The study's limitations included its small sample size, missing data for three cohorts, inconsistencies in test scoring (some external facilitators allowing the trainees to score the test themselves), uncertain validity of the KAP test (did it measure improved knowledge or simply detect rote knowledge?) and concerns about the cultural relevance of the curriculum and assessment tools.

Modifications to the training programme may include formal guidance on cultural expressions of psychological conflict for external facilitators, for example about suicide. Gender patterns, methods and triggers for suicide differ in Sudan and other LAMICs and suicide often occurs in the absence of a diagnosable MNS (Vijayakumar & Rajkumar, 1999). Management is therefore quite different. Other modifications may include translation of the mhGAP-IG into Arabic; integration of religion and spirituality into the training; adding an observed interview to the final evaluation; fewer and shorter cases on the KAP test, with a simpler and more standardised scoring system; two consistent external facilitators for the entirety of the training, rather than two per week per cohort, to avoid inconsistent scoring; and teaching in Arabic via a translator.

The next step of this project includes ongoing training of PHC physicians by internal facilitators with internet-based support from external facilitators. This issue is seen as critical for the sustainability of the intervention.

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SPECIAL PAPER

Six decades of community psychiatry in India

R. K. Chadda

Professor of Psychiatry, All India Institute of Medical Sciences, New Delhi, India, email drrakeshchadda@gmail.com

The community psychiatry movement started in India in the early 1950s. It has gone through different phases of development, beginning with family care of people who are mentally ill in the campus of the mental hospitals, followed by satellite clinics and a national mental health programme. Other initiatives have included the camp approach, initiatives by non-government organisations and the media, and mental health services for disaster-affected populations. The paper traces the development of community psychiatry in India over the past six decades.

Historically, on the Indian subcontinent, patients with psychiatric disorders were cared for informally in the community by their families. There has not been a formal community psychiatry service in the country, although a few teaching departments have a community psychiatry unit. Community psychiatry in India has generally included a range of services providing mental healthcare outside the main hospital. In the past six decades, a number of developments have taken place in the field in India, including the integration of mental health services within primary care, community-run clinics and initiatives by non-governmental organisations

(NGOs). This paper reviews the development of community psychiatry in India over the past six decades.

Background

The genesis of community psychiatry in India can be traced to the early 1950s. At that time, services in higher-income countries were generally characterised by deinstitutionalisation and the down-sizing of mental hospitals, human rights initiatives and the development of the community psychiatry units. Around this time, India had relatively few psychiatry beds – a total of about 10 000 in 30 mental hospitals (Sharma & Chadda, 1996) for a population of about 360 million – and hence institutionalisation was not a major issue.

A unique experiment was done by Dr Vidya Sagar in 1952 at the mental hospital in Amritsar, in northern India. In the overcrowded hospital, it was not possible to accommodate all the patients. Sagar made arrangements for family members to stay with patients in tents within the hospital grounds, and also provided treatment and group sessions for patients and families. The experiments, having been conducted outside the main hospital, may be considered a form of community psychiatry.

Formal community psychiatry in India started about a decade later, independent of deinstitutionalisation, but rather as an attempt to provide mental health services in the community because hospital-based services were inadequate to serve population needs. Down-sizing of certain big mental hospitals did take place in the 1990s, but more in response both to a judicial intervention regarding complaints of human rights abuse and to the overstaying of improved psychiatric patients in mental hospital (Sharma & Chadda, 1996; Murthy & Sekar, 2008). Most patients are now discharged to their families for rehabilitation.

Beginning of the community mental health clinics

In the 1960s, a new phase started with the community mental health movement in India. In 1964, a weekly community mental health service began functioning at a comprehensive rural hospital at Ballabhgarh, near Delhi, a rural extension centre of the All India Institute of Medical Sciences. In 1967, another rural clinic started at Mandar, near Ranchi, in eastern India. The experiences were followed by two major initiatives in the 1970s, which would change the community psychiatry scene in the country. These were the establishment of community psychiatry services at Raipur Rani, in Haryana state in northern India, and at Sakalwada, in Karnataka state in southern India. Both involved community clinics at primary health centres (PHCs) and the training of medical officers and multipurpose health workers; they were the forerunners of the National Mental Health Programme (NMHP) of India. The projects also included school mental health initiatives, home-based follow-up of patients by nurses and the organisation of psychiatric 'camps'. The two projects, although they provided the impetus for the NMHP, had a major drawback: the absence of long-term follow-up. Indeed, neither continued long, because of the absence of budgetary support (Agarwal *et al*, 2004).

