第105回日本精神神経学会総会

シンポジウム

Breaking the Barriers—The Challenges in Mental Health Care in India

Kalmane Sridhara Pavitra (Consultant psychiatrist,
Sridhar Neuropsychiatric centre Shimoga, Karnataka, India)

India is the seventh largest country in the world, and the second largest in Asia with an area of 3.29 million square kilometers. It is also the second largest populous country. It is multilingual, multicultural country and people there are diverse in culture, and language, geographic and climatic conditions. It constitutes 16% of world's population.

Psychiatric beds & professionals

Though the number of psychiatric patient was estimated to reach 7.5 million, the mental health resources are far from satisfaction. Table 1 shows number of mental health resources per 10,000 population in India.

Mental health services in India

Mental health services in India constitute of

- Mental Health Institutes
- Psychiatric departments in Government General Hospitals
- Private Sector-clinics, nursing homes and corporate hospitals

Psychiatric training in India at undergraduate level constitutes of clinical postings for a month. Medical students often skip a psychiatry class. Psychiatry seems to be considered as a non medical subject by most students. Stigma against psychiatrists, or against psychiatric patients is highly prevalent among medical students. In most cases, a new psychiatrist gets western style postgraduate psychiatric training. However, for Indian young trainee psychiatrists, the conceptual frameworks of western psychiatry are wholly foreign to the milieu of his birth and habitation. The type of patients, the duration of contact and the service his patient needs may be different from what he learned.

When we look at Indian patients, they are full of expectations. They are ready to accept overt situational support. However, they have great difficulty in understanding the western diagnostic methods. Most of them are skeptical about the need for long term follow-up with medication. By patients and medical profes-

Table 1 The number of mental health resources per 10,000 population in India[12)]

Total psychiatric beds	0.25
Psychiatric beds in general hospitals	0.05
Number of Psychiatrists	0.40
Number of Psychiatric Nurses	0.04
Number of Psychologists	0.02
Number of Social Workers	0.02
Number of mental hospitals	43

sionals, psychiatrist is often seen as a "Professional" who has ability to do everything through "talking".

Stigma and help seeking patterns in India

Stigma against mental illness, psychiatrists, and psychiatric patients is highly rampant in India. Mental disorders are viewed as a curse, a result of bad deeds, or a understandable predicament which has to be endured by the patient and the family[6].

Epidemiological studies in 1970s showed that mental morbidity was the same in rural and urban areas, but less care was available in rural areas[6]. The drop out rates after the first contact was very high. Ignorance, incorrect knowledge about psychiatric disease (e.g. beliefs of evil spirits, black magic, punishment for past bad deeds) or lack of knowledge regarding modern methods of treatment were the main reasons for non-use of psychiatric services. Lack of mental health resources and shortage of the budget for this field, which forced the patient in the rural area to travel long to get the medical services costing a lot of money, is another reason.

These studies also revealed that the psychiatric care delivery systems were grossly inadequate. The number of trained psychiatrists was far less from the requirement. They were not absorbed in government institutions. There were no posts for clinical psychologist, psychiatric social workers and psychiatric nurses in government institutions.

The model psychiatric services in Sakalwara and Raipur Rani[13] were two important projects in 1980. They revealed that majority of mentally ill patients first went to traditional healers. Psychoses and epilepsy were undetected for over 2 years. Key informants, health workers could identify and report about existing cases easily. It was also noted that hospitalization was rarely required. It was seen that medical and non-medical workers were able to learn how to manage major mental disorders in short term courses. Most of the patients with acute psychosis improved with short term medications and subsequent rehabilitation were also done also within their villages. Improved patients were accepted in the mainstream of life without stigma[4].

Lacunae in psychiatric training were also pointed out. There were few training centers. Focusing in undergraduate medical training was inadequate. There was difficulty in implicating theoretical and tertiary practices in community.

National Mental Health Programme NMHP—1982

NMHP 1982 focused on prevention and treatment, quality of life and decentralization of the mental health services[10].

Workshops at state and national level were conducted as part of this. District mental health programmes were planned and developed.

Major difficulties identified in NMHP were as follows.

- Health sector—the least priority area
- Mental Health—most neglected
- Non representation of psychiatrists in policy making bodies
- Utter ignorance and misconceptions about mental health in administrators and policy makers.
- No organized patient/family groups.

It was noted in NMHP that professionals enjoyed working in their specialty hospitals but they seemed to be uncomfortable in community

settings. They felt helpless when the resources were limited.

General practitioners and primary care physicians could recognize psychiatric problems in their patients. But they were not equipped with the skills to manage them. They looked at psychiatry either as a mystery or as time consuming, less useful 'science'. They preferred to get rid of these cases by referring them to mental health professionals. Fear of loss of work, identity and income hindered appropriate and timely referrals.

NMHP pointed out that the society had not worked out the loss of man-hours and cost of not treating mentally ill. The society also did not understand the burden they should carry on. It was ready to invest for the care and prevention of heart disease and cancer. But not for mental disorders.

Mental health act—1987

Mental health act passed in 1987[5] was an act to consolidate and amend the law relating to the treatment and care of mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith or incidental thereto. However it came in to practice only in 1993. It has 10 chapters and 98 sections.

