristics so that they are representative of this population.
- d) **The Epidemiological Method:** Epidemiological inquiry is designed to measure the risk of attack by specific disorders within communities and to uncover clues about their origin and mode of spread. These clues are gleaned from the distribution of diseases in relation to time space or the distinguishing characteristics of the individuals or social groupings which are affected. In the study of mental disorders, the epidemiological approach has been used to investigate genetic, physical, psychological and social factors in the etiology and evaluation of mental illness.

- e) **Community Based Participatory Research (CBPR):** CBPR (Wallerstein and Duran, 2003) is a collaborative approach to research that equitably involves all partners in the research group and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community and has the aim of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities. CBPR differs from more traditional forms of research by involving community members at the levels of input (communities initiate research ideas and projects), process (communities remain intimately engaged throughout data collection and interpretation phases) and outcome (communities play significant roles in mobilizing the knowledge attained in CBPR projects for social change).
- f) **Practice-Based Research Networks (PBRN):** PBRN were developed in North America (AAFP, 1998) more than twenty years ago to study the health and health care events that are common in every day primary care practice. During the past two decades, the number of PBRNs has increased and they have made major contributions to the science base of health and health care.
- g) **Participant Observation:** It is a type of research strategy which is widely used methodology in many disciplines, particularly anthropology, and also in sociology, communication studies and social psychology. Its main focus is to gain a close and intimate familiarity with a given group of individuals and their practices through an intensive involvement with people in their natural environment. It is a qualitative method with roots in traditional ethnographic research, whose objective is to help researchers learn the perspectives held by study population (De Walt et al, 1998).

1.5.1 Importance of Community Based Research (CBR)

CBR is important for the following reasons:

- a) Understanding of risk and protective factors in the causation of common mental disorders from a variety of social circumstances.
- b) To reduce the risks through targeted intervention.
- c) Building of partnership/alliance where in the teams from academic institutes and community (Panchayat members, religious leaders, NGOs, teachers, youth and self help group, health providers, caregivers) come together to address issues of mutual concern to decide that relevant questions are posed and the research findings are rapidly disseminated.
- d) CBR has an advantage because it can reach out to the marginalized population who may not come in contact with health care facilities, eg marginalized children, women, persons with different sexual orientation, HIV infected and victims of stigmatizing illness.
- e) For regular funding and survival of these community based interventions there is a need of accountability and efficiency and it can be possible through regular flow of information between researchers, treatment providers, policy makers and the service users.

Self Assessment Questions 4

Discuss the importance of Community Based Research (CBR).

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1.6 LET US SUM UP

The era of community mental health has slowly progressed in India. Right from the ‘camp approach’ by Dr.Vidya Sagar to the development of community mental health model under Indo-Australian collaboration we have come a long way. In the community, different types of community mental health models are being used, each with its distinct style of operation and suitability as and when the situation demands. Treatment of the mentally ill in the community does have its advantages and many common mental illnesses like anxiety; depression etc can also be treated in the community, thus saving both time and money for the service users. The Government of India has taken a very bold and healthy step by initiating the National Mental Health Programme which does have a greater role to play in the field of community mental health. For bringing the treatment facility at the door step of the people and for the community mental service to be more effective the District Mental Health Programme is being revamped and its progress is to be monitored by developing effective systematic mechanisms .Thus in a nutshell, India seems to be moving in the right direction so far as rendering community based mental health services is concerned.

1.7 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

- 1) Vidya Sagar started his innovative ‘camp approach’ wherein families were also involved in the treatment and care of the mentally ill. He put up tents within the hospital premises and requested the relatives of the patient to stay there and take care of the patient there.

Self Assessment Questions 2

- 1) The concept of therapeutic community was initiated by Tom Main in 1946 and popularised by Maxwell Jones. It is a residential facility for a variety of disorders like mental illness, substance abuse and even for prisoners.
- 2) The District Mental Health Program (DMHP) was started following the success of Bellary district (in Karnataka).
- 3) Alcohol Anonymous
- 4) Helpline services are basically the provision of telephone services to assist and guide people regarding health related issues. Helpline programs related to Psychiatry include Suicide Prevention Helpline, Smoking Cessation Helpline, and Child Helpline etc.

Self Assessment Questions 3

- 1) During the late 1970s and 80s, the Community Mental Health Unit at NIMHANS developed an approach and strategy for integrating basic mental health care with the existing general health care services in India. Initially it was tried in various PHCs in Karnataka state and later it was expanded to the whole district, in Bellary district of Karnataka. The overall strategy which evolved after 5 years of trial in Bellary came to be known as the 'Bellary Model' of District Mental Health Program (DMHP) and was adopted by the Ministry of Health and Family Welfare, Government of India for staggered country wide implementation as a fully centrally funded program (Issac, 2011; Srinivasa Murthy, 2011).
- 2) The aim of the DMHP is to extend mental health services to persons suffering from mental disorders in the district through the existing health care personnel and institutions.

Self Assessment Questions 4

- 1) The importance of Community Based Research is as follows:
 - a) They help in understanding of risk and protective factors in the causation of common mental disorders from a variety of social circumstances.
 - b) It can be used to reduce the risks through targeted intervention.
 - c) It helps in building of partnership/alliance where in the teams from academic institutes and community (Panchayat members, religious leaders, NGOs, teachers, youth and self help group, health providers, caregivers) come together to address issues of mutual concern to decide that relevant questions are posed and the research findings are rapidly disseminated.
 - d) CBR has an advantage because it can reach out to the marginalized population who may not come in contact with health care facilities, eg marginalized children, women, persons with different sexual orientation, HIV infected and victims of stigmatizing illness.
 - e) For regular funding and survival of these community based interventions there is a need of accountability and efficiency and it can be possible through regular flow of information between researchers, treatment providers, policy makers and the service users.

1.8 UNIT END QUESTIONS

- 1) Write Short Notes on:
 - a) Half-Way Home
 - b) Community Based Participatory Research
 - c) Self-Help group in mental health
 - d) School mental health
 - e) Depressive disorder
 - f) Indo-Australian collaboration on development of community mental health in India.

- 2) Long essay type questions:
 - a) Critically evaluate the District Mental Health Programme
 - b) Describe briefly the features of “common mental disorders”. How will you manage the “common mental disorders” in the community?
 - c) Is treatment in the community setting a viable alternative to hospitalisation for treatment of mental illness? Justify.

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