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Introduction

Mohan Isaac

Wow! A book on Community Mental Health in India! That too authored and edited by mostly Indian mental health professionals based on their experiences in attempting to provide meaningful mental health services to over a billion populations. When the editors invited me to contribute an introduction to this book, I was indeed delighted. I was naturally reminded of my own entry to the field of community mental health in India almost 35 years ago, during the second half of 1976. The first and only specially designated community mental health unit in the country was set up at the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru and the late Professor Ravi Kapur was appointed to the first Chair of Community Psychiatry in India at NIMHANS. The main goal of this unit was to develop methods of taking mental health care out of the psychiatric institutions to the large sections of unserved and underserved populations, particularly in the rural areas.

Those were the days when Milton Greenblat had famously termed 'psychiatry' the 'cinderella of medicine' in the New England Journal of Medicine and Fuller Torrey had predicted the "death of psychiatry". Specialization in psychiatry by young medical graduates was not considered very commendable. After my initial years of postgraduate training in psychiatry, my decision to join the newly formed community mental health unit at NIMHANS as one of its few earliest staff members (against the possibility of working as a junior consultant in the hospital setting) and carry out my doctoral thesis related work in the villages around the Sakalawara Rural Community Mental Health Center was frowned upon by many around me. However, the quick acceptance with minimal changes and publication of my thesis related work on detection of psychosis and epilepsy in the community by multipurpose health workers of rural primary health centers in journals such as The Lancet and the British Journal of Psychiatry convinced me that we were in the right direction. I was also convinced that the only way mental health care could be delivered to the unreached populations in the country was by big development of community mental health. I continued to be attached to the community mental health unit at NIMHANS for nearly the next 30 years. During this period, I also had the privilege of personally knowing the work in the field of community mental health of most of the authors of this textbook. Subsequently, after I moved to the University of Western Australia where I continue to be attached to a community, culture and mental health unit, I learned on the first hand basis how very different is the delivery of community based mental health services in a resource rich developed setting and a developing country. What follows in this introduction is my personal perception of issues in community mental health in western and non-western settings such as India.

COMMUNITY MENTAL HEALTH

Community mental health, in very broad and simple terms, refers to care of and services provided to persons with mental health problems and their families in community settings. In developing countries such as India, community settings would include a person's home, large joint family setting, a general practitioner's clinic, a government run primary health center (PHC), community health centre (CHC) or a district hospital, a non-hospital residential facility such as a half-way home or hostel run by non-governmental organizations, a private psychiatrist's office/clinic, a counseling center or a rehabilitation center in a community location running day programs and providing a range of other community based services. Such care or services may be provided by; besides trained mental health professionals (psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses), trained general practitioners, primary health center doctors and multipurpose health workers, counselors, rehabilitation workers and family members and other carers under the overall supervision of mental health professionals. The broad range of services can include early identification

and prompt treatment of both common and severe mental disorders, management of persons with chronic mental disorders in the community, referral to secondary and tertiary mental health services as well as other social welfare services, attention to the mental health needs of persons with various physical health problems, and interventions aimed at mental health promotion and mental health prevention in community organizations such as schools, anganwadis (pre-school institution), industries and in the larger community itself. The goals and principles of community mental health ideally are decentralization, comprehensiveness of care, accessibility of appropriate, affordable and equitable basic mental health care to all, multidisciplinary and multisector (including private sector) involvement, community participation and inter-sectoral collaboration.

COMMUNITY MENTAL HEALTH IN THE WEST

In the rich and developed countries of Western Europe, Scandinavia, and North America and in Australia and New Zealand, community mental health care really began only during the second half of the twentieth century. Up until the 1950s, care for persons with severe mental disorders in these countries was provided only in large stand-alone institutions called asylums (mental hospitals). Such institutions steadily grew in number, size and occupancy in most of these countries during the previous two centuries. However, beginning in the early part of twentieth century, due to a variety of factors such as overcrowding, poor living conditions, declining financial resources, unmotivated staff, growing public and professional discontent, etc. The mental hospitals progressively started declining in their therapeutic role and functions. The serendipitous discovery of the first effective antipsychotic medication, chlorpromazine in 1952 and its subsequent widespread use triggered a process which was later referred to as deinstitutionalization. Deinstitutionalization was not preconceived and has been variously defined. Mental health historians are divided about whether to call it a 'policy', 'concept', 'movement', 'protest movement' or just an 'era'. Some critics of deinstitutionalization have referred to the phenomenon as a 'factoid'. Deinstitutionalization essentially meant moving severely mentally ill people out of large institutions—mental hospitals and shifting their care and support to community based settings and later closing part or all of the institution. For example, the total number of severely mentally ill inpatients in all mental hospitals in the United Sates of America which was 558,329 in 1955 came down to 71, 619 in 1994 (US population in 1955 was 164 million and in 1994, 260 million). In USA, the growth of community mental health was accelerated by numerous factors including the final report of the Joint Commission on Mental Illness and Health (appointed by President Eisenhower in 1955) titled "Action for Mental Health" submitted in 1961. President John Kennedy called for the closure of large stand alone psychiatric institutions and their replacement by home and community care services. The enactment of the Community Mental Health Centres Act (signed by President Kennedy in 1963, three weeks prior to his assassination) paved the way for the creation of community mental health centers in USA.

