



COMMUNITY PSYCHIATRY IN INDIA NEEDS A HOLISTIC APPROACH

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ABSTRACT

Citizens with neuro-psychiatric disorders fatigue their caregivers at both physical and mental levels. In absence of optimum social support systems, much of the caregiving role for the psychiatric disorders is left to the family members, often shouldered by the unaffected spouse, often a woman that happens behind our eyes. Health professionals, besides caring for the patient, need to explore with empathy to find capacity building in support of mechanism of skill building and relief for the caregivers among relations and relatives. Health care delivery systems in low and middle income countries, despite their fragilities need to address such emerging challenges in neuro-psychiatric care, and care delivery machinery will have to adopt as well as solve an array of these problems. Setting up of reasonably priced and comprehensive care for persons with mental ill-health remains a challenging task even in developed world and the situation is worse in low-income and middle-income countries. Priority should be given to models with comprehensive, cost-effective and sustainable care. Community Psychiatry need to be developed as a tailor-made individualized services to the mentally - ill individuals, where the erudite psychiatrists will guide and contribute not only to curative services but also provide comprehensive package of services including promotive and preventive aspects of mental health. While an extensive body of research is currently being developed, there are innumerable of unexplored openings for potential research that have impending strengths to supplement the knowledge base and provide critical information to the health care providers as well as stakeholders as clear clinical practice guidelines in the call of the day in India.

Key words: Community psychiatry, social support, neuro-psychiatric disorders

Prologue

Community Health Services have been concerned at large with the control of communicable diseases in the last millennium. In the course of development, it has become more and more alarmed with the need to cross the barriers every single aspect of health of individuals in the community life including on the zig-saw puzzle of mental health. We need in-depth clinical research of psychiatric management and examine the implications of a research bias.

Historical evolution of community psychiatry

Community psychiatry is in formation and needs collaborative efforts to provide comprehensive interventions engrossing multifactorial causation of psychiatric disorders arising out of multiple stressors and risk factors from the individual, the family and the community. Way back in history, two hundred years back the budding concepts of moral approach of Pinel and a humane face of William Tuke made a paradigm shift towards care of the mentally ill with a kind and tolerant approach. ¹ In

the middle of last century deinstitutionalization of mentally ill patients with the advancement of newer protocols of treatments, the concepts of community psychiatry was initiated within historical global recession.² In our country also we have observed progressive approach in the concepts of management in mental health tribulations from sin and witchcraft to treatment in asylums through advent of psychoanalysis and exploration of risk factors to the sluggish development of community psychiatry.³ Traditional Indian health care providers qualified in Ayurveda and Unani medicine in their day-to-day services provided special attention to the mentally ill general population.⁴ Further, breakthrough in the community based research studies helped us to assess the magnitude of mental health problems prevailing among general population for which at first we need to have a situational analysis for our sensitization.⁵

Where we stand as of now?

Depth of problem

World Bank reported in 1993 that, considering Disability Adjusted Life Year (DALY) loss, 1 in 10 in general population suffers from neuro-psychiatric disorders that are much higher than individual common communicable diseases. WHO estimated that from present 12 percent of the global burden of disease trend is upwards to reach 15 percent by 2020 with 25 percent of families to have at least one member with a behavioral or mental disorder. Even in absence of good management, only in ten percent cases, the families provide physical and emotional support as well as bear the negative impact of stigma and discrimination.⁶

Since last three decades we have experienced an explosion of information base of the neurosciences, epidemiology and therapeutics with a comparable growth in interdisciplinary associations, which support integrated socially and culturally apt methodologies to mental health care services. It is sometimes difficult for contemporary practitioners to entirely understand the widespread encounters to uproot barriers among mental health professionals in the period following India's independence. However, it is imperative to think of the foundations for the current knowledge base was laid during those early years.⁷

