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NATIONAL MENTAL HEALTH PROGRAMMES FOR INDIA (1982)

1. INTRODUCTION

India is a signatory State to the Alma Ata Declaration which envisages health for all by the year 2000 as the goal. Efforts to ensure the achievement of this goal will have to include approaches and strategies for the improvement of all aspects of health - physical, mental and social. While the Government of India is fully seized with the formulation of a national health policy since mental health forms an integral part of total health, a plan of action aiming at the mental health component of the national health programme needs tobe put forward.

The importance of mental health cannot be over emphasised in the national health planning. The scope of mental health is not only confined to the treatment of some seriously mentally ill persons admitted to mental hospitals but it relates to the whole range of health activities. Man is essentially a thinking and feeling being. No scheme of health planning can be complete which does not take the mental health component into account.

In the past, mental health did not find its appropriate place in the national and State health planning perhaps due to a common misconception that prevalence of mental health illness is low in India, particularly as compared to the West. In addition, it was also thought that no effective treatment is available.

Research studies from different parts of the country have shown that mental illness is as common in India as it is elsewhere and is equally common in rural and urban areas. Mental illness causes immense suffering to the affecting individual and his surroundings, although this suffering may not be clearly visible to others.

Following major scientific discoveries in the field of psychotropic drugs, physical methods of treatment,

psychotherapy and other behaviour modification techniques, simple, effective and cheap methods of treatment are now available for a large number of serious and disabiling mental disorders. Further, it has been proven in many countries including India, that effective treatment can be delivered, for a certain range of disorders, without having to solely rely on doctors/psychiatrists.

Just as modern scientific knowledge can help us to prevent and treat disabling mental illnesses, the mental health skills can be used to improve the quality of general health services. There is good evidence to say that about 13-20% of all patients who seek help in general health services both in developed and developing countries, seeking help for emotional and psychosocial problems. Current medical methods of dealing with these problems by unnecessary investigations and costly medicines are not only inadequate and ineffective but produce widespread frustration to both the seeker and the provider of these health services. Mental health principles can improve the current health delivery system and thus reduce the ever increasing threat of dehumanisation of modern medicine so repeatedly talked in all countries. The proper mental health inputs in general health programmes like family planning campaign, immunisations and nutrititon educational programmes can and will enhance the acceptance of these health and welfare activities of the country by the people.

In full accord with the national health policy of India, and in pursuit of the goal of Health for All by the year 2000, it is now possible and feasible to draw a national programme which would not only provide a minimum mental health care to all at a reasonable cost but also aim at healthy psychosocial development of the people. The proposed plan would also ensure that the benefit of mental health services would reach to those who need it most and that to our vast number of people living in rural areas and urban slums.

It is obvious that the implementation of the National Mental Health Plan will be possible only through a strong commitment of the Governments of the States as well as at the Centre and through dedicated endeavours by not only

all health personnel of all categories but also the personnel working in individual and integrated programmes of national development and by the active participation of the community.

PLANNING MENTAL HEALTH SERVICES FOR THE COUNTRY

We have to take into account the following three aims:

1. Prevention and treatment of mental and neurological disorders and their associated disabilities.

2. Use of mental health technology to improve general health services.

3. Application of mental health principles in total national development to improve quality of life.

2. ANALYSIS OF THE PRESENT SITUATION: NEEDS, SERVICES AND FACILITIES

A wealth of information is available in India concerning the prevalence of mental disorders. According to most of the surveys about 10-20 per thousand of the population are affected by a serious mental disorder at any point in time (point prevalence).

This would constitute about 10 million citizens of India. The figures for neuroses and psychosomatic disorders are about two or three times higher, thus indicating that 20-30 million people may require our attention. Mental retardation is estimated at 0.5 to 1.0% of all children, while alcohol and drug dependence rates, though still low as compared to the world scene, reveal a disturbing rising trend in pockets, for example alcohol consumption in Punjab, use of narcotics and Cannbis in urban student population.

The main burden of psychiatric morbidity in the adult population consists of:

(1) Acute mental disorders of varying etiology like acute psychoses of schizophrenic, affective or of

unknown etiology, paranoid reactions, psychoses resulting from cerebral involvement in communicable diseases like Malaria, typhoid or bacterial meningitis, alcohol psychosis, and epileptic psychosis. These conditions usually lead to temporary disability but they cause much distress, and they can evolve into chronic disability if not properly treated.

(2) Chronic or frequently recurring mental illnesses, like some cases of schizophrenia and of periodic or cyclic affective psychoses, epileptic psychosis and dementias, encephalopathies associated with intoxications or chronic organic disease, etc. Modern treatment can achieve stable remissions, or reduce disability in a significant proportion of these cases. Epilepsies constitute another important group of disease to be included here.

(3) Emotional illnesses such as anxiety, hysteria, neurotic depression are often associated with physical diseases. The majority of these patients would seek help at the general health services, but failure to recognise and treat the psychological component of their problem leads to prolonged distress and to unnecessary and wasteful prescriptions, investigations and referrals.

(4) Alcohol abuse, and alcohol and drug dependence appear to be growing problems, associated mainly with the new stresses of urbanisation and industrialisation, but their prevalence is also high in rural areas :

> The number of new cases of serious mental disorders which become manifest each year ((incidence) can be estimated to be roughly 35 per 100,000 or about 2,50,000 in the country. With the methods for treatment and prevention available in modern health care, chronicity and disability can be avoided in about 80% of the cases. Complete and lasting recovery is possible in no less than 60%.

Reliable separate data on psychiatric disturbances among children especially learning and behaviour problems in school children do not seem to be available. However,

there is evidence that their number is in the order of 1-2% of children. Similarly, psychiatric problems among older people especially in the large urban areas are assuming importance due to the weakening of the traditional family structure and social support systems.

No factual data are currently available regarding the loss of productivity, of income and even of life due to mental illness. But it should be pointed out that suffering due to mental illness often is not confined to the affected individual, but it causes severe social dysfunction of entire families.

2.1 EXISTING MENTAL HEALTH SERVICES

The presently available mental health facilities in India include about 20,000 beds in 42 mental hospitals and 2000 to 3000 psychiatric beds in general and teaching hospitals. For an estimated population of 680 million, there is one psychiatric bed per 32,500 population. Moreover, it is safe to assume that atleast one half of those beds are occupied by long-stay patients adding to the shortage of active "treatment" beds. The psychiatric units and mental hospitals operate out patient clinics which are currently the main source of mental health services in many cities. The number of specialised in-patient and out-patient facilities for children is insignificant.

Self help groups of parents with mentally retarded children exist in a few cities only.

From the available data it is safe to conclude that not more than 10% of those requiring urgent mental health care are receiving the needed help with the existing services. The situation is worse in the rural areas due to the heavy concentration of the services and facilities in the cities. It is also to be noted that a simple extension of the present system of care also will not be able to ensure adequate services to the vast majority of our population in the near foreseeable future.

2.2 MANPOWER

(a) Psychiatrists, Psychologists, Social Workers and other Para-Professionals

The manpower includes approximately 900 qualified psychiatrists working in hospitals and having private practice, 400-500 psychologists, 200-300 psychiatric social workers and

and about 600 psychiatric nurses. Of the 108 recognised medical schools, only half have an academic department of psychiatry. There are only two dozen centres for post-graduate training in psychiatry with a total output of about 100 psychiatrist per year. It would be evident from the above, that the psychiatric and parapsychiatric services in India are woefully inadequate. The problem is aggravated by the unequal distribution of psychiatrists with majority of them being concentrated in the urban areas. Hence, even with an increased rate of training of specialised staff, there is little hope to reach substantial portions of the rural population within the next two decades without major changes in the approach.

3. STRATEGIES FOR ACTION

In view of the gross disparities between needs and available services, there are essentially two approaches for immediate action. They are not alternatives since the difference between them lies mainly in the emphasis and in the level of priority assigned to different levels of service development. The first option would be to direct available resources to the establishment and strengthening of psychiatric units in all district hospitals. It would be hoped that these units would become foci of an expanding mental health service through setting up out-patient clinics and mobile teams. In general terms, the approach would be directed from centre to the periphery. In contrast, an alternative approach would be to train an increasing number of different categories of health personnel in basic psychiatric and mental health skills. There would thus, be a functional infrastructure before completing, in all instances, a physical independent mental health infrastructure. The approach would basically be directed from the periphery to the centre.

This latter type of strategy would be truly innovative in as much as it would allow for a method of planning according to needs perceived at the grass-root level, and it would allow for a speedy coverage of

the hitherto under or unserved rural poor and other neglected sections of society within a reasonable period of time.

As pointed out above, these two strategic approaches are complimentary. Both will allow a private sector of mental health care to continue, but in the second option the emphasis of the public sector will be primarily directed towards the poor and the under-priveleged. The programme when in action will directly benefit atleast 200 million population living in backward areas of the country. There will be no competition with the private sector nor will there be competition with psychiatric services and facilities existing in the cities. Of course, the services in the cities would continue to have a role as referral source, as well as centres of training and evaluative research.

Most mental health facilities in India actually function as passive recipients of patients. They become operational only where coping mechanisms in the community fail. The institutions have little knowledge and hardly any impact on these coping mechanisms as they exist and operate in the community. It is essential that the role of all mental health institutions in India becomes more active in concerning themselves with the social mechanisms involved not only in the development of mental illness but also in the more important issue of maintaining mental health.

4. OBJECTIVES

I. To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of population.

II. To encourage application of mental health knowledge in general health care and in social development.

III. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

5. APPROACHES TO THE ATTAINMENT OF PROGRAMME OBJECTIVES

In order to achieve the objectives formulated above, the programme will adopt the following approaches:-

5.1 Diffusion of mental health skills to the periphery of the Health Service System

This would mean that, instead of exclusively centralising and concentrating mental health skills and expertise in specialised facilities, the capacity to provide mental health care will be spread over the existing network of services, with the aim to incorporate mental health awareness and skills at all levels of health care. Specifically this calls for reaching the periphery (i.e. the primary health care structure at the community level like the primary health centre, sub centre and village health worker) in the performance of specified relatively simple tasks. Mental Health care thus must start at the grass root level.

5.2 Appropriate apportionment of tasks in mental health care

The tasks to be performed at each level (village worker subcentre, primary health centre, district hospital, regional hospital) will be specified and a referral system set up so that the total system works in an integrated fashions.

The Community Health Volunteer at the village level (approximately 1 worker for 1000 population) who is a community volunteer and only a part-time health worker, would be expected to act essentially as the liaison person between mental health caring system and the community. He will participate in case identification and referral of patients, and will help to supervise follow up of patients, and will help to supervise follow up of patients in need of long term maintenance therapy. The multi purpose worker (M.P.W one for a population of 5000) who is the first level full time health personnel of our health service structure would act as the first link with health service system by providing first aid care and follow up service.

The senior and more experienced primary health care personnel i.e. Health Supervisors (Health Inspectors, Lady Health Visitors etc) would be entrusted with the task of early recognition and management of priority psychiatric conditions which he/she would carry out under the supervision of the medical doctor at the primary health centre. The medical doctor would have the over all responsibility of organising and supervising the primary level mental health care for the whole population under the jurisdiction of primary health centre or sub-centre. Details of the proposed activities for each level of health staff will be discussed below. The referral system will operate in a way which will make it possible that mental health problems are handled effectively at the appropriate level of the health system.

5.3 Equitable and balanced territorial distribution of resources

Coverage of unserved and under served population will receive a high priority. Every effort will be made to introduce or strengthen mental health care first in those regions which are at present deprived of it or where it is seriously deficient.

5.4 Integration of basic mental health care into general health services will facilitate the application of mental health skills when dealing with patients without gross psychiatric disturbances. It will also enable the health workers to identify psychosocial problems under the disguise of physical complaints and manage them more adequately. And it will sensitize the primary health personnel to psycho-social factors contributing to ill health and to human suffering.

5.5. Linkage to community development

An important approach would be the involvement of State, district and block leadership in the implementation of the mental health programme to ensure community involvement in preventive efforts directed at psychosocial problems like alcohol and drug abuse, behaviour problems

of childhood and adolescence including delinquency and other negative and eventually avoidable side products of rapid socio-economic change.

This need for linkages calls for further research into issues of psychosocial factors. It is also important for the future development, that linkages with other sectors of the community be fostered like with housing; education, town planning, legal agencies, to enhance the total mental health care awareness as well as for the application of mental health skills and knowledge for all persons.

5.6. Mental Health Care Programme - The service component will include three sub-programmes, treatment, rehabilitation and prevention.

(1) Treatment : The focus of the treatment sub programme will be morbidity categories (1), (2) and (3), as outlined in section 2. Specified forms of treatment and of diagnostic work will be implemented by personnel at the following levels of the regional health care system.

(a) Primary Health Care at the village and Sub-Centre level :

Multi purpose worker (MPW) and Health Supervisors will be trained to deal with the following problems within his own community under the supervision and support of the medical officer. (1) management of psychiatric emergencies (e.g. acute excitement, crisis situations) through simple crisis-management skills and appropriate utilisation of specified medicines (2) administration and supervision of maintenance treatment for chronic psychiatric conditions in accordance with guidance by the supervisors (3) recognition and management of grandmal epilepsy (particularly in children) through utilisation of appropriate medicines under the guidance of medical doctors, (4) liaison with the local school teacher and parents in matters concerning the management of children with mental retardation and behaviour problems, (5) counselling in problems related to

alcohol or drug abuse. These tasks will be performed in accordance with simple operational instructions included in the MPW's manual. For each task, an appropriate difficulty/severity level will be specified, beyond which the problems would be automatically referred to the next level of health care.

(b) Primary Health Centre

The medical doctors aided by health supervisor will be trained to provide the following services : (1) supervision of the MPW's performances of specified mental health tasks (2) elementary diagnostic assessment of cases, using diagnostic and management flow charts, and performing a standardised basic neurological examination; (3) treatment of functional psychoses, (4) treatment of uncomplicated cases of psychiatric disturbance associated with physical diseases like malaria, typhoid, mild to moderately severe depressive states, anxiety syndromes & initial stages of functional psychoses with appropriate drugs, (5) Management of uncomplicated psycho-social problems without the use of drugs, (6) epidemiological surveillance of mental morbidity in the area and compilation of estimates of needs which would be submitted periodically to the next echelon for review and planning future services. In a way similar to the MPW's method of work, the medical officer will be guided by specified cut off points for referral of problems to a higher level of health service set up.

(c) District hospital

There is an urgent need for psychiatric specialists attached to every district hospital as an integral part of the district health services. The services provided will include (1) medical consultation, community based with only a limited involvement of the health service personnel. The main focus of the sub programme in its initial phase will be the prevention and control of alcohol related problems, with time, experience and gain in credibility, however it will be possible to expand its concerns to problems like addictions, juvenile delinquency, acute adjustment problems (eg. suicidal attempts), and to an ability to articulate community mental health needs from the citizens' point of view. The main carriers of this

sub-programme will be the medical officer and community leaders at the primary health centre levels.

5.7. Mental Health Training Programme:

Having accepted that mental health specialists like psychiatrists would not be enough in the near future in our country to deliver mental health care to all those who immediately require it, we have to think in terms of alternative general health service cadres like general medical doctors and para-medical health workers, providing first level of care. As an immediate solution we will have to train as large a number of health personnel of all categories as possible in the minimum essentials of mental health tasks at their own level of performance as outlined above. However, for future investment, we must give top priority to the better training of under-graduates, the future medical doctors.