During the succeeding years, similar events occurred in most rich and developed countries. Care of persons with severe mental disorders moved out of the mental hospitals and into the community. The process of deinstitutionalization and the creation of various alternatives to mental hospitals occurred at varying pace in different countries. Factors which determined the pace of reforms included changes to mental health legislation, financial resources and funding arrangements, availability of trained human resources, social acceptance, political will and administrative commitment. For example, in Italy a new mental health law, called the "Law 180" was enacted in 1978. The law aimed to change mental health services radically. It had four main components namely: (1) Phase out mental hospitals and cease all new admissions, (2) Establish general hospital psychiatry wards (maximum 15 beds), (3) Restrict compulsory admissions and (4) Set up community mental health centers. The mental health care scenario changed dramatically following the enactment of the legislation.

The development of the type of community based services varied internationally. Non-hospital residential facilities such as half way houses and hostels and different forms of supported accommodation in the community were established. Catchment area teams and multidisciplinary community mental health teams were created to deliver different types of services for the persons discharged from mental hospitals. A form of intervention consisting of initial engagement with patients, assessment of their needs, individualized care planning, environmental interventions, regular monitoring and review and patient advocacy referred to as 'case management' was developed. Different forms of case management including a particular form of intensive care called 'assertive community treatment' (ACT) became the predominant mode of community based care in all resource rich settings. The current form of mental health services in the West is a pragmatic balance of community and hospital based care, referred to as "balanced care" wherein treatment and a variety of community based services are provided either at home or close to home, coordinated by mental health

professionals and agencies. Such care also includes short-term hospitalization when needed, invariably in a general hospital based psychiatry unit. In many western countries, mental health reform is still an ongoing process (Burns, 2007; Fagin, 1985; Fakhoury and Priebe, 2002; Isaac, 2007; Thornicroft and Tansella, 2004).

COMMUNITY MENTAL HEALTH IN DEVELOPING COUNTRIES SUCH AS INDIA

In most Asian and Latin American countries with very modest financial and trained human resources mental health services continue to be provided largely through mental hospitals or stand alone psychiatric institution. The mental health reform process has barely begun only during the past decade in most countries. In Japan, the number of institutionalized mentally ill increased over the years. In many countries of Africa, formal mental health services are rudimentary.

The story of community mental health in India is very different from the West. Persons with mental disorders traditionally have always been treated within the community. Such persons were generally taken care of by the family, the larger community and traditional healers. Asylums which later became mental hospitals were opened in India, initially by the British East India Company and later by the country's colonial rulers, primarily for British soldiers and British nationals who suffered from mental disorders. For a large country with a huge and growing population, the total number of mental hospital beds available was always very small. At the time of India's independence in 1947, the country had just 17 psychiatric institutions and about ten thousand mental hospital beds. Since the mental health care facilities were so inadequate, some more mental hospitals were built in the country during the first two decades after independence. However, more than fifty years later, when the country's National Human Rights Commission (NHRC) surveyed all the then existing mental hospitals (total of 37, most of them funded by various state governments), and other mental health care institutions in the country, the total number of hospital/institutional beds for persons with mental disorders was still less than twenty thousand. Bold reforms involving the family members of those admitted to the hospital were initiated as early as the mid 1950s and 60s in the mental hospitals at Amritsar and Agra and certain centers such as Vellore. Strength of institutions such as the joint family, marriage, the close knit community, greater tolerance of deviant behaviour not only within families but also in the larger community, lower expectations from persons with mental disorders, religion and faith based coping as well as healing strategies, all contributed to large numbers of persons with various mental disorders being taken care of in the community. Many years later, the 2 years, 5 years and 25 years follow-up of persons with schizophrenia studied on a long-term basis by the World Health Organization's Division of Mental Health at Agra, Chandigarh and Chennai centers showed that such patients, in general had relatively a much better outcome in India than in many other developed countries in the world.