In the era of demographic transition, the family and social support system is increasingly being affected by unplanned urbanization, drug use, and changing family issues. Community Psychiatry in India is in a developing phase of decreased reliance on hospitalization, and attempts integration of everyday life of chronic patients into the mainstream. Yet, it is painful to accept that in our medical education system psychiatric disorders are 'ne-

glected diseases'; that the psychiatric problems are positive diagnosis and can be explained by classical pathophysiology as all other somatic diseases and curable to a great extent, is ignored. Along with common citizens, health care providers of all approaches and all levels (other than directly related to psychiatric care) have gross misconceptions regarding pathogenesis of psychiatric disorders and their management. India is a multicultural and multilingual home to more than a billion people with an amalgamation of ill health, disability, scarcity and solitude can have adverse impact on the mental health of older people.⁸

To manage above issues in a good move the Bellary model of District Mental Health Programme (DMHP) has been promulgated by the Government of India under the National Mental Health Programme with the ambition to make primary mental health care accessible to all by setting up psychiatric services in peripheral areas, training all levels of primary health care personnel and linking community participation in letter and spirit to promote mental health care to the last man on the road. DMHP was started with four districts in 1996, and the programme covered 123 districts in the 11th Five year Plan. Further we need multi-pronged approach involving experts from Community Medicine, Psychiatry, Family Medicine, Sociology etc. and involvement of Not-for-profit organizations for integration of health care and health education to develop a network of comprehensive Primary Mental Health Care involving social determinants, and different levels of mental health provision in differential settings. We need futuristic attitude in all pervasive integrated planning for mental health through network of facilities and human resources to reach last man on road even at the remotest corner with a sustainable referral system and technical leadership center. All these can see the light of the day from the positive political will and close collaboration to take challenges of community level mental health agenda in the Sustainable Development Goals.⁹

However, preventive psychiatry remains in its initial stages and necessitates considerable community efforts to be well developed. The concept of multiplicity of risk factors in the causality of psychogenic disorders has become largely acknowledged. The factors are considered to involve the individual, the family and the community are Environmental stress with Social deprivation and Phenomena characterizing modern life; Promote community mental health; Accommodate the mentally - ill within the community paradigm; Avoid un-necessary in-patients and curbing in specialized centre; Make available social therapy.

Community mental service is provided in general hospitals, mental health hospitals, by primary health care providers and many other health authorities in different socio-economic situations around the global environment and living.

What is to be done?

Integration of health provision and medical education, and development of a network of Primary Health Care, addressing basically rural population, improved general health indicators in Iran. The effects of unplanned urbanization, illicit drug use, familial matters like divorce, altering presentations of diseases, public-private partnership, social determinants of mental health, and the relationship between different levels of mental health provision in the urban settings are important factors for future programme.

Community Psychiatry in India is in a developing phase of decentralized services, reduction of dependence on hospitalization only, and integrates the everyday life of chronic patients into the mainstream of social life. It needs to be interdisciplinary and with a multipronged approach, involving experts from Community Medicine and Psychiatry. Further, personnel from the background of Family Medicine, Forensic Medicine, Sociology, Not-for-profit organizations etc. can make this programme a success. Behaviour Change Communication will be the backbone with amalgamation of intensive Health Education in the General Education that psychiatric problems can be explained by classical pathophysiology as all other somatic diseases and are curable to a great extent. It is painful to accept that Health care providers of all approaches and all levels (Other than directly related to psychiatric care) have gross misconceptions regarding pathogenesis of psychiatric disorders and their management as a positive diagnosis. Health promotional approaches of Community Psychiatry with boosting of salutogenesis can only halt the global pandemic of psychiatric diseases in general as well as in India.¹⁰

What we practice?

Present problem solving exercises of clinic based approaches in Community Psychiatry in the developed countries provide a comprehensive array of recovery-oriented mental health to help thousands of individuals and their families. These clinics help out community members from serious mental illnesses to the challenge of daily life to help them achieve their recovery plan. There are multidisciplinary teams and set of programs designed to reach out, understand, and share individuals with serious and persistent mental illness with clients in defining productive living in our community. Services provided range from clinic based to off-site,

community-centered treatments like Outpatient Community Mental Health Clinics, Assertive Community Treatment, Psychiatry Rehabilitation and Residential Programs, Case Management Services and Shelter Care, Representative Payee Program¹¹

Stop defiance and increase awareness

Experts in Indian scenario has opined that fulfilling community psychiatry in real life settings is be a challenge even for the health systems of high income countries more in under-resourced health systems. (In India, cost-cutting measures by convergence various centrally sponsored overlapping mandates, like the public health programs for cancer, geriatrics, non-communicable diseases and mental health, have already started.¹²

