Perspective

Community Psychiatry – Transcontinental Lessons of the Last Quarter Century

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Abstract

Fueled by the discovery of effective medications and the debilitative effects of psychiatric institutionalization and driven by the social winds of change, community psychiatry took shape all over the world. The gradual closure of asylums and the move to community signified not only a geographical shift, but also led to the development of a whole new raft of practices in delivering services in the community. Many of these have become mainstream practices elsewhere. After a promising start, initiatives in community psychiatry have stalled in India, with the lack of resources being the most obvious cause. For various reasons, the field of social psychiatry has also not been in the limelight as psychiatry shifted its focus to the possibilities held out by biological psychiatry. This is unfortunate because the need for broader models is never more relevant than now, as social inequities continue to grow. Therefore, the time is ripe to look back over the developments in community psychiatry of the last quarter century and search for relevance in the light of our current realities. What are the main developments and more importantly, can these be implemented in a cost-effective manner in India? This article is a reflective attempt to argue for the feasibility of models using those principles but adapted for our social and economic realities.

Keywords: *Community, culture, mental health care, models, social*

The Decline of Social Psychiatry Ideals

It is indeed a genuine concern that social psychiatry has been in decline after the renaissance it enjoyed during the post-World War II decades. In the UK and elsewhere, inspired by the work of people like George Brown, there was much interest in the social causation of mental illness and in understanding individual illness experiences in the context of family and social interactions.

The decline began after increasingly strident questions began to be asked about the obvious inequalities in mental health and the robustness of psychiatric diagnostic categories and of many mainstream psychiatric practices. As Pilgrim and Rogers wrote in 2005, "criticisms of psychiatric theory and practice from sociologists (and many psychologists) have emphasized: the weak construct validity of diagnostic categories; the relative absence of longitudinal studies in psychiatric epidemiology; the dominance of empiricism at the expense of theoretical development; a lack of explicit reflection on the ideological nature of psychiatric theory and practice; and the interest work of the drug companies in the mental health industry."[1] Mainstream psychiatry moved away from the awkward questions being asked of it, and proponents of the "anti-psychiatry" movement were sidelined. It moved toward refining its diagnostic systems and exploring the brain basis of its diagnostic categories and treatment practices. However, small dissenting voices continued to emerge, a recent example being the Critical Psychiatry Network in the UK (www.criticalpsychiatry.co.uk).

The Birth and Infancy of Community Psychiatry

As the attention paid to social psychiatric ideals waned, what was happening on the ground as services transitioned from being institution (asylum) based to being based in the community? By the mid-1990s, when I reached the UK for the first time, the closure of the asylums, most of them dating back to the Victorian era, had become a reality. My first job was at a newly built small psychiatric unit, 5 miles away from the sprawling asylum that it had replaced. My

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colleagues were divided about the tumultuous happenings around them. History was being made, deinstitutionalization was happening after 3 centuries, and the 100 or more asylums built after the first one opened in the 18th century were closing. There was chaos on the ground, I felt, at least in the unit that I worked. There were power struggles going on, between doctors and nurses and between the old guard and new. The nurse in charge, soon to be eased out of his post, was clearly grieving over the loss of the old empire. There were rumblings from the residents of the localities into which the previous long-term residents of the asylum had moved, to live in communal arrangements. Most of the tensions were over who to keep out of hospital and how. As a freshly arrived doctor from India, I was taken aback that so many people seemed to prefer life on a psychiatric ward to life outside. The commonest threat was of self-harm or suicide. The task of the system was to decide on the risks involved in living in a world without the protection of the asylum walls of and to then prevent that perceived risk by an inpatient stay. Clinical care was slowly being replaced by risk management.

However, there were genuine attempts to meet the needs of the people with mental health needs, now living in the community. It was recognized very early that people could be lost to the services, now that they were all dispersed in the community. A few but very public tragedies caused serious social debate about people "falling through the net" and "services failing them." *So, the need for ensuring continuity of care became the cornerstone of provision of mental health care in the community*. This is the single most important lesson that we need to learn from the West. Asylums did provide continuity of care for its long-term inhabitants (at one time numbering more than 100,000 people or 0.2% of the population!) There was the very clear realization and acceptance that there can be no quality care without providing for continuity of care. Most of the following innovations are linked to this need.

Elements of the UK model

- Establishments of community mental health teams (CMHT) – The geographical location of services shifted from the hospital to the community and the delivery of service became the responsibility of CMHTs
- Multidisciplinary care – Community psychiatric nurses, psychiatric social workers, community psychiatrists, and occupational therapists all work together with minimum of hierarchies
- Age-based teams for under-16s, adults aged 16–65 years, and for the elderly, above the age of 65
- Services for specific problems – Intellectual or learning disability, substance misuse, or addictions service
- Intensive home treatment teams and crisis resolution teams
- Assertive outreach programs
- Early intervention services
- Rehabilitation services
- Day services
- Supported housing
- Various legal and regulatory frameworks and guidelines
- Systems to ensure continuity of care – The care program approach
- Patient-centric care, user led – Voices of users and carers heard more
- Social inclusion programs and stigma reduction programs
- Recovery-based, co-produced care – Newer methods of conceptualizing care and the role of the users within care systems.