Around this time, a steadily increasing number of mental health units in the general hospital and medical college based teaching hospital settings were set up in the bigger cities in the country. General hospital psychiatric care meant shorter periods of hospitalization and greater involvement of family members in the care of person with mental disorder. More and more persons with various less severe forms of mental disorders too sought help in general hospital psychiatry units. All over the country, almost every person with any mental disorder was initially treated/managed primarily by traditional healers of various types including healers and priests who worked from within religious institutions such as temples. One of the consequences of the grossly limited modern facilities for care of mental disorders was that many mentally ill persons became "wandering and homeless mentally ill" across the country. Widespread misconceptions about causation of mental disorders, all pervasive stigma, and lack of community demand for modern mental health care services, grossly inadequate budgetary inputs for mental health in the midst of competing needs for infectious and communicable disorders and nutritional disorders, severe shortage of trained mental health professionals, all contributed to neglect of mental health care. Health planners, administrators and even other medical specialists and general practitioners were unaware of the wide prevalence and suffering caused by mental disorders.

Unlike most other newly independent developing countries of Asia, Africa and Latin America and despite the above mentioned problems, psychiatry grew in India slowly and steadily, but definitely. Amongst several developments which took place in the country during the initial post-independence decades which contributed to not only the growth of psychiatry but also the starting of pilot community mental health projects, three are worth mentioning. These three important developments were: (i) Starting of the Indian Psychiatric Society (IPS) – the professional body of psychiatrists in India, with a membership of 42 in 1947. First annual conference of the Indian Psychiatric Society was held in Patna in January 1948. Not many years later, in 1958, the IPS began publishing its academic journal – Indian Journal of Psychiatry (or the IJP, as it is popularly referred to in India), currently in its 53rd Volume. (ii) Conduct of some very good epidemiological surveys of mental disorders in the community during the late fifties and early sixties, in places such as Bengaluru and Agra.

Agra later was chosen as one of the nine centers in the World Health Organization International Pilot Study of Schizophrenia (IPSS) – one of the only two centers in the developing world, the other was Ibadan, Nigeria. (iii) Perhaps the most important development was the starting of an institution for training and research in the field of mental health – the All India Institute of Mental Health (AIIMH) in Bengaluru in 1954. It is interesting to note that such an institute for training mental health professionals (psychiatrists, clinical psychologists, psychiatric nurses and psychiatric social workers) was opened even before the starting of other major training and research institutions in the overall field of medicine such as the All India Institute of Medical Sciences (AIIMS) in New Delhi and the Post Graduate Institute of Medical Education and research (PGIMER) in Chandigarh. It is also interesting that the All India Institute of Mental Health in Bengaluru had full fledged departments of Neurology, Neurosurgery and allied basic sciences departments such as Neurophysiology, Neuropathology and Biophysics right from its early days – the realization of the close links between mental health and neurosciences, "brain and mind", the concept of clinical neurosciences in action, well ahead of such developments taking place much later in developed countries of the West. To convey the true nature of the institution more appropriately, AIIMH became the National Institute of Mental Health and Neurosciences (NIMHANS) in 1974, now arguably one of the most productive and prestigious research and training institutions in the fields of mental health and neurosciences in the whole of the developing world. Realizing the need to develop and evaluate meaningful and feasible alternate approaches/strategies to mental health care delivery in the country, NIMHANS created a Chair of Community Psychiatry and started a specially designated Community Psychiatry unit in 1975, much before positions and units for developing community psychiatry became fashionable elsewhere in the world.

During the late 1970s and 80s, the Community Mental Health unit at NIMHANS developed an approach and a strategy for integrating basic mental health care with the existing general health care services in India. This approach involved decentralized training in basic mental health care for primary health center doctors and multipurpose health workers, making essential psychotropic medications easily available at all peripheral primary health care institutions and providing continued on-the-job training, support and supervision for the trained primary health center staff to carry out simple mental health care services under the overall supervision of a mental health professional at the district head quarters level. This approach was initially tried in various primary health centers (PHCs) in Karnataka State which those days covered a population of hundred thousand. Later, it was expanded to a whole district (i.e. all the peripheral health care institution in a district), in Bellary district of Karnataka State. The overall strategy which evolved after 5 years of trial in Bellary came to be known as the "Bellary model" of District Mental Health Programme (DMHP) and was adopted by the Ministry of Health and Family Welfare, Government of India for staggered country wide implementation as a fully centrally (federally) funded programme (Isaac, 2011; Srinivasa Murthy, 2011). It is interesting to note that nearly three decades later, an international consortium of 422 researchers, advocates and clinicians working in more than 60 countries have identified "integration of screening and core packages of services into routine primary health care", "reducing the cost and improving the supply of effective medications", "providing effective and affordable community based care and rehabilitation" and "strengthening the mental health training of all health care personnel" as some of the top "grand challenges in global mental health" (Collins et al., 2011).