The prevailing low level of public awareness about mental health problems is a true barrier that prevents access to mental health care. Common mental health problems, like depression and dementia in later life, remain as the iceberg of magnitude of mental health problems and we have to put forward steps ahead to solve out as the hidden agenda of health promotion in India.¹³

Classical debate: Body and mind

Health caregivers of all shades-levels-pathies are infrequently faced with situations which are purely somatic, rather than psychosomatic in origin [and 'insertion']. To find out 'How much pain has been generated from biochemical and physiological activities out of anatomical structures within human tissue-organ-system' vis-a-vis 'How much is subjectively assessed by the care-seekers' often puzzles caregivers. Further, pain threshold is variable across socio-demographic as well as socio-economic strata. A contractual miner with insomnia due to stress and other factors has no time to discontinue duty for seeking health care even for one day as he or she may be the only bread earner for his or her family.

Old is not always 'Gold'

Mental hospitals, with all their inherent flaws and drawbacks, are powerful institutions for the apposite care of a subsection of mentally ill persons, especially those with severe forms of illness and poor familial/social supports. Classical age-old mental asylums were notorious for irreparable social damage for the patients. Yet how much safe are newer models of mental health care also need to be evaluated in the light of highest research integrity. 'Claim of superiority' of any clinical practice guideline should not end in 'Blame of inferiority' later after years of use on global scale like multi-drug therapy for Leprosy.

Need sensitization among public health specialists

The problems of mental health have a spectrum from reversible mood changes during physical illnesses to overt problems that lead to many downstream complications ranging from helplessness, alienation, uncertainty, loss of earning amidst expenditure of illness among others. We have to inject positive philosophy of life 'We have to think on what can be changed in near horizon of vision' instead of 'what not' with candid support from the local communities.¹⁴

We need holistic primary care approach

In India vast majority of the citizens depends on the primary care health care providers of different shades for all their healthcare requirements with whom they feel comfortable at odd hours from womb to tomb to diagnose their problems at their courtyard. The main burden of psychiatric care by default falls on the ever increasing broad shoulder of primary health care providers. Yet they need to be sensitized to stop indiscriminate prescription, if they are not sure of the positive diagnosis of psychiatric illnesses.

Home based care: an example from Kerala

Community level domiciliary care with a health worker providing personalised support, would be ideal in the currently accumulated evidences. However, it is challenging to make it a success in real world settings even in well-resourced developed countries, and most of the responsibilities will have to be entrusted to a low cost multidisciplinary workforce. The author describes a putative model for home-based care with convergence of two programs - as a putative model for dementia care that are already functional in Kerala – the District Mental Health Program (DMHP) for decentralized mental health care and the Palliative Care Program (PCP) for homebound debilitated patients (mostly cancer).¹⁵

Research in Community psychiatry: Points of concern

In the era of rapid proliferation of knowledge and quick propagation of information, scholastic updating is lifeline for health care providers. With the optimal utilisation of the state-of-art knowledge and cutting-edge skills the quality of life can be enhanced by implementation at grass-root levels as well as by imparting capacity building in teaching and research for futuristic superiority of health care manpower.¹⁶ In the era of evidence-based health care, we shall never forget the glory of life with a mind-set to generate data of our own people. All the persons in health care fraternity need to know the basics of research, as well as a science

and art of publication. Yet, undergraduate and postgraduate health care curriculums in India learners usually are not systematically exposed to research methods or scholarship.¹⁷ In the researches on Community psychiatry in India, in line with the researchers in other fields, we need to be sensitized to perform subgroup analysis for responses involving female gender and they should prospectively design to evaluate potential sex differences. Similar problem is true for elderly population also. As people begin to live longer due to upgraded medical technologies, it is essential that researchers need to include the elderly and find ways to respond to emerging trends within clinical trial models.

