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ASSESSMENT OF INNOVATIVE COMMUNITY MENTAL HEALTH PROGRAMMES IN INDIA

R.L. KAPUR

Introduction:

1. The term mental disorder covers a broad range of conditions which share in common, an experience of psychological distress and social dysfunctioning either by the affected person or the family or both. On one end there are diseases which have a genetic origin and are accompanied by demonstrable, neuro-chemical imbalances or structural changes in the nervous system. On the other end are syndromes, which reflect a breakdown of a vulnerable person in response to environmental pressures. The vulnerability may be due to an extremely sensitive and reactive personality right from birth, or social inequity and deprivation, often both. There are also conditions where the pathology is primarily in the social sphere, enticing people from susceptible backgrounds into anti-social behaviour. Because of a varied and complexly interrelated aetiological factors, the treatment and prevention strategies as well as the role of the community in these strategies are likely to be different. In some conditions the role of a medically trained person will be more important. For others, social agencies need to take a lead and for some others nothing short of a change in socio-economic and political structuring of the society will do.

2. On the biological end there are conditions like schizophrenia, manic-depressive disorder and organic brain disorders, which have to be managed by appropriate medication and social support. At least 2% of the population suffer from these conditions at any given time. In spite of best efforts in the least of circumstances, at least one third of the people affected by these conditions end up suffering a chronic illness, unable to fend for themselves and needing to be protected.

   What is required here is, (a) early recognition of the illness, (b) sensitization of the community to the fact that such people need understanding rather than punishment, (c) provision of necessary medical help, and finally, (d) provision of a caring environment for the chronically ill.

   A number of experiments have been conducted in India to target these conditions (Kapur 1994). The most important experiments have been where the members of a primary health centre team have been trained to recognize and manage these illnesses in the community. In one such experiment (ICMR 1987) it was discovered that while the PHC team can be taught to do this task very adequately in a research situation, the motivation, facilities and morale required to carry out the treatment in unsupervised PHCs falls short of the expected. Just to illustrate, the cost of medication required to manage the psychotic population in a community is more than the total budget for medication in a PHC. Further, in an average PHC there are so many priority targets that mental health does not elicit

sufficient enthusiasm from the personnel. That good intentions and good training programmes are not enough, was demonstrated by the poor outcome of the National Mental Health Programme instituted in the 7th Plan (DGHS 1982 and DGHS-WHO SEARO 1990).

One negative impact of an otherwise enlightened approach has been the attempt of old mental institutions to discharge chronic patients into the community because they have been shown to fare better within the family (Pai and Kapur 1982, 1983).

What is not realized is the fact that because of increasing migration to the cities, gradual diminution of family size and fewer people available at home to look after the chronically ill, families are unable rather than unwilling to carry out this task. Many chronic patients sent back to their families remain neglected. That more residential places for the chronically ill are needed is demonstrated by the fact that for 250-300 places available in the private hostels, rehabilitation centres etc., there are long waiting lists in spite of prohibitive costs.

Notwithstanding the above, individuals and organizations are continuing to develop and establish programmes for the care of patients suffering from severe mental morbidity. For example. NIMHANS, which evaluated the first such programme, is now adopting districts where the GPs, also village leaders, are taught to handle such problems (Rao et al 1990). Programmes for educating the public about mental health are also going on. There are also temples and dharmashalas as well as modern rehabilitation centres across the country for the care of the chronically ill. However the quality of service these programmes are able to offer is not sufficiently documented. Research is needed to assess these programmes.

3. At least 8-10% of the population suffers from neuroses (anxiety, depression and conversion reactions), psychosomatic illness, personality disorders and substance abuse. It has been shown through research that at least one third of the clients, who go to doctors in the PHCs or a private GP, suffer primarily from these disorders (Wig et al 1981). Most of these patients require counselling and social support to develop coping strategies, rather than medical help. Unfortunately the doctors, not trained in consulting techniques offer tranquilizers which work only temporarily and if used for a long time, lead to dependence and abuse.

There was a time when people in need of such help were looked after by faith healers, priests and spiritual masters. Stories from folklore and mythology were used to rouse a person to a meaningful existence in spite of trials and tribulations. There were clear-cut values to live by. Social change has diluted these values and the stories which were effective before, now appear to be naive and irrelevant. The situation is worse in urban slums where the alienation is even greater and social support even less. But people still go to faith healers and spiritual masters. The popularity of lectures on spiritual matters, yoga centres, Vedanta courses and

spiritual retreats is apparently on the increase. In addition, counselling centres based on modern psychological techniques are also available. One hears of transactional analysis, personality development courses, Reiki and Pranik Healing. It is estimated that only in the city of Bangalore at least 5000 people pass through these centres every year (Chopra 1994). In many cities there are now centres for de-addiction based on a variety of specified or unspecified strategies.

One does not know how these centres work; what are the philosophies and strategies they use; the nature of financial transactions and their effectiveness. Research is needed to examine these aspects.

4. Many psychological problems arise out of social deprivation, social inequities and unhealthy power relationships in the society. The problems of battered women, battered children, and suicides because of hopeless existence, are well known. While this is an issue for the whole society to consider, special centres dealing with such problems have also come up. Programmes are also available in institutions, like schools and colleges as well as some jails, to deal with factors which lead to anti -social behaviour. Once again enthusiasm is not matched by a rigorous assessment of effectiveness of these endeavours.

5. There are very significant changes occurring and anticipated in society because of economic re-structuring which is going on in the country. Research has been undertaken by some organizations, such as ISST in Delhi, to assess the social consequences of these programmes. There is also lobbying, education and political action being undertaken to counteract the ill effects of the programmes. Research is needed to assess the impact of such programmes.

The proposed study:

(1) **Aims and Objectives**: The overall aim of the study is to examine and assess the innovative mental health programmes in the country and to establish a network amongst them so that the facilitators could learn from each other. More specifically the inquiry will cover the following questions:

(a) The scope and content of the programmes.
(b) The nature of community involvement.
(c) The financial management of the programme.
(d) The effectiveness of the programmes.

Methodology: The assessment will be carried out using the qualitative rather than the quantitative approach, since the formalization required in the latter comes in the way of obtaining rich information and thick descriptions. One is not yet at a stage where specific hypothesis can be set up for examination.

The work will be first carried out in the city of Bangalore. First a directory will be prepared of all such programmes, remembering that one is interested not only

in efforts by professional organizations but also by semi-professionals and non-professionals. Centres offering counselling of any nature (including spiritual help) which aid in psychological well being will be looked at. This will be followed by classifying the programmes in different categories (e.g. programmes for the acutely ill, programmes for the chronically disabled, suicide prevention, lay counselling, spiritual counselling, counselling and advocacy for the deprived etc.). Example from each category will then be chosen for further inquiry. This inquiry will be carried out by the examination of (a) published literature by the organization (b) interviewing the staff members (c) sitting in on some of their work sessions and (d) interviewing the users. Attempt will also be made to find out through a life history approach how those delivering the services got interested in the pursuit.

This phase is expected to take 12-18 months. The design of the study will be streamlined and used to carry out similar work elsewhere in the country.

Funding required:

1. Salaries of senior consultant and one research assistant/ associate.
2. Funds for local travel.
3. Funds for stationary and secretarial help.
4. Funds for 3-4 meetings to evolve an informal network of sharing & learning.
5. Funds for
   (a) Directory
   (b) Interim Report which will be circulated to all those who participated and/or are interested.

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