In 1982, India was one of the first countries in the developing world to formulate a National Mental Health Programme (NMHP). But budgetary allocation for the implementation of the NMHP was made only since 1996-97, during the ninth (1997-02), tenth (2002-07) and the eleventh (2007-12) Five Year Plans by the Government of India. Recently, several authors have critically looked at the successes and failures in the implementation of the NMHP and its main component namely the District Mental Health Programme (DMHP) and have offered numerous corrective suggestions (Goel, 2011; Isaac, 2011; Jacob, 2011; Patel, 2011; Srinivasa Murthy, 2011). Most experts believe that the DMHP has failed to "integrate mental health care delivery into primary care" due to a wide variety of administrative, managerial and technical reasons. However, experts observe "… the programme has ensured wider availability of essential psychotropic medication…" (Jacob, 2010), the DMHP is "essentially a psychiatrist led out-patient clinic in district hospitals" (Patel, 2011) and "major gains have been made…. The NMHP is now accepted as a relative low-cost, high-yield public health intervention which is doable, as shown in states such as Kerala and Gujarat" (Goel, 2011). The country can soon expect a "radical revision and re-haul of the dysfunctional NMHP" and a "re-written" DMHP for the 12th Five year plan (2012-2017) in independent India's first mental health policy as in early 2011 the Ministry of Health and Family Welfare, Government of India constituted a Mental health policy group comprising diverse stakeholders (Patel, 2011). The country is also on the threshold of seeing a new

National Mental Health Care Plan with specific reference to the NMHP and DMHP, with specific strategies and activities to implement the priority areas of action identified in the National Mental Health Care Policy and an estimate of financial resources required to implement the Plan by April 2012, according to the 'Terms of Reference' of the Policy Group (GOI-MOHFW, 2011).

A BOOK OF COMMUNITY MENTAL HEALTH FOR NON-WESTERN SETTINGS

This multiauthored book of Community Mental Health largely follows a 'mental health systems' approach to deal with various topics. The term mental health system includes (i) mental health policies, plans, programmes (ii) legislations and regulations governing mental health service organization and practice (iii) organization of service programes for detection and treatment of mental disorders including reliable supply of psychotropic medicines and rehabilitation services (iv) programmes that are devoted to mental health promotion (v) social arrangements that promote social participation including work and income support for persons with mental illness and (vi) the political, socio cultural and economic environment in which all the above occurs, besides other topics (Minas and Cohen, 2007). The book begins with an introductory chapter on the needs, relevance, growth and current status of community mental health in India (Section I). The historical evolution of mental hospitals as an institution in India, growth of general hospital psychiatry units and the genesis of the national mental health programme and its flagship programme, the district mental health programme are described in Section II. Integrating mental health into primary care in developing countries is different from such integration in developed countries because the primary care network itself is very differently organized due to a variety of factors such as limited trained personnel and poor financial resources. Chapter 29 describes the challenges in the integration of mental health into general health services. Innovative approaches such as mental health camps and extension clinics in smaller towns and big villages have been developed to reach the vast unreached populations in rural areas. Various such models of community mental health care are described in Chapters 25 and 26. It is well known that almost all people who need mental health care in developing countries often seek such care and help from traditional and indigenous healers. Chapter 28 reviews the role and significance of alternative therapies in mental health care. When support for research is limited, the area which is often forgotten is community mental health. There is a need to build research capacity in community mental health in developing countries. Models of research in community mental health are explained in Chapter 40.

There are comprehensive chapters on community based services for special populations such as the elderly, children and adolescents, children with learning disabilities and those suffering from substance use related problems (Section V). Issues of specific relevance to developing countries such as India including steadily increasing suicides in the country and farmer's suicides (Chapters 21 and 22), continuing difficulties related to stigma (Chapters 8, 31, 53 and 54), homelessness of the mentally ill with special problems relevant to developing country settings (Chapter 10), mental health aspects of manmade and natural disasters which are endemic in India (Chapter 24), and the role of gender in community mental health (Chapter 11) are included. Contributions to the development of community mental health by professional organizations such as the Indian Psychiatric Society are reviewed in Chapter 37.The section on legislation (Section IV) also includes a chapter on the Narcotics and Psychotropic Substances Act of India.

