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Innovations in Neuro Psychiatric Services

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Introduction

The development of health services in the country has taken great strides since independence. The situation in terms of medical colleges to train doctors, the schools of auxiliaries for different categories of health personnel and the primary health centres-sub centres close to the villages have become a reality. What is impressive about the Indian situation is the consistant efforts to strengthen the primary health care programme. For example, in the last decades three major health welfare programmes, namely - the Multi-purpose scheme (1972), the Integrated Child Development Scheme (1972) and the Community health Workers Scheme (1977) ;were put into action. Though there are problems in the total benefits reaching the people, notwithstanding all these programmes and personnel, the direction of development is clear indeed. The Alma-Ata Conference in 1978, on Primary Health Care has come as a shot in the arm for further development in this area. It is in this context of growing health services, that this report reviews the developments in organising neuro-psychiatric services with a focus on innovations emerging from the National Institute of Mental Health & Neuro Sciences, Bangalore - 560 029 (NIMHANS).

Mental health, till recently, has been a neglected area. The administrators, planners, and even the medical professionals were unaware of the wide prevalence and suffering caused by the mental and

neurological disorders. The wide ranging misconceptions and ignorance of the population resulted in a lack of public demand for modern services and their under-utilisation.

Till about a decade and a half, there were no epidemiological studies regarding the prevalence of various types of mental illnesses in the country. Even now good epidemiological information in neurological or neurosurgical disorders in the general population is limited. It is only during the past two years, some epidemiological studies of neurological diseases has been taken up. However, several epidemiological studies in various parts of India have shown the wide prevalence of all types of mental disorders both in rural and urban populations in the different parts of the country [1], [2], [3]. To the surprise of many, the prevalence rates are in no way easy than the rates reported from the west. The various forms of severe psychosis and epilepsy range from 0.5 to 2.0 per cent (5-20 per thousand). Thus the number of people suffering from serious neuro-psychiatric problems in India amounts to several millions.

The facilities available to tackle these enormous problems are very limited. There are only 38 mental hospitals in the country and only 83 out of 110 medical schools have full Departments of Psychiatry. The Departments of Neurology and Neurosurgery are far less and exist only in about 35 medical schools. In many medical colleges the neurological and neurosurgical diseases are treated by general physicians and surgeons respectively. In all, total psychiatric beds available is around 25,000. Most of the services available (hospital beds, trained personnel etc.) are situated in the urban, or semi urban areas. There are no services for the majority of the rural population. The existing services are estimated to provide care only for less than 10 per cent of those urgently in need of mental health care.

The number of psychiatrists available in India is very limited. The psychiatrist population ratio is 0.15 psychiatrist per 100,000 population while similar figures for England, West Germany, USSR and USA are 3.7, 4.7, 5.5 and 12.5 respectively. Though about 100 psychiatrists are being trained every year, it will take many decades before the required number could be made available to the existing population of 700 millions. If the present rate of population growth is maintained, probably it will never be possible to provide adequate specialists.

However, it is gratifying to note that this is changing. There are more neuropsychiatric facilities around the country and public use them with less fear and misapprehension. The planners have become aware of this need. In the last meeting of the Central Council of Health (October 1982) mental health needs figure prominently and a national plan is recommended.

NIMHANS is one of the unique institutions where all the disciplines, relating to brain functions are working under one roof, for the alleviation of neurological and psychiatric disorders. In addition to clinical divisions of neurology, neurosurgery and psychiatry, number of related paraclinical and basic science disciplines as varied as biophysics and Indian philosophy, Ayurveda are developed to pursue the three pronged approach of service, teaching and research in the field of mental health and neuro sciences. The service and training have formed the main foundation on which the clinical and basic research activities have been developed.

Thanks to the farsighted vision of late Dr. M V Govindaswamy - founder Director of the All India Institute of Mental Health - the Departments of Neurology and Neurosurgery were started in the mental hospital. Though this raised the eyebrows of many professionals at that time, the advantages and the impact of this co-existence are now well appreciated and the benefits are clear. The multi-disciplinary approach to the problems of mental health and neuro sciences has paid great dividends. The public who used to shy away from mental hospitals due to social stigma, started seeking help readily. They

considered that mental illness is one form of physical illness, like a neurological problem. The multi-disciplinary diagnostic and therapeutic approach also provided for better understanding of the patient. The trainees in mental health and neuro sciences are exposed to different approaches and disciplines and have been able to develop the team spirit and ability to view the needs of patients from multiple view points.