Genesis of national programmes and further development

The 1982 NMHP was a major initiative for mental healthcare. It was based on the community psychiatry approach and had three key objectives:

- ensuring the availability and accessibility of minimum mental healthcare for all
- encouraging the application of mental health knowledge in general healthcare
- promoting community participation in the development of mental health services.

The initial phase was not so successful, due to some inherent weaknesses, including unrealistic targets, absence of adequate staff resources and inadequate budgetary support.

One important achievement of the first decade was the evolution of the district model of providing mental health services, with satellite clinics in over a dozen PHCs in any one district providing mental healthcare to over 2 million people (Murthy, 2011). This was later extended to four districts.

The District Mental Health Programme (DMHP) was formally launched at national level in 1996 as an extension of the NMHP. The rationale for the DMHP model was that a large proportion of those with a mental illness were already seeking help for various medical problems from the existing PHC facilities, and could also get help for their common mental health problems at the PHC. Those with severe illness could be referred to the district hospital. The programme included training components for the PHC doctors, paramedical workers and community leaders. Over the period 1996–2002, the DMHP gradually extended to 25 districts in 20 states of the country (Goel, 2011).

In 2003, after an extensive review of the NMHP and discussions with various stakeholders, a re-strategised programme was formulated (Goel, 2011). That programme aimed to develop a judicious balance between various components of the mental healthcare delivery system, with clearly specified budgetary allocations. Until recently, the programme had been extended to cover 123 districts in the country. A plan for integration of the NMHP with National Rural Health Mission was also developed (Agarwal *et al*, 2004; Goel, 2011, Murthy, 2011). The re-strategised programme has also focused on increasing staff numbers by creating new training facilities and enhancing existing facilities in the mental health sector.

The NMHP failed to achieve its goals, especially in the first decade, because those goals were overly ambitious. The second decade saw its expansion to 25 districts and the third decade to 123 districts, although a re-strategised NMHP had a target of 200 districts (about a third of the total number in

the country). India has also been able to expand its mental health staff resources by enhancing its training facilities, but still the numbers are grossly inadequate.

Other initiatives of the community mental health movement in India

Other community initiatives have included the camp approach, mental health services for disaster-affected populations, school mental health, initiatives by NGOs, suicide prevention, interventions by the media and telephone help lines.

The health camp approach has been used in India for many decades. The camps provide healthcare services to a remote population who have difficulty reaching hospital services. The duration of the camps may vary from one day to a fortnight. The community camp approach has also been used for mental healthcare in places where there are not enough services. Most such endeavours have involved one-day camps, although a few have included follow-up. The camp approach has mostly been used in the field of treating addictions (Raj *et al*, 2005).

Mental health professionals in India have provided their services to disaster-affected populations as and when required, for example following the Bhopal gas tragedy in 1984, the earthquake in Uttar Kashi in 1991, the earthquake in Latur in 1993, the earthquake in Gujarat in 2001, the tsunami in 2004 and the earthquake in Kashmir in 2005 (Chadda & Malhotra, 2006).

Initiatives in school mental health have included sensitising school teachers to the mental health problems of children and adolescents, and a life skills education programme for school children and adolescents (Srikala & Kishore Kumar, 2010).

Various NGOs have provided services in areas such as rehabilitation, suicide prevention, disaster care, telephone help lines and school mental health (Thara & Patel, 2010).

The media have also played a vital role in the field of mental health in India, in form of regularly publishing educational material on mental illness, 'agony aunt' columns on various mental health issues (these are often written by or with the support of mental health professionals) and regular programmes on mental health (Chadda, 2001).

Critique

A number of initiatives have been taken in the field of community psychiatry, including the NMHP, efforts by individual psychiatrists and by NGOs, with funding from a variety of sources. However, there has been an absence of adequate coordination across different sectors, although this is made difficult by the size of the country. Individual efforts have often proved unsustainable over the long term, in the absence of the continuing financial support, whereas the state's NMHP has suffered from a lack of realistic goals, inadequate staff numbers and an absence of adequate budgetary allocations in the initial period.

Conclusion

India can offer examples of a number of initiatives in the field of community psychiatry; these may be successfully implemented in various low- and middle-income countries. The lessons learnt could be of immense value in the planning of national community mental health services.

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