The authors who are predominantly Indian and who come from multiple backgrounds – well known academicians, researchers and teachers, clinicians from the governmental as well as private sectors, health administrators from the government in charge of mental health program, practitioners and activists from the non-governmental sector, care providers and a media person who writes about mental health issues in the popular print media (Chapter 59) – add to the richness and variety of the contents and coverage in this text book. The continuing role of the federal government in supporting community mental health is discussed in Chapter 38 by senior officers who were in charge of the mental health program at the time when the chapter was commissioned (and subsequently submitted for the book). The role of non-governmental sector in various mental health programs is being increasingly recognized in India. There are a growing number of such organizations carrying out different types of community based activities all over the country. The relevance of the voluntary non-governmental sector is well described in Chapters 12 and 34. Carer and consumer participation in mental health programs have only begun in a small way in India. Carer and consumer advocacy organizations are very few unlike western settings. Chapters 57 and 58 provide caregiver perspectives from the caregivers as well as the professionals points of view. A fairly large section on community mental health in some South and East Asian countries such as Sri Lanka, Pakistan, Malaysia and Singapore and developed countries such as the USA, UK, Australia and New Zealand (Section X) will give the reader an opportunity to compare and contrast issues across the world. The fact that the authors

of chapters about community mental health in developed countries have had training and first hand experience of situation in non-western settings adds value to their chapters.

The community mental health professionals' understanding of the relevance of clinically applied anthropology in their work is very limited. An entire section (Section XI) is devoted to cultural critique of community mental health in India and related issues including what cultural validity is and why it is often ignored. Editors have chosen to include few papers not very easily accessible such as the ICMR-DST Collaborative Study on Severe Mental Morbidity and some of the initial papers describing work done in Raipur Rani near Chandigarh and Sakalawara near Bangalore which describe the early phase of developments in community mental health in India as appendices (Section XIII).

Most psychiatry postgraduate training centers in India do not provide any organized and structured training or exposure to community mental health related topics. This book can immensely contribute to filling up the lacunae in community mental health training of not only psychiatrists but other mental health professionals as well. Although, the issues are largely based on the authors work and expertise in India, the book will be valuable to any mental health professional working in non-western settings.

Published literature in peer reviewed journals on issues related to community mental health in developing countries including India is very limited. The authors have reviewed the grey literature consisting of various documents, papers in non peer-reviewed and non-academic publications and the lay print media. There are numerous contradictions and puzzles yet to be clarified and answered as far as mental disorders in developing countries such as India are concerned. One such puzzle is raised by Sartorius (2011), an internationally recognized leader in mental health, a distinguished past President of the World Psychiatric association and for over 25 years the Head of the World Health Organization's mental health division and under whom I had the privilege to work for a number of years. He has visited all the mental hospitals and a variety of other institutions in India. He raises a question "simple to ask" but "without a satisfactory answer". "How was it possible that India had in all approximately 20,000 beds in mental hospitals and psychiatry departments in general hospitals when by conservative estimates in India there were at least 10 million seriously mentally ill people who need in-patient care for at least 2 weeks a year?" He goes on to observe that "Some patients were probably living as vagrants or beggars and others were undoubtedly in prisons. Still, with all these calculations – and taking into account that the incidence of severe mental illness such as schizophrenia in India did not differ from that in other countries and that there must have been more people with various forms of brain damage due, for example to poor perinatal care, infectious diseases and malnutrition in childhood than in Europe – it was not clear what was happening with the millions of people who were acutely ill and who needed help and more millions whom mental illness left impaired and unable to look after themselves". "The extended family system might explain part of the puzzle – but not all of it: in surveys families did not have as many mentally ill people in their midst as could be expected if most of the mentally ill were cared for in this way". The various chapters in this book on Community Mental Health describing largely the current situation in India may provide at least part of the answer to this puzzle.

CONCLUSION

During the past 35 years, after the starting of the community mental health unit at NIMHANS, many things have changed in the field of mental health care all over the world. Significant developments have occurred in community based mental health care in India too, most of which are well described in this book. However, as a series of comprehensive and authoritative reviews of the situation of mental health in low and middle income countries, including India published recently in journals such as The Lancet have shown, the treatment gap in mental health continues to be quite wide and much needs to be done to fill this gap. It is interesting to note that the broad principles of community mental health in developing countries have changed very little over the years as indicated by the recent mental health gap action programme of the World Health Organization (mhGAP) and similar programmes elsewhere (Jacob, 2011) and some of the top "grand challenges in global mental health" (Collins et al., 2011) as identified by more than 400 experts in the field of mental health from all over the world. Meaningful partnerships and collaboration between diverse stakeholders are urgently required for progress in community mental health in India. True innovation and leadership are needed, more than ever before.

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