Innovations at NIMHANS

Till 1968, the hospital was providing mainly in-patient care with about 990 patients. There was not even a well organised out patient service for psychiatric patients except for individual psychiatrists, providing help at a personal level. The out-patient services for neurology and neurosurgery were well established. It was in 1975, that the mental hospital and the All India Institute of Mental Health came together and integrated as the National Institute of Mental Health & Neuro Sciences, Bangalore (NIMHANS).

During the last fifteen years, the following innovative approaches have been developed at NIMHANS:

1. Organisation of out-patient services.
2. Family psychiatric services.
3. Rehabilitation services.
4. Community mental health services for rural and urban population.
5. Training of school teachers and lay volunteers.
6. Domiciliary care programme.
7. Extension services - "Satellite" Clinics.
8. Self-help groups of parents.

1.

Organisation of Out-Patient Services

During the past two decades, the emphasis on treatment of mentally ill, has been slowly shifting from custodial in-patient care to the management of as many patients as possible in the out door setting. This becomes more effective and acceptable to the public, when there is organised services, and the availability of specialists help all the time is enabled. Therefore, daily out door services were established with a team of specialists. The team consists of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurse. The patient is examined and assessed by the team and management is instituted. At the out-patient department, adequate support is provided by way of - frequent follow up with regular medication and social assistance. The public assurance and confidence is maintained by attending the patient promptly and even admitting unmanageable patients for active treatment for a short period. Constant efforts were made to reduce the number of 'long-stay' beds and to convert them into 'active treatment' beds. An example of the result of these efforts is the average length of stay of patients. The current average length stay is 52 days as compared to 157 days in 1967 and this is further reduced to 38 days for new (first) admissions (Fig. 1).

Average duration of stay over 15 years

Currently, the out-patient services are built up at two levels. The walk-in-clinic team which provides quick and relevant urgent care and an appointment for detailed examination. This reduces the waiting period, sorting out the wrong referrals, starting of treatment without delay and better planning of the detailed evaluation on a planned basis. In the 'main' out-patient clinic, each patient is seen by a multi-disciplinary team to plan a comprehensive and long term treatment. Since patients are seen by appointment this has become possible. An attempt is also made to plan the visit of 'long-care' patients by appointment system, by developing a team to look after them so that patients do not see different therapists during each visit. An equally important part of the outpatient work is the making available of a limited range of drugs to patients from one week to four weeks at a time.

2.

Family Psychiatric Service

The involvement of family members during inpatient treatment in mental hospitals was initiated in the country by the late Prof. Vidyasagar at Amritsar Mental Hospital in 1957 [4]. He organised this by putting tents and allowing family members to stay with the patients. Similar work was started at the Christian Medical College, Vellore in early 1960's. It was in 1968, the formal attempts at involvement of the family was started at NIMHANS. A pilot study conducted found that 40 per cent of the relatives were willing to and wanted to stay with the patient during treatment. Further analysis showed that most of them were belonging to middle and poor socio-economic group and many were from rural areas [5], [6].

Initially one open ward was converted to a family ward. Arrangements were made by partitioning the ward with curtains and a common kitchen was provided to all the families. This experiment had a stimulating and encouraging results. In the family wards only close relatives were insisted to stay with the patients. They were made to be responsible for the patients care on the advice of the psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurse. Group activities like bhajans, prayers, picnics and other social activities were encouraged. A spirit of participation and cooperation to the benefit of one another was evolved, among the families, irrespective of caste, creed and religion. The number of days of stay in the family wards was reduced to 18 days compared to 76 days in the regular ward of similar patients [5], [6]. The follow up of the patients became better and relapse rate has reduced because of this continued management.

Since 1976, a separate 20 bedded family psychiatry centre with facilities for each family to cook was built. This set up has adequate facilities for group therapy and other activities like prayer, dining and recreation. The philosophy of the family ward is not to use drugs as parts of the therapy but to mobilise the resources in the patient and the family and to treat the family as a unit. The advantages of family therapy are

(1) patient is not separated from family
(2) family members undergo a learning experience and modify their behaviour
(3) it serves as a focus for mental health education, and
(4) improves skills of community living.