Current Scenario in the UK

Many of the above innovations have all become standard practice and part of the history of community psychiatry. Nearly a quarter century later, after my first exposure to community psychiatry in the UK, I am in Scotland at the time of writing, during a short break from my work in Kerala with the Mental Health Action Trust (MHAT) organization. Despite all the above innovations, the same tensions from a quarter of a century ago are felt at the coal faces of community mental health care. Expressions of the intent to end life and the evaluations which follow dominate the agenda. Who is responsible if the rare eventuality of death from suicide happens? The general practitioners, the gatekeepers to the National Health Service (NHS), refer patients marked urgent for people who have confessed about their desire to end their lives. The psychiatric ward serves mainly one purpose, to help with managing the risk which is felt throughout the system. When the risk seems too much at the primary or secondary level, an admission to the hospital (tertiary level) is triggered. At this level, the challenge is about achieving a quick turnover – do remember that it is no longer an asylum with long corridors and limitless beds but a small unit, following the acute medical model – while seeming to "manage risk."

So, what has gone wrong, you might wonder. Therein lays the dilemma of modern psychiatry, in the UK and probably in other parts of the world where the State tries to discharge its obligations to citizens through universal health coverage. Both the asylums and the move to community psychiatry were attempts by the society to look after the mentally ill in its midst. But, in an attempt to do so, the system seems to have been bogged down by the very social problems that mainstream psychiatry has tried to ignore by rejecting the social models of psychiatry. There is an overrepresentation of people with social handicaps – poverty, homelessness, victims and perpetrators of violence, the abused, traumatized, victims of lack of or poor parenting, scarred by marital and relationship breakups, children of unstable family structures who carry their stigmata to their adult lives, poor literacy and limited education, unemployment, and subcultures of substance misuse. If all these social

issues are not important in how we see mental health and illness, why are they overrepresented on psychiatric wards?

Lessons from the UK Model

So, what are the lessons for us in India? There are both good and bad lessons. There is much to be admired about the National Health Service (NHS), formed in 1948, and tasked with unenviable task of providing universal health coverage. Despite the problems outlined above, the NHS has delivered for 70 years! The failings of the models adopted by the psychiatric mainstream (focusing on the brain than the society) cannot be blamed on the NHS. Though not ideal, care is still available to most that need it.

What about our situation in India, when we or more accurately, the governments we have elected, do not have the felt need to provide universal health coverage? What happens then? Mental health care becomes a purchasable commodity like all other aspects of health care, bought by people who can afford it. Most of the care becomes available only in the private sector whether sold by individual practitioners or by hospitals into which money has been invested and therefore needs to be recouped.

It is a sad reality of our times that the mirage of universal health coverage is becoming ever fainter in India. We have given up hope that the public health system can be our right. We are happy to absolve the governments we elect of the crime of dereliction of public health. Millions are pushed into poverty by medical expenses.

However, for us tasked with looking after the mentally ill, paradoxically, there is the advantage that we can concentrate on the medical aspects without needing to bother about social issues. The ethics pertaining to that is another issue but let us leave those concerns aside for the moment. As the expectations on the State to provide mental health care are minimal, the admixture of social and psychiatric problems that psychiatric services are expected to deal with in the West is replaced by mostly treatable problems that we are trained to treat. That does not mean that we ignore the social underpinnings of mental illness, but it allows us to *choose* to address the social and financial problems of our patients. While doing that, we can focus on what has worked in the West as outlined above. The Damocles sword of "risk management" hanging over everyone's head in the UK is absent. Many of the concepts listed above were about meeting the complex requirements of people living with mental illnesses outside of the protection of institutions. That is where the vast majority of mentally ill patients live in India. These concepts are as relevant in India as in the West because continuity of care is sadly lacking. Whether in the public or private sector, there are no provisions or systems of aftercare.

The Current Indian Scenario

Our attempts to move to community psychiatry at a national level from the early 1980s are well documented. Three and a half decades later, hardly anyone would claim that it has achieved its aims. As discussed above, the transition to community psychiatry anywhere in the world should have two aspects. First, the location close to where people live so that people do not have to travel and the focus is no longer the hospital as the dispenser of care. Wherever our district mental health program has been implemented, the location has shifted from the center to the peripheries and that is indeed very welcome. But, the second and crucial aspect of community care, the innovations listed above, to provide quality care is where it has not been successful. There is no individualized care and no systems to ensure care. Psychosocial interventions are almost nonexistent. With honorable exceptions, rehabilitation does not feature on the menu. The total number of mental health professionals in the country is grossly inadequate, given the size of our population, and mostly located in urban centers and in the private sector.