Currently the amount and type of mental health training to medical undergraduates in our country is grossly inadequate (According to recent Medical Council of India's rules the obligatory psychiatric training during 5-1/2 years of undergraduate career is only 2 weeks at a psychiatric centre - which is usually at a distant mental hospital). Thus the potential of using these future medical doctors as agents of a new and better mental health service system for our country as envisaged in these pages is seriously handicapped. At present 13,000 new doctors leave the portals of our medical colleges in every year. It is very important that the amount and content of training is quickly altered in such a manner that a newly qualified doctor is able to discharge his responsibility for better mental health care of the community. This single step, on implementation can become an important resource of all future mental health programmes.

Alongwith the better training of medical under-graduates, it is equally important to include essentials of mental health training in the teaching programmes of nurses, public health administrators and health staff or primary care system. Details of such training programmes for immediate action are given in the following chapter "Outlines of the plan of action".

5.8 Mental retardation is not mental illness but often associated with it as well as physical illness.

Often the mentally retarded first come to the notice of the medical services. The health workers therefore should be able to counsel the parents, provide public education in this subject as well as have the know-how to refer such children to approach social welfare agencies for rehabilitation. Simultaneously the Integrated Child Development Scheme (ICDS) personnel should be given the know-how to refer the mentally retarded, recognised by them, to medical agencies when indicated.

5.9 The group noted the formulation of a scheme under the VIth Plan towards the problems of drug dependence and endorses the action taken in this regard.

6. OUTLINE OF PLAN OF ACTION

The plan of action aiming at achieving the above objectives will consist of a set of targets and of detailed activities.

6.1 Targets

(a) Within one year each State of India will have adopted the present plan of action in the field of mental health.

(b) Within one year the Government of India will have appointed a focal point within the Ministry of Health specifically for mental health action.

(c) Within one year, a National Coordinating Group will be formed comprising representatives of all States, senior health administrators, and professionals from psychiatry, education, social welfare and related professions.

(d) Within one year, a task force will have worked out the outlines of a curriculum of mental health for the health workers identified in the different States as most suitable to apply basic mental health skills, and for medical officers working at PHC level.

(e) Within 5 years, at least 5000 of the target non medical professionals will have undergone a 2 week training on mental health care.

(f) Within 5 years, at least 20% of all physicians working in PHC centres will have undergone 2 weeks training in mental health.

(g) Creation of the post of a psychiatrist in atleast 50% of the districts within five years.

(h) A psychiatrist at the district level will visit all PHC settings regularly and atleast once in every month for supervision of the mental health programme for continuing education. This programme will be fully operational in atleast one district in every State and Union Territory, and in atleast 1/2 of all districts in some States within five years.

(i) Each State will appoint a programme officer responsible for organisation and supervision of the mental health programme within 5 years. Amongst other responsibilities for the programme he will organise training courses in co-operation with the teaching Institutions, and he will be the focal point of data gathering including evaluative data.

(j) Each State will provide additional support for creating or augmenting community mental health components in the teaching institutions. This programme will be operational within 5 years.

(k) On the recommendation of a Task Force, appropriate psychotropic drugs to be used at P.H.C. level, will be included in the list of essential drugs in India.

(l) Psychiatric units with in-patient beds will be provided at all Medical College Hospitals in the country within 5 years.

6.2. Detailed activities

6.2.1 Activities within the sole responsibility of the

Ministry of Health, Government of India, which will be pre-requisites to the implementation of the National Plan.

(a) Establishment of a National Advisory Group on Mental Health. The suggested constitution of the group appears under 7.5

(b) Nomination of an Assistant Director General of Health Services within the Directorate General of Health Services, specifically for mental health action and who would also act as Secretary to the National Advisory Group on Mental Health.

6.2.2 Activities within the responsibility of the Ministries of Health within the State Governments.

(a) Adoption of this National Mental Health Programme as plan of action at the State level.

(b) Appointment of one Programme Officer in their Directorate for mental health at a senior level.

(c) Creation of the post of atleast one district psychiatrist in every district.

(d) Provision of facilities to the District Psychiatrist to visit the PHC physicians, regularly where possible, in connection with other outreach and supervisory activities.

7. NEEDS FOR COOPERATION AND COORDINATION

7.1 The programme outlined is clearly and deliberately reaching beyond the traditional tasks of a specialised psychiatric service.

In the first instance, it is proposed to use the Primary Health Care structure to provide basic psychiatric and mental health services. This means that atleast at the grass root level of health care, mental health will be totally integrated into general health care delivery. A close cooperation of mental health professionals with other carriers of care is thus imperative.

In fact it is hoped that mental health would become an integral part of all health and welfare endeavours in our country.

7.2. A strong linkage of the programme should be with Social Welfare. In fact, the split between agents of social welfare and mental health may have its roots in the artificial separation of psychological (i.e. intrapsychic) and social (i.e. communicative) phenomena. It would seem an innovative achievement if this traditional splitting of tasks could be overcome in India. The PHC physician, of the district psychiatrist would then do individual as well as social (e.g. marital) counselling, and would advise at the same time a rural development committee on questions relating to a nursery school or the opening of a liquor store in the village. A social worker could bring a destitute for psychiatric consultation and a psychiatrist would refer a "complainer" to a social worker for help in his social needs.

7.3 Social, behavioural and learning problems are manifesting themselves in schools. Addition of mental health inputs in the school health is likely to play a major role in their amelioration. Teacher's would therefore have to be given adequate orientation in early diagnosis of most of the common mental health problems.

7.4 Necessary links with the mental hospital and medical colleges have already been mentioned. They will be centres of referral for special cases as well as centres of various teaching activities. On the other side, it is hoped that the medical colleges will take advantage of the integrated mental health services to increase the community health component in their under and post-graduate training.

In addition, they will be actively participating with ICMR/other research organisations on various research projects in the field of mental health.

7.5 The central mechanism of this co-operation will be the National Advisory Group, the formation of which will be an integral part of the programme. It will consist of representatives of all States and of the Institutions and professions referred to above. It will

thus be the central organ not only for cooperation between the States but also between the different professional groups and agencies, on a central level, together with the focal point in the Dte. G.H.S. and Ministry of Health.

NATIONAL ADVISORY GROUP :

CONSTITUTION

1. D.G. (Ex-Office) - Chairman
2. Key person in Dte. G.H.S.
3. Key person in I.C.M.R.
4. Key person in M.C.I.
5. Key person in Planning Commission
6. Joint Secretary (in charge) in Ministry of Health
7. Joint Secretary (in charge) in Ministry of Social Welfare.
8. Joint Secretary (in charge) in Ministry of Labour
9. Joint Secretary (in charge) in Ministry of Education
10. Joint Secretary (in charge) in Ministry of Law
11. Key person in University Grants Commission/Sec. University.
12. Psychiatric Association
13. Key person from I.M.A.
14. Eminent people in the above field nominated.
15. Eminent person from Law

It is envisaged that similar Advisory Bodies at a State level be also formed.

7.6 In view of diverse and varying level of development and health infrastructure in the country, a certain degree of flexibility will be essential in the implementation of this programme. The proposed plan needs to be reviewed periodically for evaluation of goals achieved. In that aspect the present plan should be understood as an initial statement of intent rather than a rigid blue-print for all future programmes. The National Advisory

Group would have the responsibility of regularly monitoring the progress of the programme.

8. LEGISLATIVE REQUIREMENTS

Appropriate legislation for better implementation of the National Mental Health would also have to be looked into.

9. RESEARCH

One basic feature of the programme will have to be a continuous monitoring through evaluative research. Very close links with the ICMR will thus be an integral part ofthe programme activities. There is already a considerable commitment on the part of the ICMR task forces in the field of mental health, in general, and especially towards issues related to service research. Such issues will need considerable strengthening. Research like the actually initiated study on determinants of the outcome of mental diseases, or an illness behaviour, have a direct bearing on service delivery. An additional focus will have to be on evaluative research on the effectiveness of the programme at its diffdrent levels of functioning, from the training of the different levels of workers to the mode of service delivery by these workers once trained.

In view of the severe scarcity of resources in India, the equilibirium between research and service efforts may have to be reconsidered. Modern research requires inputs from many sources. For a major national programme like this, there would be need for bilateral and multi lateral collaborative research between national and international groups.

Pursuing the rightful policy of creating a network of centres of excellence, and of research workers of excellence in the country, due consideration may have to be given to the orientation of such research efforts in the light of the overall health policy of the country which is directed towards health for all by the year 2000. Every system of medicine as practised in India should continue to conduct research in the field of mental health and exchange views and research data for the mutual enrichment & benefit.

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RECOMMENDATION MADE BY THE CENTRAL COUNCIL OF HEALTH AND FAMILY WELFARE IN ITS MEETING HELD ON 18-20TH AUGUST, 1982.

MENTAL HEALTH PROGRAMME

The Joint Conference considered the importance of Mental Health in the total development of society and appreciated that mental health is an integral part of total health and it should therefore be viewed in that light. The Joint Conference recommends that:

i) Mental Health must form an integral part of the total health programme and as such should be included in all National policies and programmes in the field of Health Education and Social Welfare.

ii) Realising the importance of mental health in the course curriculae for various levels of health professionals suitable action should be taken in consultation with the appropriate authorities to strengthen the Mental Health Education components.

While appreciating the efforts of the Central Government in pursuing legislative action on Mental Health Bill the Joint Conference expressed its earnestness to see that the bill takes a legal shape at the earliest.

COMMUNITY HEALTH CELL
47/1,(First Floor)St. Marks Road
BANGALORE - 560 001

NATIONAL MENTAL HEALTH PROGRAMME (1982)

SUMMARY

1. India is a signatory State to the Alma Ata Declaration which envisages health for all by the year 2000 as the goal and primary health care as an approach. Health has been defined not merely as absence of disease but as a state of positive well being, physical, mental and social. Mental health, therefore forms an essential part of total health and as such must form an integral part of the national health policy.

2. Contrary to the popularly held belief, mental illness is widely prevalent in India and the prevalence is certainly not less than what is reported in the Western countries. Further more, the figures in India are as high in rural as in the urban areas. The Indian research scientists have brought out enough evidence that atleast 10-20 per thousand suffer from severe mental illness at any given time and at least three to five times that number suffer from other forms of distressing and socio-economically incapacitating emotional disorders. It has also been shown that 15-20% of the people who visit general health services such as a medical outpatient department or of private practitioner or a primary health care centre have in fact emotional problems appearing as physical symptoms.

3. With the help of the Government of India and the WHO, a series of meetings were arranged with specialists in the field of mental health as well as experts in education, social welfare, law, labour and leaders engaged in various national development programmes. As a result of these meetings, a proposal for national mental health programme for the country has been formulated. This programme has been designed keeping in view the magnitude of mental health problem in the country, existing resources, both human and material, advances in the mental health technology particularly in the field of delivery of health care to the people in the rural and far flung areas and outcome of research studies in various fields. Under this programme, it is envisaged that atleast 200 million people particularly belonging to the socially and economically backward areas of the country are likely to benefit.

4. The programme thus has been formulated with the following objectives :

a) to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under-privileged sections of population.

b) to encourage application of mental health knowledge in general health care and in social development.

c) to promote community participation in the mental health service development and to stimulate efforts towards self help in the community.

5. In order to achieve the above objectives, the programme has been designed to have the following approaches :

a) integration of the mental health care services with the existing general health services,

b) to utilise the existing infra-structure of health services and also to deliver the minimum mental health care service,

c) to provide appropriate task oriented training to the existing health staff,

d) to link mental health services with the existing community development programme.

6.1 The programme will have three components namely, treatment, rehabilitation and prevention of illness and promotion of positive mental health. The treatment programme has been planned keeping the primary health care approach as the sheet anchor. At the same time, it consists of the creation of an appropriate referral system at various levels. It is proposed that the specialised psychiatric services should be made available

at the district level. The other major responsibilities for the health personnel at the district level would be to provide training and supervision to theworkers at the primary health centre level. The mental hospitals, medical colleges, teaching institutions and mental institutes shall also be linked together into the national grid for the mental health care particularly in the field of education and research.

6.2 The rehabilitation sub programme will develop services for the rehabilitation of the chronically disabled both due to mental illness as well asmental retardation. This programme envisages linkage with the rehabilitation programme of other Ministries particularly the Ministries of Labour and Social Welfare.

6.3. In the field of prevention and promotion, the sub programme visualises counselling services for common mental health problems like alcohol and drug abuse, delinquency and genetically inherited mental illness.

7. An exercise has also been done in order to identify the various targets that would have to be attained in a time-bound frame. It is proposed that a small co-ordinating group at the Centre be formed immediately which would go into the phasing of the programme.

8. The salient recommendations for further action are as under :

a) Mental Health must form an integral part of the total health programme and as such be included in all national policies and programmes in the fields of health, education & social welfare.

b) Considering the importance of mental health in the total development of society, mental health aspects should be kept in view in the planning of activities for national development.

c) Appreciating the importance of mental health in the course curriculas for various levels of health professionals, suitable action should be taken with the appropriate

authorities to strengthen the mental health educational component.

d) The practitioners of Indian Systems of Medicine should continue to play their respective distinct roles in the field of health inclusive of mental health.

9. The above recommendations are commended for consideration by the Central Council of Health. Keeping in view the importance of mental health, as an integral part of the total health, the Central Council of Health may kindly lend its support for adoption of the programme.

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A COMMUNITY MENTAL HEALTH PROGRAMME IN RURAL TAMILNADU

R.Thara*, R.Padmavathi

This is a brief report of a community mental health rehabilitation programme carried out in a rural area in Tamil Nadu by the Schizophrenia Research Foundation (SCARF). SCARF is a non-governmental, non-profit organisation in Madras, working for people with chronic mental illness, and has been involved in community mental health work in the past decade in urban slums and rural areas. The community mental health project is funded by a Canadian donor (IRDC) and is carried out in Thiruporur. Covering an area of 14,181 square miles with over 100 villages, this area has a total population of 1,10,758 persons, most of whom live below the poverty line. One Primary Health Centre (PHC), a few sub-centres, and rural dispensaries cater to the health needs of the population. Two major religious centres in the area, a Dargah and a Hindu Temple, are prominent healihg sites for mental illness, and often are the first point of contact. Therapeutic measures in these centres include special prayers, offerings, special food and other rituals, undertaken over varying periods of time.

THE MENTAL HEALTH PROGRAMME

While the primary objective was to operate a community mental health programme in the defined catchment area, the other programme components included training lay volunteer workers to detect and manage mental disorders, operating a mental health service system in the area, planning and implementing an intervention programme for the identified mentally ill, integration of menta[l] health with primary health care infrastructure in the area, and conductin[g] periodic awareness programmes in th[e] community.

TRAINING

The Community Rehabilitatio[n] Workers(CRWs) were lay voluntee[rs] identified from the community with th[e] help of village leaders. The trainin[g] consisted of five sessions each for te[n] groups of CRWs, followed by periodi[c] reinforcing sessions. Medical officer[s] and multi-purpose workers (number[-] ing 50 for the training) from the PHC

were also trained during four sessions. The choice of CRWs from the local population helped to facilitate easier acceptance and accessibility to the homes of the mentally ill. The training included detection of mental disorders in the community such as psychoses, neuroses, mental retardation, substance abuse disorders and epilepsy, implementation of simple intervention strategies, working closely with families of the mentally ill, and making appropriate referrals. Manual and audio-visual training materials were used for the sessions.

