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MENTAL HEALTH

(Working Paper submitted by the Government of India)

The 30th World Health Assembly, in its resolution WHA30.38 called upon the Member States to accord adequate priority in their health policy and development plans to actions that will prevent mental retardation and provide necessary care and support for mentally retarded idividuals and their families. Again in 1986, the 39th World Health Assembly passed a resolution highlighting the magnitude and public health importance of mental, neurological and psychosocial problems and called upon member countries and Regional Committees of WHO to initiate activities aimed at promoting mental health and preventing mental health disorders.

As a follow-up, the South East Asian Regional Committee, vide resolution SEA/RC30/R4, called upon the Member Countries of the Region to initiate and strengthen preventive, promotive and rehabilitative activities at the community level for the promotion of mental health. The Regional Committee again, vide resolution SEA/RC41/R5, called upon the members to formulate National Mental health policy and programmes that aim to reduce mental, neurological and psychosocial disorders and to promote mental health well being. In spite of the well intentioned resolution of the world community and the Member Countries of the Region, mental health care has not received the priority and attention it deserves.

The Alma Ata declaration, which envisaged provision of minimum level of health that would enable all people to lead a productive life and participate actively in the community, has made substantial progress in developing and expanding basic health services aimed at physical health care. This, unfortunately, has not been matched by mental health care. This is more so in developing countries which are preoccupied with the heavy burden of 'traditional' communicable diseases. The attitude of the community and the family members towards the unfortunate mentally ill remains one of fear and revulsion. The facilities and trained manpower available to take care of the mentally ill are also grossly inadequate. If this situation is to be improved, the issues involved have to be examined seriously, a pragmatic policy and programme drawn up and translated into action.

Political forces play a dominant role in the shaping of health services of a community. This is applicable in mental health care too. The place assigned to mental health in public health programmes is modest. The last few decades have, however, shown an increasing awareness in developing countries, some of whom have initiated mental health programme development. It is essential to mobilise political commitment to develop this programme and obtain decisions on resource allocation, policy, choice of technology manpower and method of making these services available and accessible to the people.

The next step is to evolve a programme structured on a rational and scientific basis. If any meaningful mental health care programme is to be implemented, it is essential to integrate it with the existing basic health services by training the existing medical and para-medical personnel in basic mental health care. These personnel can be trained in early recognition of all severe mental disorders, suitable referral and regular follow up. They are very useful in educating the families and the community in the care of mentally ill patients with sensitivity. India has made some progress in this area. However, much more needs to be done in extending this service in the developing countries to cope up with the enormous problem. Considering the magnitude of the problem, the trained manpower available is grossly inadequate. In spite of the best efforts of the few training institutions, the annual turn out of manpower trained in mental health care is easily outstripped by increasing population and patients. While every effort must be made to train more specialists in this area, other innovative approaches need to be evolved to meet this challenge.

The approach in dealing with mentally ill patients was to build asylums, which were more custodial than the therapeutic. Although various alternative forms of care have subsequently been developed, mental hospitals continue to play a major role in delivery of services. The quality of care and services has been very poor due to the large number of chronic stay patients without family supply and who cannot be discharged, over-crowding, poor, resources and funding, lack of adequately trained staff and lack of facilities for rehabilitation facilities. In the recent past, however, these hospitals have begun to acquire newer roles and functions. They now run regular outpatient services for ambulatory care of new patients and follow up and after care of discharged patients, rehabilitation services of various types which never existed are beginning to be added. Some hospitals have opened 'short stay' wards and 'open' wards. These new roles of the mental hospitals need to be expanded and encouraged. Since these institutions with the new role and functions will continue to be a major component of mental health services, especially for the care of severely disabling conditions, there is an urgent need for additional resources and support.

Government Hospital Psychiatric Units (GHPU) provide an impetus for the greater acceptance of psychiatric services by the public without fear of social stigma. As the Indian experience shows, these units have also brought about a change in the training of professionals and in research in mental health. These units need to be extended further to cover the population in the periphery.

Family members have been an important resource in mental health care at several levels: (i) family members as care providers in hospital setting, (ii) family involvement in therapy, (iii) family members as trainers of mentally retarded and (iv) family members as a pressure group for policy change and better facilities. This family involvement, which has now become the trend in developed countries, need to be encouraged and adopted in the developing countries.

As in the other health programmes, this group is a very important and powerful force in mental health care programme. They are capable of mobilising public support and demand for services, mobilising funds for care of mentally ill, pressurise the authorities to improve living conditions and the treatment meted out to the inmates. Their services are invaluable in educating the family and community in accepting the mentally ill into their fold. These agencies need to be involved more and more in mental health care.

These are some of the basic issues and challenges which are perhaps well known but has been more or less neglected. It is necessary now to face these challenges, take a collective decision to give due priority to mental health care, develop pragmatic programme involving all concerned sectors and initiate action. The South East Asian Regional Committee may consider the following issues and resolve to take action on a priority basis for improvement in mental health care of member countries:

(1) Mobilize political support for developing mental health care.

(2) To mobilise community support in order to formulate pragmatic mental health programmes based on rational and scientific basis along with due consideration of the social and cultural ethos.

(3) Decide upon time frame for implementation of a programme to upgrade the facilities and improve the functioning of the existing mental health institutions to ensure humane treatment to the inmates, so that the dignity of the patients and the quality of their life are maintained at an acceptable level.

(4) WHO may play an active role and provide constant and active support to the member countries in developing and implementing suitable mental health programmes, especially through dissemination of intra-country experience.

(5) In India, institutes with an excellent track record of caring for those less fortunate like the National Institute of Mental Health and Neuro Sciences, Bangalore, have been developed. WHO may identify such institutes of excellence in the SEA Region and arrange a networking in order to improve these institutes collectively.

(6) Greater involvement and education of the family and the community in mental healtlh care of the mentally retarded.

(7) Utilising the existing infrastructure of secondary level hospitals by introducing a Department of Psychiatry in these hospitals at least for outpatient purposes.

(8) Open departments of Psychiatry in the medical teaching institutions/colleges.

(9) Initiate action to involve the basic health workers, especially para-medics and nurses at different levels of health care.

(10) Exposing general practitioners of medicine both in the public and private sector and involving the practitioners of traditional and herbal medicine in the treatment of the mentally ill. We in the SEA Region have a rich knowledge of herbal medicine developed over the centuries.