The 10 chapters are

- Change of offensive terminologies
- Procedures for establishment of mental health authorities
- Guidelines for establishment and maintenance of psychiatric hospitals
- Procedures of admission and detention of mentally ill
- Inspection, discharge, leaves of absence and removal of mentally ill
- Protection of human rights in mentally ill
- Maintenance of mentally ill in a psychiatric hospital
- Judicial inquisition regarding alleged mentally ill persons possessing property and management
- Improved standards of mental health care
- Provision for separate places for children, convicted and substance use patients
- Prohibition on any research without proper consent

Criticism of the act

- Licensing authorities do not have a doctor
- No incorporation of general hospital and centres
- Much stress on hospital admission and discharge procedures
- No provision for after discharge care and rehabilitation
- Different news for government and private hospitals
- Complicated licensing process

The Erwadi tragedy—2001

The Erwadi tragedy in 2001 marked the death of 26 mentally ill persons in a religious place where they were chained and met with an accident[7]. This raised concerns regarding the beliefs of the general population, the reasons for chronicity and disability of mentally ill, the needs of the families and state responsibility and regulation of services.

Facing challenges ahead

Dedicated, culture sensitive and culturally educated psychiatrists are the needs of current Indian psychiatry. Alternatives to institutional care have been utilized which constitute of out reach services-Camps held in rural areas once in 3 months. All types of treatment including ECT are given in outpatient set-ups.

Integration mental health services in to primary health care

This has been thought to be the most feasible strategy. This would involve screening of patients, education of primary health care staff, delivering stepped care approach and active collaboration of mental health professionals[1,3].

The barriers to this integration are multiple[9]. They are

- -Limited skilled mental health resources
- -Vastly different social and cultural contexts
- -Already constrained primary care system
- -Infrequent/inadequate use of antidepressants
- -Frequent use of vitamin injections
- -Low adherence to medication regimens minimizing the gains of treatment
- -Inadequate use of psychosocial treatments because of scarcity of personnel with the time and skills to deliver them

MANAS intervention

As an effort to integrate evidence based treatment for common mental disorders, MANAS intervention study was carried out in Goa, India[2]. It constituted of

- Mental health intervention involving health care workers
- Psychoeducation, interpersonal therapy, antidepressants being the main intervention strategies.

The reasons for irregular follow ups or dropouts were identified

- Engaged in work—cannot find time to get to treatment (50%)
- Became better and felt no need for follow-up (19%)
- Caring for other family members (19%)
- Long wait to meet the doctor (16%)
- Side effect of medications (8.3%)
- Expense of transportation (5.5%)
- Feeling worse since last consultation and did not feel advice was useful (5.5%)

Psycho education as part of the MANAS intervention was given at the onset in the following manner

- Brief, emphasizing the connection between stressors and symptoms
- Delivered in an empathetic manner
- No stigmatizing terms
- Group IPT delivered in community locations-temple courtyards, local schools during evenings
- Yoga as one of the group activities available to all primary care attendees and staff to de stigmatize the whole programme

The role of The Health Counselor

- Most important human resource of MANAS
- Participants opined that this should be a woman
- Fluent in local languages
- Good in communication skills
- Be available in clinics on a regular basis
- Called as 'Salagar' to reflect local understanding and improve acceptability

Multiple roles of a psychiatrist

A psychiatrist in India has to fulfill multiple roles

- As a clinician
- As an educator to public as well as non-psychiatric medical professionals.
- As a community worker
- As a communicator with policy makers,

politicians and caress

・As a multipurpose worker

Care delivery also has been at different levels and approaches

・Short stay wards—From few hours to 48 hours
・Subsidized drug supply
・Satellite clinics in rural areas

Counteracting stigma

Education needs to be an important approach to counteract stigma, to identify mental health problems early and for primordial prevention through teaching life skills[8,11].

Education can be

・Through media television, radio, news papers
・Patient information handouts
・Back—referrals to the referring doctor after managing the immediate crisis
・Communicating with referring doctor

We have been working on this through

・Education—at individual and at community level
・Instituting early recognition and Successful treatment
・Aiming at effective Successful rehabilitation

School mental health programmes

Another innovative strategy has been school mental health programmes. Mental health problems and learning problems related to schooling are highly prevalent but undetected. Hence school mental health programmes have been devised to

・Conduct training programmes for teachers
・Changing the attitude towards problem children
・To encourage School reports in cases of problem children

Utilizing health workers

As a step towards integration of mental health services into primary health care training of grass root level, health workers has been undertaken in the following ways.

・Training in basic mental health care
・Identifying and referring mental retardation
・Improving the child rearing practices
・Training student/peer volunteers

Our experience

Our centre where I have been working as a consultant has been conducting outreach services in the community. To increase awareness and to facilitate early recognition and treatment we started mental health camps at all villages with a population of 500–1,000 every 5 kilometers. Before each camp, local clinicians are personally contacted from the samples given to consultants. Free medicines to the possible extent are given. Medications are also given at subsidized rates and free electroconvulsive therapy is given. Certification for mentally retarded children for government benefits are provided in these camps. Camps are conducted in the vicinity of mercy healers, god places.