MENTAL HEALTH SERVICES

An active outpatient clinic was operated twice a month in Thiruporur town. Patients identified in the community by the CRWs were treated by a psychiatrist, and reviewed periodically. A similar procedure was followed in camps held in remote villages, which were not accessible to the clinic. Some simple interventions offered by the CRWs included support to the client, educating families on mental illness, management of behaviour problems, ensuring drug compliance, training patients in self care and activities of daily living, job placement, and initiating small businesses as a measure of rehabilitation. The emphasis was on utilising local resources and mobilising local support. Over a period of five years, 637 patients suffering from mental illness were registered and offered treatment, and at the end of the sixth year, 235 were being followed-up.

INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE

This was initiated by training health care personnel in PHC services to detect and manage mental illness. Active liaison with the government health and medical service departments, as well as sustained efforts at ensuring a supply of basic psycho-tropic medicines at the PHCs have paid dividends. It was therefore possible to refer a number of patients to the PHCs in that area.

AWARENESS PROGRAMMES

These were periodically held in different villages, using local folklore, dance and music. The emphasis was on early recognition of mental illness and prompt treatment. Following the awareness programmes, it was noticed that referrals to the clinic increased, mainly from village leaders, traditional healers, community workers and general medical practitioners

COMMUNITY INVOLVEMENT AND EMPOWERMENT

The project has been community oriented in that over 80% of the staff were drawn from the same community facilitating easier acceptance and greater involvement. Village leaders, teachers, religious heads and others with influence were involved in the programme at various stages.

Most of rural India is devoid of formal mental health services. It was evident soon that communities by and large favoured traditional and religious forms of treatment, not only because it suited their explanatory models of mental illnesses, but also because of the easier availability of these services, in comparison with formal medical facilities. The project staff established good links with traditional healers in that area who gradually began referring cases to the centre. No efforts were made to thrust into the community a medical model of illness or to persuade them to give up the existing help they were used to. Within a few months, it was clear that this rural community was ready to abandon its traditional treatments for some of the mental disorders, while it continued to hold on to its view points regarding others. This is not an uncommon phenomenon, and it is probable that most stigmatising illnesses are faced with this kind of "mixed loyalties".

It is possible to train lay community volunteers to identify various mental disorders and implement simple psycho-social rehabilitation strategies. Involving and training lay community workers from the community facilitated easier acceptance by the patients and their families. The interventions offered as part of this programme have facilitated community integration of the mentally ill. Interventions have been individually tailored to the needs of the patients and their families. Establishing rapport with the family and the community through the involvement of local village leaders has ensured the acceptance of such a programme by the population.

The programme has shown that there are some basic elements of psycho-social intervention that are essential in any community mental health programme in a rural community, particularly in developing countries. These should include, besides provision of psycho-tropic drugs, the involvement of the family and the mobilisation of local community resources. Structured and skilled psycho-social rehabilitation programmes may be too complex for implementation and may not be necessary for the rural population. Besides, these cannot be implemented by the lay community volunteers.

Mental health care is undergoing a transition the world over from institutionalisation to community care. Understanding community perceptions, attitudes and coping styles will increasingly become more crucial in community based programmes. This is even more relevant in developing countries, where "stereotypes" about the mentally ill have existed for centuries. Making a change in this without antagonising or hurting the feelings of the community would be a challenge. In this respect, this project has been a kind of forerunner and provided a model which may be replicated in other parts of the world.

*Schizophrenia Research Foundation
Plot R/7A, West Main Road
Annanagar, (West extension)
Chennai - 600 101, India

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IMPLEMENTATION OF MENTAL HEALTH PROGRAMME IN YELANDUR TALUK IN COLLABORATION WITH NON GOVERNMENTAL ORGANISATION

Dr.R.SRINIVASA MURTHY,[1] Dr.K.V.KISHORE KUMAR,[2] Dr.H.SUDHARSHAN,[3]
Dr. SRIDHAR[4] & Dr. SHIVAKUMAR[5].

INTRODUCTION:

The myth that mental illness is a phenomenon of the developed, rich, industrialised nations only, has been squarely dismissed by consistent epidemiological investigative efforts in our country. About 17 epidemiological studies till date of varied research sophistication have been conducted across the length and breadth of the country covering both urban and rural population. The insight gained by such investigations reveals that the mental morbidity is comparable to developed nations and that there are no rural and urban differences in determinants and distribution of severe mental disorders. While epidemiological studies unequivocally suggests the presence of such disorders, the range has however varied due to differences in methodology and case identification methods. The range of severe mental illness varies from a figure as low as 1.1/1000 (Sethi et al., 1972) to 43.2/1000 (Nandi et al., 1975). Further the document (WHO, 1975) 'Organisation of mental health services in developing countries' points out that at any given point in time 1% of population suffers from severe incapacitating mental disorders and 10% of the population have life time risk of developing severe mental disorders. Considering this evidence and extrapolating these figures, nearly 9.3 million people need urgent help for their incapacitating mental disorders, while 93 million would potentially need help some time in their life.

Unfortunately the manpower and resource available to tackle this major public health problem is very meagre. This is evidenced by the fact that there are 3000 psychiatrists in our country. This figure makes it upto 1 psychaitrist for about 300000 population. The situation in United Kingdom is about 1 psychiatrist for every 30000 population. There are 42 mental hospitals and 200 General hospital psychiatry units in India both yielding nearly 26,000 beds which is comparable to that of Holland which has 15 million population. This gross mismatch between the morbidity and resource (both in terms of manpower and infrastructure) needs have to be addressed by prophesising the strategy of integration of mental health into general health services.

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1. Professor & Head, | Department of Psychiatry,
2. Psychiatrist | NIMHANS, BANGALORE 560 029.
3. Secretary & Managing Trustee |
4. Peadiatrician | VGKK, BR Hills, Yellandur.
5. Medical Officer |

The impetus for this approach has been possible due to the following, (a) the commitment of the country to provide health care service to all, (b) the Alma Ata Recommendation on Primary Health Care, (c) the existence of a large infrastructure of general health service (PHC system), (d) the approach to utilise multipurpose workers and to provide health care to rural people, (e) development of simple interventions to manage mental disorders. Feasibility and effectiveness of mental health care using this strategy of integration has been demonstrated in our country in the last 2 decades. They are (i) Raipur Rani Project (WHO collaborative multicentred international study titled 'Strategies for extending mental health care' (1975-1981) involving seven developing countries ,(Harding et al.,1980, Wig et al., 1981). (ii) Sakalawara project initiated in the villages of Karnataka, South India in order to develop models of mental health care, (Chandrasekhar et al.,1981, Isaac et al., 1981, Isaac et al., 1982), Parthasarathy et al., 1981). (iii) Jaipur Project, (Shiv Gautam, 1986). (iv) ICMR/DST multicentred collaborative study on severe mental morbidity (ICMR, 1987). (v) Mental Disorders in Primary health care (ICMR/CMH, 1985). (vi) Bellary project (1981-1990) (Isaac et al., 1986). The first two of the above mentioned studies resulted in the formulation of the National Mental Health Programme for India, (GOI, 1982) with the following objectives:

1. To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and under privileged section of the population.

2. To encourage application of mental health knowledge in general health care and social development.

3. To promote community participation in the mental health services development and to stimulate efforts towards self help in the community.

It is important to appreciate that all the major initiatives towards integration has occurred in public sector, while collaboration with NGOs has been completely absent particularly in this area. Further continuation of such work in the long term in public sector has not been satisfactory for the reasons of lack of essential drugs, preceived over work of the staff,lack of motivation, frequent transfers etc. Therefore, lately such an effort has been given importance since the Governmental agencies alone may not be able to address the needs of mentally ill population in the country. Work in this direction can generate useful insights pertaining to feasibility and sustainability of mental health care through integrated approach in NGO sector.

Current report focuses on such a debutant effort in the area of integration of mental health in general health services through an NGO in our country.

DESCRIPTION OF THE STUDY AREA:

Yelandur Taluk is part of Mysore district in Karnataka, South India. It is located 100 kms. from Bangalore and has a population of seventy thousand. Health care is provided by Government administered primary health centre and by the non governmental voluntary agency 'Karuna Trust'. The medical service provided by the NGO includes primary health care for general medical problems, domiciliary care for leprosy and tuberculosis and care for persons with seizure disorders. Agriculture is the main occupation of the people which largely depends on the monsoon, a small proportion of the area is irrigated. This taluk is a reserved constituency politically since the majority of the population are scheduled castes and scheduled tribes. A part of this taluk is inhabited by 'Soliga Tribes' who are confined to the forests of BR Hills (Biligiri Ranganna Beta). The quality of life of the Soliga tribes have changed dramatically over the last 15 years due to strong commitment and sustained efforts of Vivekananda Girijana Kalyana Kendra headed by Dr. H. Sudharshan. The efforts have resulted in organization of primary health care, development of educational infrastructure, vocational training facilities and social development for the tribal population.

METHODOLOGY:

AIM: To examine the feasibility of utilising the existing personnel of an non governmental organisation in providing mental health care as part of primary health care.

GENERAL OBJECTIVE: To orient the existing personnel in the NGO in mental health care by a short training programme to include mental health care activities in their total health care.

SPECIFIC OPERATIONAL OBJECTIVES:

1. To enable them identify persons with severe mental illness among those attending health facilities and those living in the community.

2. To enable them to provide services to the persons with severe mental illnesses in their institutions.

3. To provide skills for follow-up of persons with mental illness and to ensure continuity of care.

4. To incorporate mental health skills into specific programmes like, ambulatory care of persons with tuberculosis and Hansen's disease.

5. To facilitate their understanding and practice of community organisation, principles to ensure community participation in mental health care.

6. To understand the cost and sustainability of such initiatives.

7. To understand the role of community based rehabilitation of chronically mentally ill persons and its efficacy.

The initiation of mental health programme in Yelandur taluk was started in October, 1994. The catchment area has two focal points of service provision (Yelandur clinic in tarai region & Jaya Vijayam tribal hospital in BR Hills). The personnel of NGO consisted of three doctors and ten health workers. The first two day training programme was started by Dr. R. Srinivasa Murthy on sever mental morbidity (psychosis, depression and mental retardation). The language of instruction was English and the topics covered were brain and behaviour, signs and symptoms, aetiology and management of severe mental morbidity. This was suplemented by video-tapes "mental health in primary health care" (WHO, 1993). The video materials are instruction tapes for primary care physicians. It has been produced to understand various forms of presentation of severe mental morbidity in primary care and to develop interviewing skills. Similar training sessions were held for Doctors and Health Workers for three consecutive months. Apart from the video demonstration, lectures and live case demonstration in field using key informant technique were used. Following these inputs, persons with severe mental morbidity were identified by the health workers and these patients were managed by doctors under the supervision of resource persons from NIMHANS (Prof. R. Srinivasa Murthy and Dr. Kishore Kumar. The specialists visited the centre every month on the second saturday and sunday till date. The cases registered in the clinic was used for on job training for both doctors and health workers on a regular basis to increase their skills in evaluation of patients, plan appropriate management, monitoring of side effects and health education to the family members. In addition to inputs in the clinic, the personnel were also given training in case identification at the level of community using flip charts on ten features of mental disorders and administration of 15 item questionnaire - Indian Psychiatric Survey Schedule (Kapur & Carstairs, 1974). These techniques are important measures to detect morbidity in the community who are not availing mental health services.

RESULTS:

Following implementation of mental health programme since August 1994 nearly 196 patients with severe mental health problems were registered who were availing services provided by doctors and health workers. Patients registered are evaluated systematically on primary care health record and details of patients are maintained in a central register. Patient details are maintained on a computer data base out of which 103 cases were analysed for the current report.

Table-1 shows the background characteristics of persons using mental health services in Yelandur taluk. The pool of patients analysed consisted of 64 males and 39 females, majority were illiterates and more than one half were single by virtue of

being separated, widowed or never married, and the rest were married. The person registered consisted of 41.8% employed, 27.2% housewives, 15.5% were students, 6.8% were unemployed. A large majority of patients belong to nuclear families, less than one quarter were from joint families, and rest were living alone. Most of the patient belonged to low socio-economic strata and majority were Hindus. The mean age of the sample was 32.7 +/- 1.49 years.

Illness characteristics of the persons using mental health services is shown in table 2. Psychosis related complaints formed more than one half of the sample, one third was depression related and the rest consisted of mental retardation, anxiety and a very small proportion formed alcohol and dementia related complaints. About 40% of patients presented with acute onset of symptoms and an equal proportion with insidious onset of symptoms respectively. The remaining patients either had subacute or unclear onset of symptoms. The most common mental health problems diagnosed in the sample were schizophrenia 40.8%, depression 20.4%, bipolar affective disorder 10.7% (depression and BPAD referred to as affective disorders form 31.1%) of the sample, mental retardation 9.7%, acute psychosis 5.8% and others 12.7% in that order.

The mean age of the sample of patients with schizophrenia and affective disorders (which forms the core of severe mental morbidity and treatable) was 36.9 +/- 13 and 31.8 +/- 15.6 respectively (Table 3). The mean duration of illness was 72.4 +/- 65.1 months and 20.6 +/- 4.6 months respectively for schizophrenia and affective disorders. Similarly the age at onset was 31.4 +/- 14 and 28.4 +/- 13.5 years respectively. Table 4 shows the distribution of dysfunction affecting biological, personal, social and occupational spheres in major mental health problems. The most commonest was dysfunction in work performance (91.3%), sleep (85.4%), social norms (78.6%), appetite (68.9%) personal hygiene (54.4%), sexual (23.3%), and bowel (18.4%) in descending order.

Table 5 shows the service utilization pattern and distance from residence to the clinic. The proportion of patients who had contacted mental health services else where prior to the development of such services in Yelandur were 35.9% i.e. only 3-4 out of 10 individuals who needed psychiatric intervention sought help, while the rest did not. Those who had availed help outside stopped using that facility due to problems like distance, non-availability of free drugs, inability to afford drugs due economic reasons and logistic difficulties involed in shifting the patient. On having access to psychiatric services locally 41.7% were regular, 20.4% were irregular, while first contact dropouts were only 10.7%. The remaining patients were new cases who did not have enough follow up period to comment upon thier utilization. The mean distance from residence to clinic was 7.8 +/- .75 kms.

Clinical and social outcome of persons using mental health services is shown in Table 6. About 23.3% of patients improved symptomatically, 28.2% remitted completely, while the 13.6% were status quo and rest were either first contact drop out or did not have enough follow up care to comment upon the outcome. However when time taken for improvement and remission in symptoms were considered for major mental health problems it was found to be 1.6 +/- 1.7 months for schizophrenia, while it was 1.2 +/- 1.8 months for affective disorder, the figure for remission were 2.1 +/- 3.5 and 4.2 +/- 12.2 respectively.

Social functioning revealed that nearly one half of patient were functioning in expected roles, while nearly one quarter of patient had impairment in this sphere and for the rest this measure could not be assessed. Subjective level of satisfaction of significant family members revealed that nearly two thirds were satisfied with care they received from the centre.