There are few points of concern in traditional researches on that marks their outcome analysis with limited generalization across global population. Firstly, majority of research studies reported in the literature are hospital or clinic-based with limited validity. We need community based studies comparing outcomes of different interventions which will be able to truly enrich this field of research in medical sciences. Secondly, randomized controlled trials with robust samples and multi-centric studies are the need of today those can produce data to be generalized across the globe. Thirdly, Women are half of the population of the world, still not only in last century but also in the new millennium, the participation of women in clinical trials had been undervalued with their involvements have been kept minimum. Role of genetic makeovers of female gender including downstream hormonal medley blueprint in pathogenesis and salutogenesis has not been thoroughly studied yet, though literature reported gender specific biological pain modulation systems. In the researches on Community psychiatry in India, researchers need to be sensitized to perform subgroup analysis for responses involving female gender and they should prospectively design to evaluate potential sex differences. Fourthly, similar problem is true of non-inclusion of elderly population also to answer the emerging trends in life expectancy and disease prevalence with complex medical backgrounds. Fifthly, the prevalence of poverty is associated with disease burden among minority as well as closed groups need to be taken care in research on Community Psychiatry to support fourth pillar of research ethics i.e. justice. Lastly, researches on sex education should form the primary line of management as sexual problems are global hidden agenda in psychiatric problems that occurs one in twenty adult Indian populations.^{18,19}

Researchers opined that within the resource limited settings in India, Dementia care is workable with cost effective models only with a holistic co-ordination of health, social and disability sector,

among others. Community-based domestic personal health care is fast emerging as a viable model.²⁰ In community there is probability of psychiatric problems due to chronic illnesses not only among the patients but to their caregivers also. Even cancer patients and their caregivers need psychological support from the community not only during active management but also during palliative therapy also.²¹ Researchers have opined that, as the age old 'Friend, philosopher and guide', the traditional healers can be usefully exploited in the community centered care after required capacity building. This will downstream not only for cheaper financial consequences, but also people at large accepts them as the traditional healers share same traditional reliefs of disease and health.²² Community psychiatry will have to face dead end if it cannot leave clinic based approaches in absence of dependable community-based translational research work. We need path-breaking primary care Community psychiatry for a cost-effective approach for India.²³

Social psychiatry vs. Community Psychiatry

World Health Organization delineates "universal health coverage" to ensure that 'all people have access to needed preventive, promotive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring reduction in financial hardship to avail these services' that encompasses 'right to information' of citizens as integral part of their 'right to health' for comprehensive health services.²⁴ We need to have idea for Protection of the very young, through promotion of family life, Prevention of social stress and insecurity, Protection of the elderly citizens suffering from cerebral degeneration, depression and/or psychopathic states, Prevention of brain damage, Public education in mental health. Provision of suitable institutions for the care of the mentally ill, Provision of legislation as regards drug abuse, compulsory admission to residential hospitals and guardianship, Provision of rehabilitation. Also, we need to look wider and deeper into the issues like Public-Private Partnership, Socio-Demographic-Economic determinants, and the relationship between different levels of mental health provision in the community settings.

Take home message

To sum up we need a more holistic look at mental health and futuristic attitude in planning, using many resources that exist in the country. The principle of Integration should remain unchanged. Firstly, Integration of health provision and medical education, Secondly, Integration of Mental Health in the network of Primary Health Care. Through this network the services and human elements of health care resources to reach even the most re-

mote parts of the country. In addition, a scientific well-oiled referral system vertically and horizontally health house in a village to the highest specialized university facilities. Thirdly, The existence and involvement of a technical leadership center. Lastly, close collaboration, between the Institute with the Ministry of Health and Medical Education on the one hand and World Health Organization to make making mental health a part of the Ministry's immediate agenda and learning from other experiences.

In a holistic approach, pitiable awareness about symptoms of mental illness, myths & stigma related to it, lack of knowledge on the availability of state-of-art updated patient care and potential benefits of pursuing treatment with a philosophy of 'living with disease' we will be able to minimize the high treatment gap. The amalgamation of mental health with the primary health care has led to a major shift from the concept of custodial care to community care and treatment. Although a huge gap between the rhetoric of this new policy and its implementation still remains, it is a matter of breaking goals down to achievable pieces and working one day at a time, one step at a time. Let us be honest on the limitations of medicine and we need the philosophy of "There is an end to CURE. There is no end to CARE."¹⁶

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