Each camp would have an educating lecture programme. They also held street play/drama on mental health in local language and distribute educational charts or pamphlets.

In these camps more than 60,000 patients have been examined till today. These camps have high follow-up rates—up to 70%. The referral rates from religious places and local doctors are increasing.

We have noted that

・Changes are possible

- Psychiatric OPD and referrals have increased by 60-70%
- Developing good rapport in minimal time is a key factor and is an essential skill for the clinician
- Involvement of significant others, local doctors, religious healers is important
- We need to be service oriented rather than study oriented

In urban areas where accessibility to mental health services is easy but stigma is highly prevalent, the centre has different strategy. A team of service oriented doctors in the centre and from other hospitals have spent one day a week. This team offers free consultation [diagnosis and referrals] and counseling every Saturday. Patients are not given free medications. User friendly and meaningful terms are named for each service unit in local language-Kannada

- Suicide prevention unit—Vimochana
- Adolescent mental health unit—Ashraya
- Addiction unit—Mukthi
- Women's mental health unit—Manini
- Marital Health unit—Paraspara
- Academic and examination related unit—Samveda
- School mental health unit—Medha

The centre also has been conducting Student enrichment programmes with focus on

- How to study
- How to learn better
- How to communicate
- How to perform well
- Role of emotional factors in learning

Planning mental health care

Thus in planning mental health care advantages must be weighed against the limitations. In a large country like India, the challenges are multiple. The small number of mental health professionals, the developing state of primary health care and welfare services, the low priority for mental health in general health services, funding limitations and lack of public pressure groups are potential barriers to mental health care.

The universal focuses in clinical practice are as follows.

- Promoting adherence to treatment
- Rapport building
- Clear and open but selective communication
- Using destigmatizing culturally acceptable and useful therapy like Yoga
- Addressing psychosocial issues
- Practical options for psychosocial problems
- Psychotherapeutic techniques in clinical practice

India has been one of the countries to develop many innovative approaches to mental health care. The advances in understanding the human behaviour and mental disorders justify our optimism of developing meaningful and realistic mental health programmes. It is mandatory to bring the fruits of science to the total population of India.

There are no universal models for mental health care. Even in countries with well-developed mental health programs, a wide variety of problems exist. It has been pointed out that the development of mental health care will continue to be affected by national, regional, and local factors[8,11]. Factors that will influence decisions about which conditions are considered mental disorders are what constitutes a mental health issue, where mentally ill persons will be cared for and what amount of resources will be made available for these activities. It is fortu-

nate that the needs of mentally ill persons in rural areas are receiving special attention from national and international agencies. Such attention can provide opportunities for new programs and new initiatives. Programmes to fight stigma and discrimination should address the study of local experiences in different groups using qualitative and quantitative methods. The interventions should be group specific and the efforts at mental health literacy should focus on the understandability of mental phenomena and on the 'normalcy' model rather the deviance model.

References

1) Bower, P., Gilbody, S., Richards, D.: Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. Br J Psychiatry, 189; 484-493, 2006

2) Chatterjee, S., Chowdhary, N., Pednekar, S.: Integrating evidence-based treatments for common mental disorders in routine primary care: feasibility and acceptability of the MANAS intervention in Goa, India. World Psychiatry, 7; 39-46, 2008

3) Chisholm, D., Sekar, K., Kumar, K.: Integration of mental health care into primary care. Demonstration cost-outcome study in India and Pakistan. Br J Psychiatry, 176; 581-588, 2000

4) Isaac, M., Kapur, R., Chandrashekar, C.: men tal health delivery through rural primary care; development and evaluation of a pilot training programme. Indian Journal of Psychiatry, 24; 131-138, 1982

5) Justice, M.o.l.a.: Mental Health Act—1987-The Gazette of India Published by Authority. Ministry of Law and Justice, New Delhi, 1987

6) Murthy, R.: Status Paper on Delivery of Mental Health Services in India the Last 40 Years. ICMR, New Delhi, 1982

7) Murthy, R.: Lessons from the Erwadi. Tragedy for mental health care in India. Indian Journal of Psychiatry, 43; 362-377, 2001

8) Sartorius, N., Schulze, H.: Reducing the stigma of mental illness. Cambridge University Press, Cambridge, 2005

9) Saxena, S., Sharan, P., Cumbrera, M.G.: World Health Organization's Mental Health Atlas 2005: implications for policy development. World Psychiatry, 5; 179-184, 2006

10) Services, D.g.o.h.: National Mental Health Programme—A Progress Report, 1982-1990. DGHS, New Delhi, 1991

11) Stuart, H.: Fighting the stigma caused by mental disorders: past perspectives, present activities, and future directions. World Psychiatry, 7; 185-188, 2008

12) WHO: Atlas: Mental Health Resources in the World 2001. WHO, Geneva, 2001

13) Wig, N., Murthy, R., Harding, T.: a model for rural psychiatric services; Raipur Rani experience. Indian journal of psychiatry, 23; 275-290, 1981