DISCUSSION

The implementation of mental health services in Yelandur taluk in collaboration with an NGO using the strategy of integrating mental health care into general health services has resulted in identification of nearly 196 persons with severe mental health problems till date. This figure represents about a third of the total cases of severe mental morbidity excepted in Yelandur taluk. These findings clearly demonstrates that with simple decentralised training inputs a high proportion of severe mental morbidity was identified by the health workers. These cases were managed by the doctors in their weekly mental health clinics.

The high rate of identification of persons with severe mental morbidity and management by the doctors is in sharp contrast to other similar studies using comparable methodology in public health settings like, 'collabarative study on severe mental morbidity'(ICMR/DST, 1982) and study on 'mental health in primary health care' (ICMR/CMH, 1985-1987). The differences observed between these studies could be related various factors. This could be due to the low image of the PHC as a system among the public; low morale among the health workers and medical officers in the PHC; poor motivation on the part of health workers and medical officers; multiple programmes; need to acheive targets; emphasis on quantity than quality; transferable jobs and frequent interpersonal problems between the staff. On the other hand personnel in NGO sector are better motivated and committed to work. As a team they are very cohessive; frequently meet to monitor the progress of work in an atmopshere of friendship and mutual respect. Lastly, the involvement of the doctors and the supervisory staff in regular field work with the health workers goes a long way in boosting their morale.

Analysis of the data of persons registered since inception till May 1994 consisted of 103 cases. The sample was

characterised by predominantly males, belonging to middle age group from low socio economic strata and hailing from nuclear families. It is striking to note that nearly 40% of individual were never married, while 45% were married, the rest were single. This emerging trend of nuclearisation of families not only increases the burden but also influences the treatment seeking pattern, eg., underutilisation of services. Such issues have been researched and reported by Murthy et al.,(1977);Wig et al.,(1981) and Jayaprakash et al.,(1987).

The most common presenting complaints were related to psychosis, depression, mental retardation, severe neurosis and others like alcoholism and dementia. This pattern suggests that if services are available persons with severe mental health problems would avail such services without any reservation arising out of factors like stigma or attempts to conceal mental illness etc. Nearly 5-6 out of every 10 persons who visited the clinic presented with acute onset of symptoms while the rest had insidious onset. This demonstrates the potential ability of such facilities to intervene at the very early stages of illness resulting in better outcome. This point is illustrated with the case examples elaborated below.

Ms. P, a 20 year old married female was brought to the clinic with 15 days history of behaving abnormally. She was subjectively feeling very happy, often she would sing and dance in public which would annoy her husband. She claimed that god was talking to her and that he bestowed her with some special powers. She was also demanding special food and had enormous appetite. Her sleep was disturdbed, would wake up in the early hours of morning and start house hold chores and would never complete the task. She felt that all the family members were lazy and often quarelled with them. This patient was treated by the doctor in Yelandur clinic with Clorpromazine 100 mg., twice daily. Over the next four weeks all the behavioral problems in the patient had disappeared and she resumed her normal functions at home.

Mrs M, a 28 year old married lady was brought to the clinic with 2 years history of being suspicious, sleepless, refusing food, talking and arguing with imaginary people. At times she used to abuse the neighbours in foul language and claimed that they were doing black magic on her. Her personal hygeine was very poor and did not do any work at home. She did not take care of children and tend to wander away from aimlessly. The family members thought that she was possesed by evil spirits and took her to faith healers and priests with no benefit. In the clinic she was very irritable and aggresive. She was very suspious and argued that she did not have any problem. She refused to take medication and felt the doctors had joined her neighbours in finishing her. The team had to admit this patient in their small primary health centre and managed her with Injection

Chlorpromazine 50mg IM twice daily. Over the next one week patient was sleeping well, started to eat and agreed to take medication. With regular treatment all her symptoms disappeared in two months time. Mrs. M. continues to take medication and has reached normalcy.

The diagnostic profile suggests that most common severe mental health problems diagnosed in rural settings are schizophrenia, affective disorder; mental retardation in that order. The service utilisation pattern revealed very interesting results. One out of every ten patients with severe mental health problems registered in the clinic dropped out of treatment after first contact, about 4 continued treatment regularly, about 2 were irregular but maintained contact with the team. This trend of treatment utilisation pattern is better compared to earlier studies. This profile of follow-up reflects the skills the team has developed over time to educate the family and the patient with regard to the importance of regularity with medication and closely monitoring the side effects. The inputs from the visiting resource personnel further enhanced their skills. This occurs in terms of the doctors requesting the problem cases to attend the clinic on the day of the visit of the resource persons from NIMHANS to discuss and review diagnosis, management plan for some patients whom they felt difficult to manage. For ex., a patient with psychosis on conventional dose of chlorpromazine who did not respond to treatment, inability to distinguish between depression and residual schizophrenia or a patient with severe side effects leading to poor compliance with medication or difficulties in differentiating organic and functional psychosis. Such discussions resulted in referring such patients for admission to a major mental health facility. These reffered patients were suffering from a) space occupying lesions which presented as acute withdrawn behaviour, b) severe side effects leading to stupor, c) episodic abnormal behaviour due to cerebral mass lesion. It is important to appreciate that with periodic inputs the doctors gained skills in managing severe neurotic problems through non medical mode of interventions like, counselling. Further, they were able to apply these skills in their regular management and improving compliance among persons with Hansen's disease and tuberculosis.

Since the medication is dispensed free of cost and concern shown to the patient is high , compliance with treatment on the part the patient and the family is definitely better. About one half to three fourth of the patients registered had biological, social and ocupational dysfuntion. The common form of dysfuntion was impairment in work. Using simple basic drugs like (Chlorpromazine, Imipramine, Injection Fluphenazine and Trihexyphenidyl) to treat severe mental health problems, nearly 5 out every 10 persons had clinically improved or remitted in a short period of time. Similarly 1-2 out every 10 persons treated remained clincally symptomatic and functioned poorly.

CONCLUSION:

The current experience arising out of this work strongly suggests that with simple decentralised training, provision of mental health care to the needy, which is accessabile and affordable in terms of minimal drugs would result in remarkable acheivement in rural India with respect to severe mental health problems. Therefore what is needed is minimal essential drugs, concern for the ill and commitment and continuity in care. These interventions bring in significant changes in the patient and releive the enormous burden on the family by the simple act of collaboration between the NGO and the Professional.

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TABLE 1 : BACKGROUND CHARACTERISTICS

No.	Variable	Value	Distribution	Percentage
1.	Gender	Male	64	62.1
		Female	39	37.9
2.	Education	Illiterates	59	57.3
		Literates	43	42.7
3.	Marital Status	Married	47	45.6
		Single	54	52.4
4.	Occupation	Workers	43	41.8
		Non workers	60	58.2
5.	Family type	Living alone	5	4.9
		Nuclear	75	72.8
		Joint	23	22.3
6.	Socio-economic status	Lower	82	79.6
		Middle	18	17.5
		Upper	3	2.9

TABLE 2 : ILLNESS CHARACTERISTICS

No.	Variable	Value	Distribution	Percentage
1.	Presenting complaints	Psychosis	54	52.4
		Depression	29	28.2
		Mental Retardn.	10	9.7
		Anxieity	7	6.8
		Others	3	3.0
2.	Type of onset	Acute	53	51.4
		Gradual	50	48.5
3.	Course of illness	1st Episode	43	42.7
		Continuous	59	57.3
4.	Diagnosis	Schizophrenia	42	40.8
		Acute Psychosis	6	5.8
		BPAD	11	10.7
		Depression	21	20.4
		Mental Retardn.	10	9.7
		Others	13	12.7

TABLE 3 : ILLNESS CHARACTERISTICS

No.	Variable	Diagnosis	
		Schiz.	MDP
1.	Age in Years	36.9 +/- 13 min=18; max=71	31.8 +/- 15.6 min=12; max=70
2.	Duration of illness (months)	72.4 +/- 65.1 (5 - 6 years)	20.6 +/- 46 (2 - 4 years)
3.	Age at onset in yrs.	31.4 +/- 14 min=15; max=70	28.4 +/- 13.5 min=12; max=56

TABLE 4 PERSONAL AND SOCIAL DYSFUNTION

SL NO	VARIABLE	DYSFUNTION PRESENT	PERCENTAGE.
1.	SLEEP	88	85.4
2.	APPTITE	71	68.9
3.	BOWEL	19	18.4
4.	SEXUAL	23	23.3
5.	PERSONAL HYGEINE	56	54.4
6.	WORK PERFORMANCE	94	91.3
7.	SOCIAL NORMS	81	78.6

TABLE 5 : SERVICE UTILISATION PATTERN

No.	Variable	Value	Distribution	Percentage
1.	Past psych. consultation	Present	37	35.9
		Absent	66	64.1
2.	Type of follow up (current)	Drop outact	11	10.7
		Regular	43	41.7
		Irregular	21	20.4
		NA (New)	28	27.2

TABLE 6 : OUTCOME AND LEVEL OF FUNCTIONING

No.	Variable	Value	Distribution	Percentage
1.	Outcome following intervention.	Improved	24	23.3
		Remitted	29	28.2
		Status quo	14	13.6
		Others	36	35
	Improvement (months)		1.6 +/- 1.7	1.2 +/- 1.8
	Remission (months)		2.1 +/- 3.5	4.2 +/- 12.2
2.	Social functioning.	Functioning well	27	26.2
		Adequate	20	19.4
		Poor	13	12.6
		Status quo	15	14.6
		Not known	28	27.1
3.	Level of satisfaction	Very pleased	47	45.6
		Satisfied	21	20.4
		Unhappy	8	7.8
		NK	27	26.2

(1)

MH 30-5

COMMUNITY HEALTH CELL
47/1,(First Floor)St. Marks Road
BANGALORE - 560 001

COMMUNITY PSYCHIATRY IN INDIA - THE ROAD AHEAD*

R. SRINIVASA MURTHY
Associate Professor of Psychiatry
National Institute of Mental Health
and Neuro Sciences,
Bangalore-560029, India.

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The recognition of integrating mental health with general health services, the more popularly called PRIMARY HEALTH CARE (PHC) has been a very recent phenomenon. This is so, in spite of the well recognised role of mental health as part of the definition of health by World Health Organisation. At this point it is appropriate to refer to the recommendation of the WHO supported international conference on Primary Health Care at Alma Ata in 1978. The recommendation includes Promotion of Mental Health as one of the eight components of primary health care. With this recognition and renewed emphasis, it can be hoped that in the next twenty years meaningful models of basic mental health care will emerge.

The development of the mental health services in India shows interesting trends over the last forty years. The initial emphasis was on mental hospitals, which shifted to setting up of the general hospital psychiatry units and then to community programmes. This area of historical development has been reviewed recently in detail (Srinivasa Murthy, 1982). For a country like India, with vast area in which people live in small relatively independent units what is of greatest importance is the COMMUNITY PSYCHIATRY MOVEMENT that has taken roots in the last ten years.

The Western concept of community psychiatry has been based on the idea of community mental health centres (CMHC, USA) or linkages with the universally available health service like the National Health Services in Europe. Essentially the attempt has been on prevention, to provide good and integrated services for catchment areas or population, and by an extension of the wide mental health infrastructure already in existence. Thus, the reaching out is not as important as it is to countries like India with nearly non-existent mental health infrastructure in most parts of the country. This point becomes very clear when we consider that still a significant number of medical colleges do not have full departments of psychiatry, there are states with no mental health facility and only about 10% of the district hospitals in the country have psychiatric units, though they cater to the needs of more than a million population!

In India, the community psychiatry has come to assume a different role and importance. It is at present considered as a movement or plan to provide basic mental health care to majority of the population in a reasonable time frame with minimum of inputs. In other words, it can be said that the attempt will be to extend the services to the periphery simultaneously when the professional infrastructure is being built up. This is a very interesting innovation in that in the country the path for delivery of most health programmes has been through PHC and by integration with general health services. This has its own limitations and needs for support. How we function and support this infant movement will decide the face and fate of community psychiatry movement in India by the end of the Century.

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*Reprinted from CONTINUING MEDICAL EDUCATION Vol.1 (Eds) Ramachandran V., Palaniappan V and Shah, L.P. (1983) Indian Psychiatric society Madras.

This present paper deals essentially with the needs for future action. The developments so far have been reviewed and published in great detail (Srinivasa Murthy, 1982, Srinivasa Murthy and Wig, 1982, Kapur, 1975, Kapur, 1977, Isaac et al, 1982).

The origins of the community psychiatry movement can be traced to a number of meetings of the Indian Psychiatric Society. The notable among these are the First Conference of Superintendents of Mental Hospital at Agra in 1960, the Madurai conference on Priorities in Mental Health Care held in 1971, the WHO-SEARO workshop on community action for Mental Health care at Bangalore in 1973 and a number of workshops at Wardha, Trivandrum in this area. All these deliberations and committments for action in this area led to the development of pilot programmes around the country. The notable among these are the programmes to develop models of rural psychiatric services at Chandigarh (Raipur Rani), Bangalore (Sakalawara) and Vellore. These programmes are too well known to need elaboration in this paper. What was achieved by these programmes hase been to identify priorities for inclusion in the PHC set up, development of training programmes including manuals, application of epidemiological tools for evaluation of the effectiveness of the interventions and training of postgraduates in mental health in community psychiatry skills and philosophy. These initial attempts have been taken up in a bigger way by the Severe Mental Morbidity study of ICMR, since 1979, where the feasibility of training health personnel is being examined at four centres, namely Bangalore, Baroda, Calcutta and Patiala. There have been also attempts in the direction of training of the general practitioners and school teachers. (Shamasundar et al, 1978, 1980, Kapur et al 1978, 1979, 1980). All these studies and experiences have made it possible to consider launching community psychiatry programmes on a bigger scale.

A recognition of this coming of age of the community psychiatry approach has been the formulation of the draft National Mental Health Plan. The first meeting of the group of more than 50 mental health professionals took place at Delhi in July 1981 (21-22) where a draft document for the National level organisation of mental health services was considered. The deliberations led to the preparation of a new draft which was reconsidered in September 1982 by a smaller group prior to consideration by the health administration and others like planners and administrators. It is gratifying to note that the draft document was considered by the Central Council of Ministers in October, 1982 and recommended for further action. Thus the stage, in a way, is set for future action and hence the title of the paper, THE ROAD AHEAD. Before considering the way ahead, it is salient to recall the important features of the past recommendations of Indian Psychiatric Society and the proposed mental health plan, namely (i) appointment of central mental health adviser, (ii) appointment of state level mental health advisors (iii) identification of 'priorities' for different levels of health care (iv) training of primary health care personnel for mental health tasks, (v) strengthening of the mental health infrastructure like improving the mental hospitals, enhancing the training in psychiatry for undergraduates, setting up of district psychiatry units, organisation of peripheral units of rehabilitation and strengthening the public involvement in mental health care.

THE ROAD AHEAD

I have referred so far to the positive developments in the field of mental health care and presented an optimistic picture. However, as we look ahead, it is well to recognise that the ground covered has not been very clean. The positive and negative aspects of mental health care in the country were poignantly highlighted by a series of lay reports titled 'the sane approach', 'playing on the gullible', and 'a moment of madness'. These reflect the gullibility of the general public to easy exploitation, the near inhuman conditions of mental hospitals and a way out of the situation by shifting the care to the door steps of the people.