However, there are a number of new developments which give us hope. I will focus on just two.

- The role of the third sector. Across India, the voluntary sector is now playing an increasing role as providers of direct mental health care to the poorest sections of people with mental illnesses. Fledgling initiatives such as MHAT, that I am part of, are following in the footsteps of larger and better established initiatives
- A growing evidence base. Evidence emanates from two sources. Academic researchers such as Professor Vikram Patel and his collaborators have proved that nonconventional delivery of psychosocial interventions by trained nonprofessionals is feasible and effective. Many of the ideas such as task-sharing and community-based rehabilitation which I believe are central to the delivery of community mental health care have been successfully tested and implemented by many including MHAT. This experiential proof is the second strand of evidence.

The MHAT Experience

Nearly 10 years ago, a group of us ventured into community psychiatry with the seemingly impossible aim of providing the best possible quality of care to the poorest sections of society with severe mentally illness, free at the point of delivery to the recipient, in the voluntary sector in Kerala. We drew our inspiration from the twain worlds of the East and the West, which proverbially are not supposed to meet. Kerala has a rich legacy of people's involvement in health and science, most recently proven by the emergence of a community palliative care movement which has revolutionized care of the chronically ill in many parts of Kerala. For the model of service provision, we drew on the lessons of deinstitutionalization outlined above. Is intensive home treatment possible in rural settings of Kerala? Assertive outreach? Community-based rehabilitation? In the absence of social security, what about livelihood

generation? And above all, can it be cost-effective so that it is feasible for large numbers?

The elements of the model

Free care

As the beneficiaries are underprivileged and in view of the shortcomings of the state system, all care is provided free. However, as a model, this is neither central nor necessary. A similar system for the better off can work equally well on a payment basis.

Entirely community based

Care is provided, at the moment in 54 places, close to where the beneficiaries live. The need for hospitalization is almost nonexistent. When it does happen, very rarely, it is because of the failure of one or more of the crucial elements below.

Role of nonprofessionals and volunteers

In terms of numbers, this is the largest group and the most important group. Most of the aspects of home treatment, assertive outreach, and rehabilitation are carried out by this group. The crucial concept here is one of *task sharing or task shifting*, defined as performing of tasks, under supervision, by people who were not originally trained to perform such tasks.

Redefined roles of professionals

For the professionals working in MHAT, whether doctors, social workers, or psychologists, there is an emphasis on redrawing their roles in line with the task-sharing model. For the nonmedical professionals, there will be an element of task sharing both with doctors and nonprofessionals. Training, support, and supervision assume more importance than in other systems.

A multidisciplinary ethos of working

Decentralization and devolution of power

The whole structure is one of decentralization and autonomy. Each unit is totally independent and raises funds locally. There is no franchising of the MHAT brand. The ownership is local, with the training and technical aspects of care being delivered by MHAT. These groups can choose to replace MHAT with another provider of mental health care.

Quality standards

These are set by MHAT and could include various aspects of clinical care such as the frequency of clinics (weekly), types and brands of medications (cost effective, safe), control over who gets care (economically backward only), systems of appointments (predecided, 20 min slots), physical infrastructure (ensuring of privacy), and standards of behavior (respect for the ill individuals and their families).

Systems for aftercare

Prevention of relapse is the main aim. For that, systems of detection of early warning signs of relapse are required. Each individual patient is expected to be assigned a fixed volunteer who monitors the patient and family at least once a week. Round-the-clock access to professionals over phone is available to the volunteers. Families are encouraged to contact the volunteers at any time.

Effective use of technology

Apart from mobile phones, there is increasing usage of video-conferencing or telepsychiatry. Case records are maintained locally on paper and contemporaneously on a laptop linked to a cloud-based database.

Provision of social and economic care where possible

All of the above cannot be provided without a community developmental perspective and a belief in social justice. Providing medications makes no sense without addressing poverty.

The reach

Over a decade, the reach has spread to seven districts of Kerala serving over 3000 patients and their families. There is one entirely community-based program serving the tribal communities of Wayanad.

Conclusions

I have come to believe what Professor Vikram Patel once wrote, "Mental healthcare is far too important to be left to professionals alone." Nonprofessionals can be trained and most importantly, trusted to provide many aspects of mental health care including psychosocial interventions. With trust, ongoing training, and supervision comes increased confidence and innovation. For professionals, our training often constrains us and blocks our innovativeness. Others, volunteers, and paid nonprofessional colleagues are not similarly burdened. Their involvement helps destigmatize mental illnesses.

Holistic care and compassion works where our medications fail. People who have experienced mental health problems have a crucial role to play in the healing system. Patients, carers, and doctors are just roles we play. None of them define us and we may play all the roles at different times in our lives. What are required are not new medicines but new ways of working and new ways of defining our roles as professionals.

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Conflicts of interest

There are no conflicts of interest.

Reference

1. Pilgrim D, Rogers A. Social psychiatry and sociology. J Ment Health 2005;14:317-20.