Community mental health care in South Asia

This report is part of a series describing the development of community mental health care in regions around the world (see 1–6), produced by a Task Force appointed by the WPA as part of its Action Plan 2008–2011 (7,8). The WPA Guidance on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care, developed by the Task Force, has been previously published in this journal (9). Here we describe these issues in relation to South Asia.

South Asia, home to 23% of the world's population and with 40% of the poorest people, has approximately 150–200 million mentally ill. For centuries, the mentally ill were managed by the community in several ways, ranging from physical restraint by using chains to treatment by ancient systems of medicine such as Ayurveda. Asylums or mental hospitals came with the British rule in India and colonization in other South Asian countries. While providing treatment and some relief for the mentally ill, they also were edifices of neglect, abuse and violation of human rights. While many such hospitals in Asia have undergone changes for the better, some of them still retain the old character and are largely custodial in their function. In India, the 42 mental hospitals catered to a mere 20% of the population, all in urban areas, with no services being available for the vast rural areas.

Current policies in the region include the development of community mental health care, the incorporation of mental health in primary care, ensuring availability of medication, involvement of users and families and a focus on human rights and equity of access to mental health care across different groups. Amongst the nations, Bangladesh, Bhutan, Pakistan, India and Sri Lanka have made some progress in the implementation of these components. Nepal focuses on providing minimal mental health care and basic medication, protecting human rights and creating awareness. Maldives has no policy, legislation or plan. Several studies in the region have highlighted the large number of untreated patients in the community. Even the existing services are under-utilized, because of varied explanatory models held by patients and families (9), which result in their seeking help from religious and traditional healing sites.

In the last 30–40 years, some attempts have been made to establish community based care in many countries of the region. In India, general hospital psychiatry units were started in the 1960s, followed by the drafting of the national mental health programme in 1982. The programme envisaged deinstitutionalization and the integration of mental health care with primary care.

The World Health Organization (WHO)'s technical report in 1990 (10) also provided an impetus for community care programmes. A series of other initiatives, such as initiation of community or satellite clinics, domiciliary care programmes, training of school teachers, volunteers and village leaders in early identification of mental disorders, also helped galvanize the community programmes.

Non-governmental organizations (NGOs) have also played a role in the growth of community care. Mental health NGOs in India, Maldives, Nepal and Sri Lanka deal with numerous mental health problems in the community. Common NGO activities include advocacy, mental health promotion, prevention of mental disorders, rehabilitation, and direct service provision (11). Some NGOs have their own community based programmes and cater to a variety of conditions. In Maldives, six NGOs are actively involved in mental health-related work, including rehabilitation, outreach, life skills training, provision of psychosocial support, and resilience building around social issues. In Nepal, the Centre for Mental Health and Counselling, a national NGO, works on various levels with preventive, promotional and curative aspects of mental health in the community. It is also supporting other organizations in their psychosocial programmes (12). It is a pity that NGOs work in isolation and are not being utilized by the governments for private-public partnerships.

Mental health is not a priority area for many governments in this region and hence the funds allocated are quite meagre. National and international funding does not come easily for community projects. This situation is however changing, at least in India. The new 5-year plan of the Indian government has increased the allocation of funds to mental health. Although a bulk of it will be spent on improving the conditions of mental hospitals, a portion has also been allocated to district mental health programmes in various states.

A huge brain drain has left some of the countries of the region with much fewer psychiatrists. There is also a lack of other mental health professionals, such as clinical psychologists, social workers and more specifically psychiatric nurses. This gives rise to a need to involve community level health workers, teachers, volunteers, key persons in the local community and family members, in the process of identifying persons with mental disorders, making appropriate referrals and providing care and simple psychosocial interventions. This has been successfully done in Sri Lanka, where community support officers, a new cadre of mental health workers, was established in the wake of the tsunami, after it was evident that in most districts the basic primary care services were overwhelmed and could not take on any additional activities (13).

Training and capacity building are critical pieces of the puzzle and should form an integral part of all community oriented activities. This would necessitate use of simple information technologies, periodic reinforcer sessions and a component of evaluation. There is a need for a new set of competencies which would focus on recovery and rehabilitation, and for training of a wider range of workers, including informal

community care workers, within the context of the practical needs of a country (14). Several countries in South Asia have developed training programmes for various groups like lay community workers, school teachers, and primary health care personnel.

Existing primary care physicians in the community are often not ready or inclined to treat the mentally ill. While training enhances their skills, they should be sufficiently motivated to take on the additional responsibility of caring for people with mental disorders. Innovations to address the challenge of inadequate personnel include the use of telepsychiatry, which is being successfully used in Tamil Nadu, a Southern Indian state, by the NGO Schizophrenia Research Foundation (15,16).

Reallocation of the mental health budget in many countries is called for, as a large part of the budget is spent on mental hospitals with long-stay patients with minimal turnover. There needs to be an increased allocation for community based care and helping families cope with the problem.

One of the pitfalls of community based programmes is the lack of access to services. Unless the community systems of care are strengthened, many patients will continue to be untreated. Priority should be given to rural areas, since most of the populations in these countries live in villages.

Community care requires a right mix of clinical skills and practical knowledge of working in and with communities. Continuing professional development and equipping professionals with skills based on evidence is critical. In many areas in this region, this translates into a greater emphasis on mental health at the undergraduate level.

In the absence of qualified mental health professionals, many countries have trained lay community workers, as in the case of community support officers in Sri Lanka. These officers have significantly enhanced both the overall access and coverage of mental health services to communities across all four districts, especially in areas where there was previously limited or no local access to psychiatric care (either due to protracted civil conflict or lack of mental health service structures) (17). For training community liaison workers, several organizations have developed tool kits and manuals in local languages, but these also should be disseminated widely and put to use.

Special programmes are needed during and after disasters and for the socially and economically marginalized, such as poor women and children, especially in rural areas. Some countries like India have drawn up clinical and practice guidelines in this respect, which need to be disseminated widely to provide uniformity in care.

Awareness programmes should be developed using local media – print, audio (community radio) and visual (local TV channels) – and organizing classes in schools, colleges and other educational institutions. There is a need for promotional and preventive components, for example referring to suicide prevention, workplace stress management, school and college counseling services. Mental health programmes should be integrated with other health programmes, such as those for women and children, or rural development. Finally, for the system to be culturally relevant, it is important to understand people's perception of mental health needs.

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