There is no single answer or approach to reaching the goal of basic mental health care as part of PHC. The factors that will decide the emergencie of meaningful services will depend on three factors:

(i) General development of the community
(ii) Growth of general health services in the country,
(iii) The organisation of mental health services on sound principles.

The situation in the country is not only unsatisfactory in terms of health and mental health but in regard to a number of basic amenities. It is essential to remember that in the country nearly 50% live in villages of less than 500 population, and 75% in units of less than 1000, that only 24% of the villages are connected with all weather roads, that more than 20% of the villages i.e. 50% of the population live below poverty line. The dramatic changes in the range, quality of mental health services can occur only along with changes in the development in these general areas in the community.

The development of health services and the current status is one of pluses and minuses. It is indeed creditable that we have such a big infrastructure of PHC services in the country and there are so many levels and categories of health personnel. However, it is also relevant to note that public health problems like tuberculosis, malnutrition are only limited successes in spite of the planning in the last 3 decades. The failures have been at different levels like lack of longitudinal planning, non-specifications of priorities, limitations in training facilities, changes personnel development and a very united amount of support in terms of supplies like petrol for travel of PHC personnel, drugs for treatment and equipment. Thus, the picture in regard to most general health problems is one of lack of adequacy and effectiveness. These problems of other National Programmes should be a pointer and caution to us in our new enthusiasm for National Mental Health Services.

FUTURE ORGANISATION OF MENTAL HEALTH SERVICES

There are four aspects that need to be given importance:

(i) The political committment
(ii) The professional committment
(iii) The crystallisation of knowledge in mental health care
(iv) Public education and involvement.

No major programme in the country can take strong roots without adequate committment at the political level and the public acceptance and support. As mentioned earlier we have had too many failures in the country because of the limitations in these two areas, to be dealt with in detail here. I will focus my attention to the role of us, the professionals in the future development of mental health care in the community.

PROFESSIONAL COMMITTMENT:

It is very gratifying and we can be proud to note that the senior psychiatrists have consistently expressed their committment to community psychiatry movement. At the point of its implimentation, the following specific points come up for reconfirmation of our willingness. The community psychiatry approach as outlined in the National Mental Health plan calls for a number of actions from the professional personnel. There is a necessity for the role of the professional to be different in the process of decentralisation and deprofessionalisation. To be more specific, the role is different from the hospital-oriented one. The psychiatrist, for example, (this is true for other professionals like psychologists, social workers and nurses) will have to devote significant portion of the time for supervision rather than direct patient care. Furthermore, because their work is carried out in a field setting rather than in the protected environment of a hospital or its clinic, they have to often accept different standards of care more appropriate to the field situations in which they are working. This calls for involvement in signification of the mental health work. Finally, they also need to acquire new skills, including managerial abilities and a community orientation and capacity to coordinate, which are not normally seen as being within the purview of a psychiatrist's abilities in the more traditional settings. At an individual level, it is not infrequent for the supervising psychiatrist to feel overwhelmed and inadequate for the multipurpose role in the community. It is needless to add that perseverance, a sense of openness and willingness to learn from the people is very satisfying and comparable to the satisfaction from the clinical responsibility in a hospital. (Srinivasa Murthy and Wig, 1983)

To support the planned mental health programmes in the community, training of psychiatrists should include supervised experience in the above area. This has been one of the important recommendations of the WHO Expert Committee on Mental Health (WHO, 1975). At a practical level there is an urgent need to have field practice areas attached to psychiatric training centres in the different parts of the country.

There are other sensitive issues that need to be taken cognisance of. The new approach will ive no results if the different professionals (i) set up 'artificial' rigid boundaries between the different mental health personnel, (ii) do not devote enough time in terms of research etc., to enhance the know-how in this area of work, (iii) lastly, one will also come up face to face with issues like allowing for limited use of drugs by paraprofessionals and non-professionals as it has happened in the areas of maternal and child welfare, tuberculosis, family welfare leprosy and malaria.

To summarise the issues in this area, it can be said that the need is to accept this approach as the REAL ALTERNATIVE rather than second rate method. This can result by a new generation growing up with these ideas, wide discussion, sharing of ideas and critical appraisal of the pilot schemes and inclusion of skills in this area during the training period.

ADVANCES IN MENTAL HEALTH KNOW-HOW:

Next I would like to focus our attention on an area of importance to the professionals and the programme. This refers to the needed simplification of knowledte on sound scientific basis. It is to be recalled that the domiciliary care of tuberculosis was demonstrated scientifically before care of tuberculosis moved out of the confines of the sanatorium. Similar examples are there in the area of public health. It is self-evident that decentralisation and deprofessionalisation can occur only when such knowledte is available and confidence levels in the day to day clinical work is high. The research efforts need to be in the areas of recognition of mental disorders, their referral, the initiation of treatments and their effectiveness.

Is this an important need? I would say yes from two counts. Firstly, professional colleagues have expressed doubts and reservations about the community psychiatry approach on the basis of the complexity of the mental health care. Opinions like treatment of psychiatric problems are based on experience, or the dosage and the type of drug used is too individually dependent, mistakes can be very dangerous etc. etc., are expressed. All these speak for the need for professionals to be the final arbitrors of the diagnosis and treatment. The second area of greater concern has been lack of research into simple but very important issues like the treatment schedules and use of drugs. A recent review of the antidepressant drug studies published in the country in the last two decades showed the lacunae clearly. (Srinivasa Murthy and Raghavan, 1983) The review of more than two dozen reports showed that (i) the diagnostic criteria was very loose, (ii) the duration of use was four weeks in most of the studies, (iii) global evaluation of the improvement was the common approach, (iv) the relevance of age of the patient, sex differences, the duration of illness, the presence of absence of associated physical illnesses etc. have not been the subject of study, and (v) the dosage variations and different treatment regimens has not been studied to offer knowledge about the ideal dosage and duration schedules. Thus, to-day, most of the treatment of depressive disorders is largely experience-based and varies from clinician to clinician. The above point is made as an example of the lacunae and the need for looking into areas traditionally thought to be not relevant when trained professionals are dealing with patients.

The needs in this area are protean and they should receive the most stringent consideration at the earliest time possible. There should not be decisions on an adhoc manner based on isolated pilot schemes but by research work in settings as similar to the field setting as possible. I can outline a few more areas that need immediate answers, namely (i) the relative effectiveness and safety of phenothiazines and ECT for acute psychoses and depression, (ii) the differences in the rates of relapse when the initial treatment for psychoses or depression is 3 months by as compared to 6 months to one year or more, (iii) the relapse rates for epilepsy when treatment is stopped after one year of fit free interval versus 2,3,4, or 5 years (iv) the methods of public education and (v) the cost effectiveness of rehabilitative measures with chronic patients.

It can be said that knowledge alone is not enough and quote the many public health programmes that have not become successful in spite of such knowledge being available (eg. tuberculosis, malaria) However, none of us can doubt the need for sound knowledge for large scale planning. The recent introduction of the health and welfare programmes like community volunteer scheme, the Integrated Child Development Scheme (ICDS) and the mid-day meal scheme show how political will can initiate massive programme touching the periphery, with or without a good technical base. Should we be caught flat-footed in future?

The review so far has highlighted the direction in which the community psychiatry movement in India is likely to move. It has also outlined the needed action at all levels especially focussing the role of psychiatrists. There is a need for considering the National Mental Health Plan both by those who work in the community as well as those who are involved in research and training. We can also support the movement and projected programme by the various activities outlined
To conclude, mental health services organisation has come a long way in the last 40 years. The current situation raises hopes of positive results in the near future. The time seems ripe for changes and with the involvement of the public, professionals and planners and by working out a long-term plan, meaningful benefits can reach the common man in the near future. Here lies the road to 'REACH THE UNREACHED'.

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WORLD HEALTH ORGANIZATION

PRESS

1211 GENEVA 27 SWITZERLAND - TELEPHONE: 791.21.11 - CABLES: UNISANTE-GENEVE - TELEX: 415 416 - FAX: 791.07.46 - E-MAIL: inf@who.int

Press Release WHO/1
10 January 2001

WHO LAUNCHES MENTAL HEALTH 2001 CAMPAIGN

The stigma is meaningless. The discrimination is unfair, if not unethical. Treatment is possible. It has to be made available. In a bid to focus attention on the stigma and discrimination surrounding mental health, the World Health Organization (WHO) is launching a year-long campaign on mental health. WHO is daring governments, health professionals and people from all walks of life to rise to the challenge posed by mental and brain disorders.

"Stop Exclusion – Dare to Care" says WHO in a message that succinctly sums up the year-long campaign that will culminate in a World Health Report on mental health scheduled for release later this year.

An estimated 400 million people today suffer from mental or neurological disorders or from psychosocial problems such as those related to alcohol or drug abuse. One out of four people who turn to the health service for medical care suffer from such disorders. Yet, few are diagnosed correctly, and fewer receive treatment. Most of their lives are characterized by undue suffering, disability and, at times, premature death.

"By accident or design, we are all responsible for this situation today," said Dr Gro Harlem Brundtland, Director-General of WHO. "Governments have been remiss in that they have not provided adequate means of treatment to their people. And people have continued to discriminate against those that suffer from these disorders," she added.

Public health authorities say stigma and discrimination are the biggest obstacles facing mentally ill people today. Rare is the family that is free from an encounter with mental disorders, yet almost universal are the shame and fear that prevent people from seeking care. The gross human rights violations in mental hospitals, insufficient provision of community based mental health services, unfair insurance schemes and discriminatory hiring practices are only some of the trials faced by people with mental health problems. Individuals and institutions bear responsibility for perpetuating these practices.

WHO says mental and brain disorders such as depression or epilepsy can be treated successfully, allowing people to function well in society. Important scientific advances have been made in reducing suffering and the accompanying disability. Successful methods of involving the family and community to help in recovery have been identified.

Prof. Mohan Isaac
for kind information.

12/1/01

World Health Day 2001, with the slogan "Stop exclusion – Dare to care," aims not only to raise awareness about barriers to mental health but also about solutions that exist to tackle mental and brain disorders.

The issue will be put before the annual gathering of WHO's 191 Member States during the World Health Assembly (WHA) in May 2001. Four ministerial round tables will discuss poverty, discrimination, gender and human rights aspects of mental health. The winners of WHO's global school contest on mental health will also be invited to read their winning essays before the WHA.

World Health Report 2001 will cover topics such as the prevalence of mental health disorders, the organization and financing of mental health programmes, the treatment gap, prevention strategies and projected trends for the future.

"We must strive for parity in the way mental and physical disorders are regarded. We know what is wrong, we know where solutions lie. We have a responsibility to push for changes in both policy and attitude and we are determined to do just that," said Dr Benedetto Saraceno, Director of WHO's Mental Health programme. "'Stop Exclusion – Dare to care' will not be a theme that is highlighted in 2001 and then forgotten," he added.

For further information please contact Ms Reshma Prakash, Noncommunicable Diseases and Mental Health, WHO, Geneva, Switzerland. Tel. (+41 22) 791 3443; Fax (+41 22) 791 4832; email - prakashr@who.int Visit our web site at http://www.who.int/world-health-day Journalists may also wish to contact Mr Gregory Hartl, WHO Spokesperson, WHO, Geneva, Switzerland. Tel. (+41 22) 791 4458; Fax:(+41 22) 791 4858. Email: hartlg@who.int All WHO Press Releases, Fact Sheets and Features as well as other information on this subject can be obtained on Internet on the WHO home page: http://www.who.int/

MENTAL HEALTH AROUND THE WORLD

Stop exclusion
Dare to care

WORLD HEALTH DAY 2001

World Health Organization

Photo: © WHO, A.S. Kochar

Photo: © WHO, Anenden

Address by Dr Gro Harlem Brundtland

Director-General of the World Health Organization

On 7 April 2001, all peoples and governments around the world will observe World Health Day. This year is devoted to mental health. We focus on mental health in recognition of the burden that mental and brain disorders pose on people and families affected by them, and with the aim to highlight the important advances made by researchers and clinicians in reducing suffering and the accompanying disability. Our message is one of concern and hope.

The road ahead is long. It is littered with myths, secrecy and shame. Rare is the family that will be free from an encounter with mental disorders or will not need assistance and care over a difficult period. Yet, we feign ignorance or actively ignore this fact. This may be because we do not have sufficient data to begin addressing the problem. In other words, we do not know how many people are not getting the help they need – help that is available, help that can be obtained at no great cost. And, because we lack this knowledge, we have not done well to address mental and brain disorders. As we fail to acknowledge this reality, we perpetuate a vicious cycle of ignorance, suffering, destitution and even death. We have the capacity – within us – to tackle the next frontier. Within people, within societies, within governments. Together we have to work to make the change.

An estimated 400 million people alive today suffer from mental or neurological disorders or from psychosocial problems such as those related to alcohol and drug abuse. Many of them suffer silently. Many of them suffer alone. Beyond the suffering and beyond the absence of care lie the frontiers of stigma, shame, exclusion and, more often than we care to know, death.

The simple truth is that we have the means to treat many disorders. We have the means and the scientific knowledge to help people with their suffering. Governments have been remiss in that they have not provided adequate means of treatment to their people. And people have continued to discriminate against those that suffer from these disorders. Human rights violations in mental hospitals, insufficient provision of community mental health services, unfair insurance schemes and discriminatory hiring practices are only some of the examples. By accident or by design, we are all responsible for this situation today.

The time for reckoning is now. Let us look at this day as an opportunity and a challenge. A day to reflect upon what remains to be done and how we can do it. Let us use this day and the weeks ahead to take stock and advocate for policy changes on the one hand and attitude changes on the other. Together with our Member States, let us pledge to work towards a day when good health will also mean good mental health.

This past century has seen spectacular changes in the way we live and think. Human brilliance and technology have come together to propose solutions we dared not imagine fifty years ago. We have conquered diseases that once seemed insurmountable. We have saved millions of people from premature death and disability. And our search for better solutions to health is, as it should be, ceaseless. The solutions to mental health problems are not difficult to find; many of them are already with us. What we need is to focus on this as a basic necessity. We must include solutions and care for mental health in our search for a better life for all in a systematic way. Only then will our successes be more meaningful. On this day, we must commit to "Stop exclusion – dare to care."

Gro H. Brundtland

Myths hurt – face them

Facts help – use them

Mental health today

A vision for the future

Where to learn more

Introduction

Mental health is an integral component of health through which a person realizes his or her own cognitive, affective and relational abilities. With a balanced mental disposition, one is more effective in coping with the stresses of life, can work productively and fruitfully, and is better able to make a positive contribution to his or her community. Mental and brain disorders, by affecting mental health, impede or diminish the possibility to reach all or part of the above. Preventing and treating them clears the road to achieving one's full potential.

As mental health is a fundamental building block for human development, we must face the facts that mental health problems are a part of life, that they can arise and that they can be addressed.

Stop Exclusion

There is no justification in ethics, science or society to exclude persons with a mental illness or a brain disorder from our communities. There is room for everyone.

The health care system can lead the way. No rationale exists for excluding mental health services from the general health care system. Parity between physical and mental health is vital.

Dare to Care

Don't fear those experiencing a mental illness. It can happen to anyone.

Don't ignore early warning signs.

Dare to challenge the myths and the misconceptions.

Provide better care; ensure access to care, insist on equity in care. All this must be done and all this is possible if we dare to believe that mental health care is a basic health concern for all.

Do mental and brain disorders only affect adults in rich countries?

No. All are affected – children and adults, rich and poor.

Photo: © WHO, C. Gaggero

No one is immune.

Number of persons world-wide with epilepsy (yellow) and schizophrenia (blue) (in millions)
Source: The International League Against Epilepsy (ILAE) 1999

	Epilepsy (yellow)	Schizophrenia (blue)
Developed Countries	7	7.5
Developing Countries	38	37.5

Mental and brain disorders affect adults, elderly, children and adolescents

Approximately one in five of the world's youth (15 years and younger) suffer from mild to severe disorders. A large number of these children remain untreated as services simply do not exist. The majority of treatments have been traditionally geared to adult patients, ignoring the need for early intervention in childhood.

- Some 17 million young persons in the 5-17 age group in Latin America and the Caribbean are affected by mental or brain disorders severe enough to require treatment.
- A study has shown that 10% of school children in Alexandria, Egypt suffer from depression. Anxiety among the secondary-level school children in their final year of school was found to reach 17% in this study.

Mental and brain disorders are a concern for both developed and developing countries

No nations and no peoples are spared:

- In a landmark WHO study in 27 developing and developed countries, no population has been found to be free of schizophrenia.
- Alcohol abuse is another common disorder that knows no boundaries. For example, in Russia, 35,000 people die every year from fatal alcohol poisoning.
- Epilepsy is universal and more frequent in developing countries
- A recent survey in a rural Pakistani village concluded that 44% of the adults were affected by depressive disorders.

Are mental and brain disorders just a figment of one's imagination ?

No. They are real illnesses that cause suffering and disability.

"Pull yourself up – it's all in your imagination." How often have we heard that? It's not just friends and family that fail to grasp the existence of a mental disorder. Even governments choose ignorance, as seen by the fact that mental health is often excluded from their health priorities and plans.

Mental disorders are real

Mental illnesses and brain disorders provoke suffering, cause disability and can even shorten life as we see from episodes of depression after a heart attack, numbers of liver disease resulting from alcohol dependence or cases of suicide. The existence of mental and brain disorders often remains hidden, voluntarily by the patient or simply unrecognized as a real illness by the person and their family. Yet the underlying abnormal substructure of many disorders has been identified by images of the brain. Thus to ignore their existence is akin to denying that cancer exists because we are unable to see the abnormal cells without a microscope. **Mental illnesses can be diagnosed and treated before it is too late.**

The symptoms are a sign of real illness

There are people who suffer from overwhelming fears that are accompanied by a host of recognizable symptoms. Others grapple with constant negative or unpleasant thoughts and turn to alcohol to escape. In some cases, the patient's pain can be so excruciating that suicide is seen as a relief. *In the year 2000, there will have been an estimated one suicide death every 40 seconds.*

It is easy to ignore or dismiss many symptoms, yet the fact is that five out of the ten most disabling disorders are psychiatric in nature. **Unipolar depression, alcohol use, bipolar affective disorder (manic-depression), schizophrenia and obsessive-compulsive disorder are among the 10 leading causes of disability world-wide in 1990.** The disability associated with mental or brain disorders stops people from working and engaging in other creative activities, e.g., a mother may cease caring for a baby, an adolescent may stop socializing with peers, and an elderly person may no longer take care of himself or herself.

Photo: © UNHCR, A. Hollmann

"If someone has a broken arm, you feel sorry for them. But when (the problem is) psychiatric, people don't know how to react because they can't see anything. But just because you can't see someone's pain, it doesn't mean they don't need your care and support."

Samoan woman, manic depressive, 29 years old, Auckland, New Zealand

Is it impossible to help someone with a mental or brain disorder?

No. Treatments exist and caregivers can be assisted.

Photo: © PAHO, A. Waak

Counselor meets with a mother and her mentally impaired child during a counseling session in a community health center

Something can be done for all mental and neurological disorders

Some people recover completely. Others have a more difficult time. But in all cases, there can be an alleviation of suffering through different methods. For example,

- Schizophrenia, a severe disorder, is treatable. People suffering from schizophrenia can be helped with medication to reduce the symptoms. A relapse can be prevented with psychosocial interventions aimed at the family, for the benefit of all.
- Most recently diagnosed children and adults with epilepsy could have a complete control of seizures for many years, provided they receive appropriate medicines.
- Rehabilitation measures, aimed at enhancing social and personal skills, assist persons with depression to regain a normal life. Anti-depressant medication can also help in many cases.

Help can be found from the medical profession on two levels.

The general health workers, such as physicians and nurses, are the first professionals whom one could consult. Most communities have access to them but in some parts of the world, they are not prepared to address the emotional needs of their patients. With proper training and supervision these professionals could be better equipped to identify and provide effective treatment for mental and brain disorders. A major stumbling block is to lift the shame so that people will talk freely of their emotional problems with their family doctor.

The specialized health workers, including psychologists, psychiatrists (for mental disorders) and neurologists (for brain disorders), psychiatric and neurological nurses, social workers and occupational therapists provide expert care where available.

It is not enough to assist only the suffering person

The family, which constitutes the main support system, needs support as well to preserve its functioning and well-being. Such help is seldom received; more services for families need to be developed in all countries.

Are mental or brain disorders brought on by a weakness in character?

No. They are caused by biological, psychological and social factors.

"You could get over it if you really tried." How often is this said? Yet, it is not a question of willpower or effort alone. In some cultures, people may also consider that "immoral" behaviour or bad fate are responsible for mental health problems. Let us not simply blame the person or poor luck but try to understand the complexities of a mental or brain disorder.

Research is being conducted to determine the genetic origins or biological factors of various disorders

Genes have been shown to be associated with the origin of schizophrenia and Alzheimer's Disease. Depression is known to be associated with changes in brain chemicals. Alcohol dependence, often branded as a vice resulting from poor moral character, is now linked to both the social environment and to genes. Mental retardation provides another example. One biological cause of this disorder is the lack of iodine, vital for brain development, in the diet of a growing child.

Social influences can significantly contribute to the development of various disorders

For example, individuals react differently to stressful situations. Loss of a loved one can potentially lead to a depression. Loss of work is associated with heavy alcohol use, suicide and depression. Poor nurturing environments, whether they are the result of broken families or violence in the home or community, can result in an increased risk of mental illness.

In some places of the world, mental illnesses are thought to be caused by evil spirits. This is a difficult issue. It pits faith against fact, faith healers against doctors, cultural beliefs against scientific knowledge. Perhaps to prevent a situation from taking a turn for the worse, mental health professionals can work with healers so that those who cannot be helped by traditional medicine can receive conventional treatments. **Mental health professionals serve the community better by understanding the cultural and social context within which their work is to be carried out.**

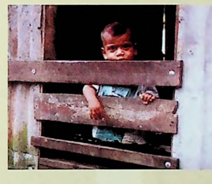


Photo: © WHO/WPRO, M. Murray-Lee

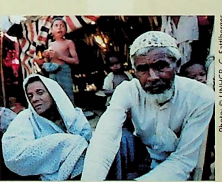


Photo: © UNHCR, C. Sattlberger

Extreme poverty, war and displacement can influence the onset, severity and duration of mental disorders.

> *"Mental illness is one of the major afflictions of mankind that has had little support in the past. During the last half century there has been quite a revolution in the understanding and treatment of major mental illness such as depression, schizophrenia, manic depression and anxiety. Rather than a flaw in character or a consequence of a dysfunctional family, recent research has shown that mental illness has biological roots."*
>
> *Julius Axelrod, 1970 Nobel Prize for Medicine in a letter to WHO Director-General on 30 June 2000*

Should we just lock up persons with mental illness ?

No. People with mental illness can function and should not be isolated or restricted.

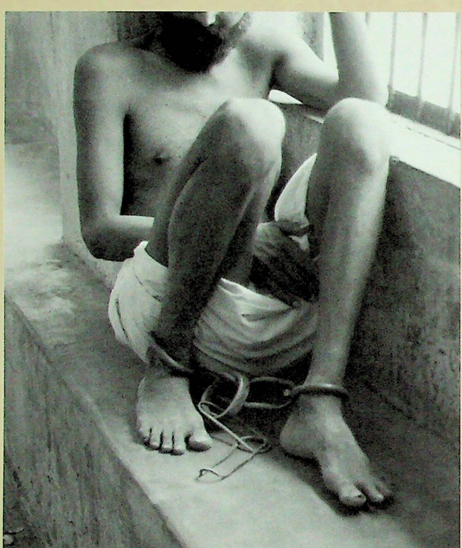


Photo: © CICR, C. Chiacchiari

Is this what we want ?

The treatment of mental illness is most often associated with mental hospitals. Institutions that violate basic human rights, stripping one's dignity through inhumane care still exist today. Too often abandonment, confinement, or isolation can be seen as the only solution when confronted with an ill person. **Yet, the facts show us that persons suffering from a mental illness or a brain disorder can improve and contribute to society.**

We have seen there are many possible treatments available; there are also better and more appropriate conditions in which we can provide these treatments.

Today, the picture in the world is far from perfect, but **care is now available in a variety of environments.** People's own homes, clinics, emergency rooms, psychiatric wards in general hospitals and day care centers are all viable options. Rehabilitation is carried out in hostels, cooperatives, sheltered workshops and through social support groups.

Like physical disorders, mental and brain disorders vary in severity. There are those that are:

- transient (like an acute stress disorder);
- periodic (like bipolar disorder, characterized by periods of exaggerated elation followed by periods of depression);
- long lasting and progressive (like Alzheimer's Disease).

Treatment must be appropriate to the disorder, and take into account the individual's situation: is the person alone at home? Does he/she have family who could provide care together with the doctor or a nurse? **The best alternative will depend on each individual, and in any situation, the human rights of people must be preserved.**

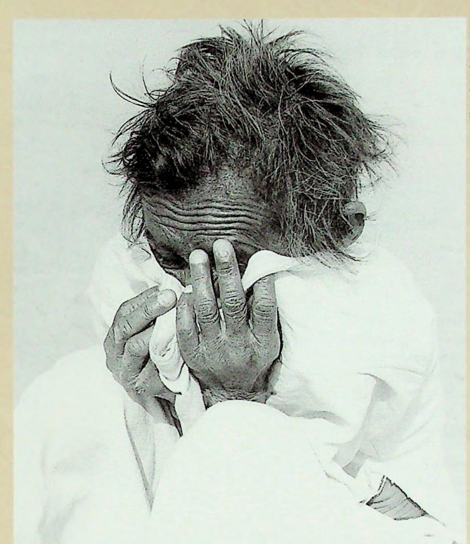


Photo: © WHO, A.S. Kochar

I experienced homelessness at one stage coming out of the hospital. I had nowhere to go. I had no other choice. My family at that point was struggling with their own view of my condition and there was no place in the family for me. If my family had been educated, taught how to help me, supported and helped, then my story would be very different. Families need to be involved – they are after all the ones we rely on the most.

Woman with a schizophrenic disorder, 43 years old, New Zealand

There are many other misconceptions about mental illness and brain disorders. To address them all here would be well beyond the scope of this brochure. Take the time to explore your own personal prejudices and unfounded beliefs.

We should all recognize that persons with mental illness suffer not only on account of their illness. They are often socially stigmatised, if not condemned. In everyday life, this impedes that people:

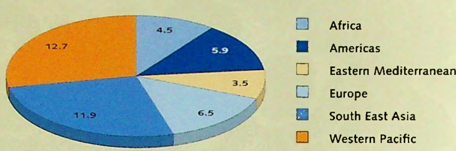
- reintegrate fully into society, obtain decent housing, a paying job or a reasonable social life. For a person who has been discharged from a psychiatric hospital, such exclusion may lead him back to the hospital;
- go for treatment when necessary, for fear that the search for help be known to others causing a loss of social status to both the person or the family. This is a serious problem since suffering is not relieved and functioning or quality of life may be affected as the disorder continues.

The myths surrounding mental health problems are responsible for terrible shame and contribute to the low levels of treatment.

I am the main care-giver for my husband's brother, who is schizophrenic. The families of the mentally ill ... need to know that they are not to blame for the illness that has torn their family apart. Shame and fear build walls of silence. Now is the time to speak out so that families can know that they are not alone, that they have nothing to be ashamed of. The public must be educated to recognize symptoms, to know that mental illness can strike anywhere and to understand that help is available.

Mrs. Kathy Esquivel,
wife of former Prime Minister of Belize, Central America

Schizophrenia



Number of people with schizophrenia world-wide (in millions)

What is it?

Schizophrenia is characterized by profound disruption in thinking and feelings, affecting language, thought, perception, and sense of self. It often includes psychotic experiences such as hearing voices or holding fixed abnormal beliefs, known as delusions.

How many suffer?

Around 45 million persons world-wide above the age of 18 suffer from schizophrenia at some point in their lives. The disorder has been found in all nations where studies have been conducted. It begins at a young age and can impair functioning causing the loss of an acquired ability (i.e., not being able to gain one's own livelihood or disruption of studies).

What can be done?

Research has advanced the understanding of the disorder and made major contributions to the treatment. Treatments are both of a biological nature (e.g. medication) as well as psychosocial (e.g. psycho education of the family and rehabilitation). The helplessness of the past has been replaced by considerable hope since conditions that once were treated in closed institutions have been giving room to interventions at home, in community services, general hospitals and hostels. Psychosocial rehabilitation has made considerable strides and has enabled patients to find a place in the workforce, in their families and communities. Early treatment is essential for better recovery.

My first-born son, today aged 39, was first hospitalized at age 17 for about four months, some four years after his mother died of cancer. The official diagnosis of schizophrenia was disclosed to me only five years after its onset.

"For about ten years while at home, my son refused to take medication due to adverse side effects, refused to see doctors leading to extreme confrontations. For the last five years he is being treated with medication and his condition has stabilized. He now lives in a very decent hostel [half way home] and works in supervised employment for few hours every working day. His social life and personal relations are much improved.

"Beyond the personal saga, I gained extensive experience in the last years. I am involved as member – and recently as chairman – of a family organization. I strongly believe that today most schizophrenia patients and their families can avoid the via dolorosa we went through, if using adequate combinations of medication and psycho-social rehabilitation – with strong emphasis on the latter. This, however, requires drastic reform – beyond lip service – by the medical establishment and the public authorities – in the allocation and proper use of the public health funds and manpower. Our families' organization is committed to struggle to achieve this reform, but it is still a steep uphill struggle.

Father of a person with schizophrenia from Israel

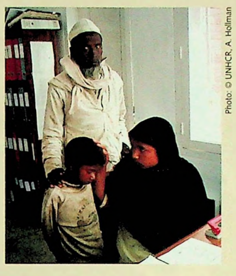


Photo: © UNHCR, A. Hollman

I am about fifty-seven years of age. I had never experienced any odd or abnormal state of mind. Neither had I ever known any such thing about any of my family members. By nature I am a very contented person, generally very helpful and cooperative, even to my casual acquaintances. Holding a very senior position in a leading educational institution, I have no problem with my job, status and family.

"In the month of April 2000 all of a sudden I observed certain changes in my mental make-up. Though there was no personal provocation I developed a kind of phobic anxiety, started attaching motives to happenings and persons around. There was a feeling of undue sadness, lack of vigour and inability to concentrate on work and personal matters. I started losing interest in all normal activities; loss in weight, appetite and sleep was also experienced, thus causing so many simultaneously occurring complications, both physical and mental.

"I was diagnosed with depression and assured that it was curable. I religiously followed my doctor's instructions. I have visited him four times and have the satisfaction that with the grace of the Almighty and with the able handling by the esteemed Doctor, I have regained my confidence and have restarted taking interest in all normal activities around.

Male patient from India

What are they?

Depressed mood and loss of interest and pleasure characterize these disorders. If they alternate with exaggerated elation or irritability they are known as bipolar disorders (one pole, depressed; another pole, elation or mania). Their severity, the symptoms that often accompany the depressed mood and the duration of the disorder differentiate them from normal mood changes that are part of life.

The causes of these disorders vary, there are psychosocial risk factors that influence the onset and persistence of the depressive episodes as well as biological factors of different kinds.

How many suffer?

Studies demonstrate that one out of seven adult persons in the USA have a mood disorder during a single year, 7% in Brazil, almost 10% in Germany and 4.2% in Turkey. In the USA, 5% of children aged 9-17 were found to have depression, a disorder thought to spare youth and adolescents. Ignoring this reality can result in suicide. Depressive disorders and schizophrenia are responsible for 60% of all suicides.

What can be done?

Despite the existence of solutions, the majority of people with depression do not receive adequate treatment. This implies that there are millions of people in the world currently affected by the disorder whose suffering and disability is prolonged because their condition goes undetected or, often, is not well treated. A reluctance to speak about ones feelings or poorly trained medical personnel can be at the root of this. Fortunately, there are now clear guidelines for the treatment of mood disorders which include both antidepressant medications and psychological interventions, such as cognitive psychotherapy and social support.

Photo: © UNHCR, E. Dagnino

What is it?

Alzheimer's Disease is a form of dementia which destroys brain cells, disrupting the transmitters which carry messages in the brain, particularly those responsible for storing memories. It is one of the most common types of dementia world-wide and accounts for 50% to 60% of all cases. Dementia is a progressive degenerative brain syndrome which affects memory, thinking, behaviour and emotion. Symptoms may include a loss of memory, difficulty in finding the right words or understanding what people are saying, difficulty in performing previously routine tasks, personality and mood changes.

How many suffer?

There are currently estimated to be about 11 million people world-wide with Alzheimer's Disease. This figure is projected to nearly double by the year 2025.

The late stage of Alzheimer's Disease is one of total dependence and inactivity. At this stage individuals are no longer able to care for themselves and do not recognize relatives, friends and familiar objects. This represents an enormous burden on families and the health care system.

A study by the American Alzheimer's Association in 1998 has shown that this disease costs US businesses US$ 33 billion a year; US$ 26 billion related to the absenteeism of caregivers – employees who take care of people with the disease, with businesses contributing another US$ 7 billion toward the total cost of care. There are no global figures as yet for the financial impact of Alzheimer's Disease.

What can be done?

There is currently no cure for Alzheimer's Disease. Over the last five years there has been a growth in the number of drugs being developed or considered for use in people with dementia, particularly Alzheimer's Disease, which seem to provide symptomatic relief for some patients. Interventions given by family caregivers can reduce the family's distress and that of the person with Alzheimer's Disease, as well as delaying nursing home placement where this is available. Support for persons with Alzheimer's Disease and their family can come from different sources but is often of limited availability. Voluntary organizations such as Alzheimer's Disease associations give practical and emotional help as well as training for caregivers and professionals.

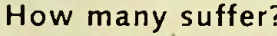
I now deeply regret that I was irritated by my husband's behaviour instead of being considerate of him in such a situation, as I did not understand what was wrong. Eventually at the age of 55, (my husband was) diagnosed (with) Alzheimer's Disease. I attended the care-giving study class at the public health centre with my husband. On a public health nurse's recommendation, my neighbours kindly attended the centre to increase their knowledge of the disease. I was helped by them enormously after his wandering started. Although I feel I will never be able to accept my husband's disease, I would like to thank him for giving me the opportunity for mental development.

A woman's story from Japan

Epilepsy

What is it?

Epilepsy is a brain disease characterized by repeated seizures ("fits") which may take many forms, ranging from the shortest lapse of attention to severe and frequent convulsions. The causes are multiple, e.g., trauma to the brain, infections such as encephalitis, parasites, alcohol or other toxic substances. However, in half of the cases, the causes remain unknown. Epilepsy is treated by neurologists when available or by psychiatrists in many other places.



How many suffer?

It is estimated that about 45 million people of all ages around the world are affected by epilepsy, while 1% of the total burden of disease in the world results from it. This calculation of the burden of disease takes into account premature deaths resulting from the disease as well as the loss of healthy life years due to disability. The number of people with epilepsy is over five times higher in developing countries than in developed countries.

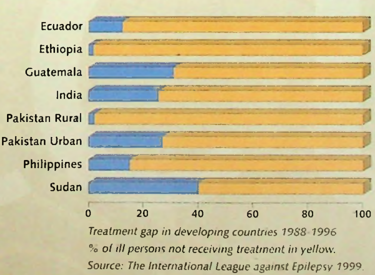
A vast majority of those suffering remain untreated. Take the case in Africa, for example, where up to 80% of people suffering from epilepsy do not receive any treatment at all.

Photo: © WCC, P. Williams

Bet-El School for children with epilepsy run by the NGSK Church in Cape Town, South Africa

What can be done?

The solutions exist so that up to 70% of newly diagnosed cases can be successfully treated with anti-epileptic medication that is taken without interruption. After 2-5 seizure free years, the anti-epileptic medication may be gradually withdrawn in 60-70% of the cases, provided the physician indicates such a course of action. Yet the health care system in many places has failed to recognize or find those with epilepsy and in some cases, has failed to provide the right treatment to those it has recognized. The important thing to note for a disorder so frequent is that there are medications which are both effective and cost efficient. Given their low price, they are an affordable remedy in all countries.



Treatment gap in developing countries 1988-1996
% of ill persons not receiving treatment in yellow.
Source: The International League against Epilepsy 1999.

Mental retardation

Photo: © Produced by S. Pic

"The Lonely Flower" painting by a severely mentally retarded adult.

What is it?

The World Health Organization defines mental retardation as a condition of incomplete or halted development of the mind, which is characterized by the impairment of skills as manifested during the developmental period that contributes to the overall level of intelligence, e.g., cognitive, language, motor and social abilities.

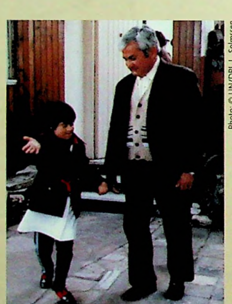


Photo: © UN/DPI, L. Solmssen

How many suffer?

It is estimated that the number of individuals with mental retardation differs in relation to the level of country development. The percentage of young persons, aged 18 and below, suffering from severe mental retardation reaches 4.6% in the developing nations and are estimated to be between 0.5%-2.5% for the established economies. The difference between both figures indicates that, potentially, preventative efforts made to reduce mental retardation, such as better maternal and child health care as well as specific social interventions, could result in an overall decrease of mental retardation worldwide.

What can be done?

The mental potential of all persons, including of those who are limited by retardation, can either be developed or wasted. A positive attitude coupled by appropriate educational and vocational programs can help those with mental retardation to adjust and succeed by performing at their highest level. To achieve such goals, services need to be provided and self help groups, of both families and individuals, need to be fostered. The empowerment of parents could accelerate the formulation of healthy policies, programs and services.

Alcohol dependence

What is it?

Alcohol dependence is a mental disorder recognizable by symptoms which can include a strong and persistent desire to drink despite harmful consequences, inability to control drinking, a higher priority given to alcohol consumption than to other activities and obligations, tolerance to alcohol, and a physical withdrawal reaction when alcohol use is abruptly discontinued.

Alcohol can trigger health problems in a large number of problem drinkers (alcohol dependent or not), including accidents and injuries, heart disease, cancer, liver disease and alcohol psychosis. Alcohol is also related to social problems including crime, violence, marital breakdown, poor school performance, high rates of work absenteeism, suicide and financial debt.

How many suffer?

While there are an estimated 140 million alcohol dependents in the world, there are over 400 million people who drink excessively and can cause accidents, injuries, suffering and death. There is no reason to blame only "alcoholics". Excessive alcohol use is a leading cause of PREVENTABLE death, illness and injury. In 1992 the economic cost to society from alcohol in the United States was an estimated US$ 148 billion, while studies in other countries have estimated that the cost of alcohol related problems range between 0.5% and 2.7% of the gross domestic product.

- **140 million alcohol dependents**
- **78% are not treated**
- **Alcohol is responsible for 1.5% of all deaths in the world**

What can be done?

It is very hard to determine exactly when a person has become dependent on alcohol and by that time a range of problems may have already occurred to the individual and others. As a result, assessing levels of alcohol consumption is the most effective way to identify problem drinkers early. For those at risk, brief interventions of only five minutes can lead to a 25% reduction in alcohol consumption, preventing progress to more severe problems, including alcohol dependence.

Treatment of alcohol dependence and withdrawl can be effectively carried out in community settings for most cases. Voluntary mutual help organizations can also play a large role in supporting recovery from alcohol dependence. However, measures aimed only at treating those who are dependent are not enough. Effective alcohol control policies are also needed.

"I went to a party, Mom.
I went to a party,
and remembered what you said.
You told me not to drink, Mom
so I had a Sprite instead.
I felt proud of myself,
the way you said I would,
that I didn't drink and drive,
though some friends said I should.
I made a healthy choice,
and your advice to me was right
as the party finally ended,
and the kids drove out of sight.
I got into my car,
sure to get home in one piece,
I never knew what was coming, Mom
something I expected least.
Now I'm lying on the pavement,
And I hear the policeman say,
"The kid that caused this wreck was drunk,"
Mom, His voice seems far away.
My own blood's all around me,
as I try hard not to cry.
I can hear the paramedic say,
"This girl is going to die."
I'm sure the guy had no idea,
while he was flying high,
because he chose to drink and drive,
now I would have to die.
So why do people do it, Mom
Knowing that it ruins lives?
And now the pain is cutting me,
like a hundred stabbing knives.
Tell sister not to be afraid, Mom
tell daddy to be brave,
and when I go to heaven,
put "Daddy's Girl" on my grave.
Someone should have taught him,
that it's wrong to drink and drive.
Maybe if his parents had,
I'd still be alive.
My breath is getting shorter, Mom
I'm getting really scared.
These are my final moments,
and I'm so unprepared.
I wish that you could hold me Mom,
as I lie here and die.
I wish that I could say I love you, Mom
So I love you and good-bye."

Author unknown, circulating on Internet

Taking stock

"Great numbers of mentally ill still live, shut away behind hopeless walls by the prejudices and incomprehension of society. The efforts of the most advanced psychiatrists to have the mentally ill treated as other sick people, who can be cured, are likely to remain fruitless as long as irrational fear of 'madness' is not conquered, as long as all the influential members of the social hierarchy do not understand that mental health is not only the business of specialists but must concern the whole community."

This statement was written forty years ago, in a special issue of World Health commemorating World Health Day in 1959. What is remarkable is that this statement is still reflected in the public image of mental health today. As we realize that the global perception and practice in mental health remains much as before, we can bring to light the incredible accomplishments in many corners of the world. Today we have the opportunity to take one giant step forward collectively– out of the darkness – into the glimmering rays of knowledge that many have endeavored to bring forth. We know many things: mental and brain disorders are real illnesses, they are diagnosable, treatable and in some cases we know how they occur and how to prevent them. Anyone can be afflicted but we pretend not to be concerned.

A change now needs to happen in our hearts to accept the knowledge which has been gained and to adopt a new attitude about mental health. We are the missing link – the minds of some billion souls – that should come to realize that one's mind and brain can become sick but can also be healed, just as the body.

We are on the path around the world to improve the care of persons with mental or brain disorders.

Photo: © PAHO, A. Waak

Group health session in Venezuela

Reorienting Mental Health services

The United Nations Commission of Human Rights stated not only that **medical treatment should be considered as a basic right for people suffering from mental illness**, but also that those people have to be **protected from potential dangers**. This was far from the case for centuries of mentally ill patients. While some countries have been moved to change this situation, still others have not. Violations of human rights can be perpetrated both by neglecting the patient through carelessness and by forcing him/her into restraining or even violent care systems. Even under optimum circumstances, persons with mental illness in most countries are often powerless. Yet, family members and patients themselves can try to influence mental health policy and service organizations.

Latin America – an example of the "consumer" movement

In the early 1990's, throughout Latin America care for persons with severe mental disorders was mostly provided in outmoded mental institutions that often violated human rights. Outraged by this situation, a group of parliamentarians, mental health workers, media, consumers and advocates, representing eleven countries gathered in Venezuela to analyse mental health care and suggest ways to upgrade it. The Caracas Declaration which resulted from this historical meeting has given further impetus to a movement of reform in mental health care that was on the making in several countries of Latin America.

Brazil is one example where considerable strides have been made. **Active participation of patients themselves in the formulation of policies to overcome past inequities provides a strong voice and vitality to a process of change that is moving the care from closed institutions into the community.** Change is resisted by some quarters, often as a result of ill-conceived notions and traditions, yet observers of the Brazil case note that the patients keep the agenda moving forward and force the pace of this reform among both professionals and society at large. The struggle has been taken to the streets and into the chambers of the parliaments. Brazil has developed innovative programmes, such as the one in the city of Santos, State of Saõ Paulo, where mental hospitals of yesteryear have given room to alternative settings of care and where consumers are gainfully employed by co-operatives.

Chile is another example of a country resolutely moving forward to transform its services. Today, community clinics are mushrooming all over its territory although, admittedly, some areas are yet to be covered. Moving north, in Central America, Panama and Belize, among other countries, are innovating the type of services offered. Belize, for instance, with just a single psychiatrist working in the country, has multiplied its resources by training family nurses known as psychiatric nurse practitioners, entrusted with the provision of mental health care. A recently conducted evaluation has shown that the public is satisfied with their services, now offered all over the country. Despite these improvements, there is still a long way to go to reach the aims that the authors of the Caracas Declaration had in mind. In Latin America, some populations do not have mental health coverage, many services remain substandard and human rights violations have not been banished.

De-institutionalization and human rights – the case in Europe

De-institutionalization (providing care to the mentally ill in community settings and not in harmful institutions) is very closely related to human rights concerns and represents a basic precondition of any serious mental health care reform. De-institutionalization is not the mere administrative discharge of inmates' populations leading to dramatic patient neglect. On the contrary, de-institutionalization is a complex process, where **de-hospitalization must lead to the implementation of a network of alternatives, outside of the walls of the mental hospital.** A more positive notion of "non-institutionalization", with emphasis on community alternatives should be the norm in all countries.

In Italy, the 1978 Mental Health Reform began a process of "humanization" of the psychiatric hospitals and led to the creation of community based services capable of enabling patients to live in normal environments. The Italian city of Trieste has created an impressive network of community based services, protected apartments and co-operatives employing mentally ill persons. The psychiatric hospital in Trieste was closed down and replaced by community mental health services operating 24 hours a day. These centres provide medical care, pyschosocial rehabilitation, social assistance and when necessary treatment of acute episodes. A number of protected apartments providing a "non-medical" and friendly environment for the most severely and chronically ill were created. Finally, work opportunities have allowed many patients to secure a substantial integration into the community life. Many other European cities have witnessed a marked shift from hospital-based to community-based systems leading to an important decrease of mental hospital beds and, in some cases, the closing of the whole institution. The Siauliai mental hospital in Lithuania, for example, is on the road to providing rehabilitation services and reintegration of psychiatric patients into the society. With the purchase of a residential building this year, increased attention is given to psychosocial interventions aiming to ensure that after treatment the patients can independently function at home and in society. Similar scenarios of community mental health care are being built in other regions of the world, yet still not in the generalized fashion that we hope for.

Photo: © L. Sepetauskas

The Siauliai mental hospital in 1980

Photo: © O. Bieliauskiene

The Siauliai mental hospital in 2000

Mental health as part of general health care services

Mental health care is a basic and essential building block for ensuring life-long good health. **The family doctor and general practitioner need to become increasingly better able to recognize any potential mental impairment or brain disorder in order to provide quality care.** In many parts of the world, different methods are being utilized to address this concern.

One example from the Middle East

An innovative approach for ensuring that basic mental health services are available to all people, even the most vulnerable and deprived groups, was conceived in Iran in 1985 as the "National Mental Health Programme".

A unique feature of the Iranian health system is the integration of health delivery and medical education in one ministry. At the base of a pyramid approach are the Health Houses in rural areas (and more recently Health Units in urban areas); each one is responsible for the basic health needs of around 2000 people. These small units rely on human resources that are recruited from the community and trained. There is one community volunteer for every fifty families to assist them in getting any necessary medical attention. Health Centers group together four or five health houses or units and provide the services of a General Practitioner. Such a center is in turn supervised by the District Health Center and has access to specialist centers that are usually part of a University of Medical Sciences and Health Services. In each province of the country (population of sixty million), there is at least one such university which is in charge of health affairs of the province as well.

The integration of mental health care within this existing nationwide structure started as a test case in central Iran in 1987. Mental health responsibilities of each level were clearly defined and appropriate training, follow-up and supervision provided. The mental health system is supported by a third specialized level composed of 650 psychiatrists and about 10,000 psychiatric beds, although most of them are still in large psychiatric hospitals. To gradually decrease the reliance on mental institutions, there is a standing decree from the Minister of Health and Medical Education that 10% of the beds in all new general hospitals should be used for psychiatric care.

At present, the programme is active throughout the country: almost 60% of the rural Health Houses and 25% of the Urban or Mixed Health Centers comprising 5,500 general practitioners are active in providing mental health services.

This approach has been adapted by other countries in the region, such as Bahrain, Cyprus, Egypt, Jordan, Tunisia, Saudi Arabia and Yemen. There is more than one recipe for success but this approach to integrating mental health care within a primary health care system is a good testimony to what may be accomplished in other parts of the world.

Photo: © A. Mohit

Training of mental health professionals in Iran.

Photo: © R. S. Murthy

Woman with schizophrenia (holding child) in care at home with her family in India.

The empowerment of families

Family involvement in the care and rehabilitation of persons with mental or brain illness is being recognized world-wide as a key factor in successful treatment.

The case in South Asia

The family has been an essential part of mental health care programmes in South Asia for fifty years.

The first formal recognition of the importance of the family as part of organised mental health care can be traced to the mid 1950's in Amritsar Mental Hospital, India. Patients were brought for hospital admission as a form of abandonment once their mental illness was long-standing and their relatives had no more hope. As an experiment, the relatives were encouraged to stay with the patient during the treatment period by pitching tents on the hospital grounds. The success of this involvement led to other similar experiments and the system of including a family member has become an essential part of psychiatric in-patient care in all countries of the Region.

The focus of family interventions, to date, has been to build a relationship with caregivers based on understanding and empathy, and helping them to:

- identify ways to promote medication compliance;
- recognize early signs of relapse;
- ensure swift resolution of crisis;
- reduce social and personal disability;
- moderate the effect in the home environment;
- improve vocational functioning of the patient;
- develop self-help groups for mutual support and networking among families.

More than 500 persons who were long-stay patients in the mental hospital have been rehabilitated in Sri Lanka, by community education and family involvement. In a number of cities such as Jodhpur and Chennai in India, a camp approach to drug detoxification has included the families as "partners in care". The home care programmes for elderly persons with dementia initiated in Kerala, India, is now spreading to other parts of the country. Another initiative is training for home care and support to family members of mentally retarded individuals. This has resulted in a movement that has generated vocational rehabilitation for the adult mentally retarded individuals. Families of a person with schizophrenic illness in many cities (such as Bangalore, Chennai, and Gauhati in India, Katmandu in Nepal and Colombo in Sri Lanka) have come together to form self-help groups and start day care centres, half-way homes, hostels and to put pressure on the policy makers to improve services for the mentally ill persons.

The successes of family care programmes have still not received the full support of professionals and planners to the extent that it becomes a routine part of psychiatric care. As we enter the 21st century, this must become commonplace for everyone around the world.

Photo: © Douleurs Sans Frontières, S. Laurent

Mental health counselling after floods in Mozambique.

Mental health care in countries in conflict

Many countries in Africa are engulfed in conflict and civil strife resulting in an adverse impact on the mental health and well-being of the affected populations. It is estimated that there are between 40 to 50 million refugees and displaced persons worldwide. Of these, only 22.4 million receive humanitarian protection and assistance and around 30% of these displaced persons are in Africa. Increasing poverty and lack of international legal consensus are some of the major factors preventing most of the refugees from receiving support.

Wars, other forms of violence and disasters contribute to the growth of psychological and socio-economic burden. Family disruption with an increase of abandoned children and women headed families; increase of street children; juvenile delinquency; prostitution; and alcohol and drug related problems are a common scenario in a number of countries of Africa. All these stressful events contribute to anxiety, depression, different psychosomatic disorders, phobias and post traumatic stress disorders.

Community Based Psychosocial Interventions – the story in Africa

Community based approaches to tackle mental health problems and other consequences of war and social disruption were recently the subject of two important inter-country meetings involving Angola, Burundi, Chad, Congo, Democratic Republic of Congo, Eritrea, Ethiopia, Lesotho, Liberia, Mozambique, Namibia, Rwanda, Sierra Leone, South Africa, Uganda and Zimbabwe. These countries have embarked on different types of community based interventions despite the difficult conditions which include:

- **prevention and promotion activities** such as peace education, conflict resolution skills, prevention of alcohol and drug abuse;
- **early detection and treatment of physical, psychological and social problems** involving nutritional rehabilitation, first aid for victims of land mines and other forms of injuries, psychological support using school teachers and self-help groups;
- **rehabilitation** through social reintegration, family reunification and the promotion of human rights.

The involvement of community and religious leaders, traditional medicine practitioners, women and youth organizations and self-help groups is very effective to ensure culturally sensitive initiatives.

Mental health care in transition economies

Recent changes in the socio-political development of many countries in the Western Pacific Region have generated considerable challenges which permeate the lives of the people in these communities. These changes affect the structure of society, and are felt especially in the mental health situation of the population. Clearly, in situations of transition economies, concerns for job security and the economic survival of the household can loosen social bonds and create enormous pressure on one's mental health stability. The resulting need for mental health programs at all levels, for strengthening promotion, prevention and care and for reorienting services to address the psychosocial issues of a changing society was addressed in Mongolia.

Innovating mental health – one example from Central Asia

Mongolia is a country which is changing from socialism to one with a market economy following a democratic political reform in 1990. This change has been affecting all aspects of Mongolian life: political, economic and social life, especially impacting on the family. In 1997, the National Health Policy has articulated the shift from a specialist to a generalist health care delivery system. As a consequence, general health services are being strengthened, and hospital based care has shifted to bring a greater emphasis on community based health care.

Policy makers and government authorities have recognized the importance of mental health by specifically including mental health services in the new national health policy. As a consequence, appropriate training in mental health and psychosocial skills is provided to all general health personnel. In addition, health promotion among youth to prevent the adverse effects of social changes (such as increased alcoholism, suicide, violence and criminality) has been undertaken. In the last two years at least 50% of general physicians in Ulaanbaatar City as well as the provinces in the eastern, western and central parts of the country have not only undergone mental health training, but have started to manage patients with mental health problems in their clinics. These general physicians have also included mental health topics in their health education activities in the schools and during their home visits. Since 1999, the mental health training has been expanded to include the community health workers; many of whom attend to the nomadic groups representing 40% of the Mongolian population.

Since 1998, a decrease in admission and in the length of hospital stay at the State Mental Hospital has been noted. An increase in the number of patients treated in the general health clinics as well as those referred to the outpatient clinic and the Center for Mental Health are also recorded. A Mental Health Law, passed in 1999, provides for the continuation of these reoriented programs in the country.

We can do better
Stop exclusion
Dare to care

Photo: © WHO/WPRO, S. Suomela

Families

- In a crisis, involve all family members to solve the issue and support each other emotionally.
- Recognize early symptoms and encourage family members to seek help if needed.
- Support those suffering and do not dismiss their symptoms. Integrate them in the life of the family and the community.
- Join with other families to support each other and change common misconceptions.

Mental health care is a collective and continuous undertaking. It implies acting to preserve and recover that which makes people human, alongside with the spiritual life. It also requires a healthy environment, one that is peaceful, in which all people may prosper, where tolerance is generalized, and where violence is diminished. Without this, we are all at a greater risk for ill mental health.

A vision for the future

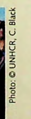
- Every individual will recognize the importance of mental health.
- Patients, families and communities will be more empowered for taking care of their mental health needs.
- Health professionals will become more skilled in prevention and treatment of mental illnesses as well as the promotion of mental health.
- Policy makers will be better equipped to plan services more rationally and ethically.

Everyone can help

Individuals

- Encourage wholesome early attachments and the acquiring of age appropriate abilities in children.
- Seek help if you have a mental health problem or think you have symptoms.
- Join in efforts to dispel the myths about mental illness and brain disorders.

Photo: © WHO, A. Waak



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Communities

- Create educational opportunities for citizens to learn the importance of mental health.
- Teach children tolerance to differences in individuals and acceptance of disabilities.
- Integrate those who have a mental health problem by providing them an opportunity to best contribute to society.

Medical professionals

- Consider your patients' emotional state as well as their physical state.
- Seek out training to recognize symptoms and acquire skills to care for those with a disorder.
- Involve the families in caring for the patient.

Policy makers (governments and insurers)

- Mental health is influenced by social factors; ensure that policies extend beyond the mental health care system to include education, labor, criminal justice and general health care systems.
- Provide coverage to assume the costs of mental health care as a basic guarantee.
- Allot funds for mental health research.

Science

- Study, in a comprehensive manner, all factors, including genes, environment and behaviour that contribute to the cause and duration of mental and brain disorders.

Mental Health professional associations

- Advocate for care to be provided equitably and in the most optimal conditions.

Media

- Contribute to empowering communities by reporting pertinent information and avoiding stereotypes and sensationalism.
- Focus on human rights of mentally ill persons.

Photo: © WHO/WPRO, S. Suomela

NGOs

- Educate the public about mental health and disorders.
- Organize support groups for families of the ill individuals.
- Mobilize public opinion about policies, programmes and welfare benefits for the mentally ill.

For more information

The WHO World Health Report which is focusing on mental illness and some brain disorders will be available in June 2001. The Report will provide more substance to the issues which have been highlighted in this brochure.

Addresses of WHO Regional Offices

Africa

WHO
Parirenyatwa Hospital
P.O. Box BE 773
Harare
Zimbabwe

Tel: (+263) 407 69 51
Fax: (+263) 479 01 46

Americas

WHO
525, 23rd Street, N.W.
Washington, DC 20037
USA

Tel: (+1-202) 974 30 00
Fax: (+1-202) 974 36 63

Europe

WHO
Scherfigsvej
DK-2100 Copenhagen 0
Denmark

Tel: (+45-39) 17 17 17
Fax: (+45-39) 17 18 18

Eastern Mediterranean

WHO Post Office
Abdul Razzak Al Sanhouri Street,
(opposite Children's Library)
Nasr City
Cairo 11371
Egypt

Tel: (+202) 670 25 35
Fax: (+202) 670 24 92

South East Asia

WHO
World Health House
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110002
India

Tel: (+91-11) 331 78 04
Fax: (+91-11) 331 86 07

West Pacific

WHO
P.O. Box 2932
1000 Manila
Philippines

Tel: (+632) 528 80 01
Fax: (+632) 521 10 36

Many non-governmental organizations are making a difference in improving mental health care and reducing exclusion. They are too numerous to list in this brochure. Visit the website www.who.int/world-health-day for links to many of these organizations.

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Concept and layout: Tushita Bosonet; logo: Marc Bizet

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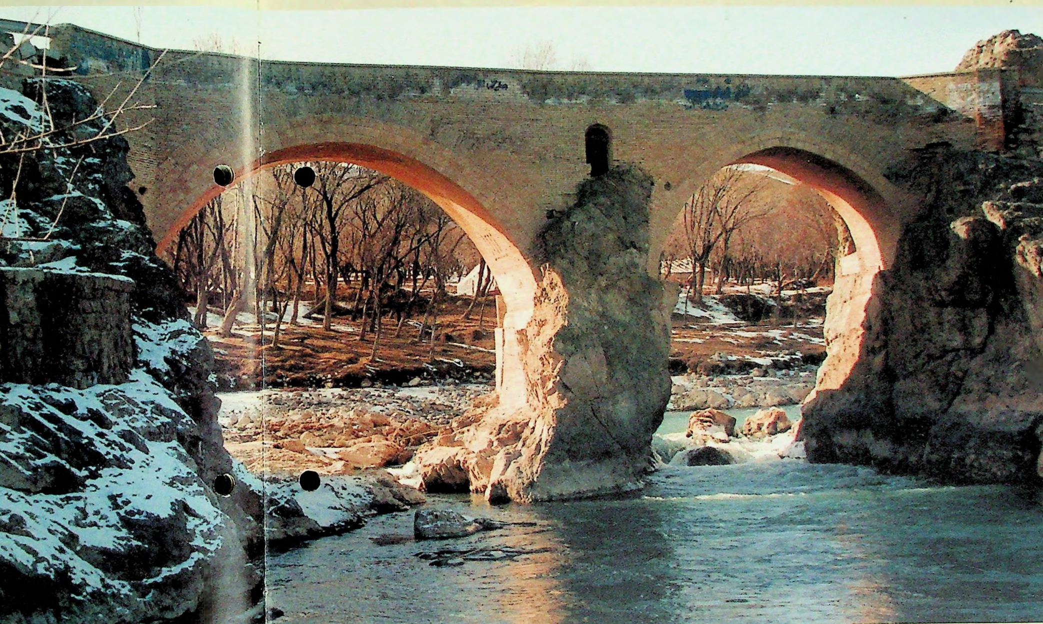

Bridge the gap

Health, as defined in the WHO Constitution, is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

World Health Organization
Department of Mental Health and Substance Dependence
Avenue Appia 20
1211 Geneva 27
Switzerland
Tel:+41 22 791 21 11
Fax:+41 22 791 41 60
E-mail: WHD@who.int
Website: www.who.int/world-health-day

WHO/NMH/MSD/WHD/00.2 /Distr. General/Original: English