A number of issues arise as a part of family therapy like what type of illness to select, which relative to stay and what type of illness to select, which relative to stay and what types of therapy are useful

(group, conjoint etc.) and the aspects of Indian family life and group dynamics. The group interaction is one of the most important components of the total management of the family [7], [8], [9]. Separate group interactions are planned for specific types like - epileptic families, schizophrenic families, families of drug addicts and alcoholics and families of adolescent problems etc. Systematic attempts have been made in these areas and further work is in progress. Some of the contributions are the development of a scale to arrive at the family typology and a scale to evoke family therapy techniques for different types of neuro psychiatric problems and the different types of families.

3.

Rehabilitation Services

One of the very active aspects of NIMHANS care programme is the multifaceted rehabilitation services. It has already been referred that with the expansion of out-patient services, the service became more treatment oriented and less custodial. Rehabilitation services have reached out to make the ill persons capable of standing on their own feet and be an asset rather than a liability to the family and society. how this was achieved is itself a mixture of professional involvement, public acceptance and utilisation of community resources.

The central focus of all rehabilitative services is the "Rehabilitation Committee". This committee consists of prominent citizens of the city, philanthropists, industrialists, in addition to the staff of NIMHANS involved in rehabilitation services. The involvement of the public has helped in many ways. This has especially created an awareness and confidence that the mentally ill can work, are manageable in the community and not dangerous. They form an important avenue to develop better understanding of mental health problems among the public.

Psychiatric rehabilitation services at NIMHANS include a Rehabilitation Clinic, Day Care Services, Occupational Therapy for in-patients, Rehabilitation Homes, Half-Way Homes for patients drawn from long stay patient groups from various units..

Rehabilitation Clinic: As a pioneering measure, a separate multidisciplinary Rehabilitation Clinic is being conducted with a Psychiatrist, Clinical Psychologist, Psychiatric Social Worker, Psychiatric Nurse and Occupational Therapist. The patients referred from various units for rehabilitative measures are first assessed by the team in this clinic and goals of rehabilitation decided and a programme drawn for individual patients.

Day Care Services: These are offered for patients who are undergoing treatment in various units of the Hospital belonging to Bangalore city, six days a week from 9 a.m. to 5 p.m. The goals of care are either vocational rehabilitation or activity therapy (Table 1). Vocations are decided depending upon the patient's clinical status, his/her family background, social status, previous vocation and aptitude of the individual. The work performance, social skills and general behaviour are measured by rating scale every month. Incentives mostly cash, either given monthly or more frequently as the case may be, are calculated according to the points he/she obtains on the rating scale.

Table I - Day care service (patients coming from their own homes and other institutions)

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The progress of the individual is discussed by the team periodically and his/her job placement of self employment measures in the community is decided accordingly. The referrals are increasing year by year and the Day care patients are mostly schizophrenics, mentally retarded and epileptics with psychiatric problems, conditions which cause more handicap. There is a fall in discharges in the three year period, mainly because the Unit now offers vocational rehabilitation programme in a methodical way keeping the patients in the programme for a longer time than before. Job placement, self employment and sheltered employment have all shown increasing trend over the past three years. Drop outs have significantly reduced to almost one third of the rate prevailing 3 years ago (Table II).

Table II - Day care service-discharged patients' mode of rehabilitation

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In patient referrals for activity therapy during their hospitalisation has increased in the course of 3 years, schizophrenics are referred mostly, followed by mental retardation, manic depressive psychosis and epilepsy with psychiatric problems in that order. The numbers referred to are 159, 197 and 228 for the last three years respectively.

Rehabilitation and Half-Way Home - include two rehabilitation homes for male patients, one rehabilitation home for female patients, all situated in the hospital campus and one Half-Way Home for female patients situated just outside the hospital campus. these homes do not have ward like atmosphere or structure. At present all the patients in these homes are drawn form long stay patient groups in various wards, who do not require very active medical or nursing care to the extent a ward patient requires. Further intensive rehabilitative measures are under-taken after their psychiatric status and rehabilitative potentials are assessed. A graded rehabilitative pattern is followed with patient moving from closed wards, open wards to the rehabilitation homes and half-way homes, with gradually increasing independence and decreasing supervision.

The admissions and total number of patients in three homes are increasing. In those female patients placed in half-way home, identification of problems in their home which worsens the illness and also preparation of the individual to look after a household subsequently are given importance. The cost of staying in the half-way home is borne largely by the family of the patient.

During the last 3 years (1979-82), 54, 48, and 48 patients were living in the above set up, the number of new admissions have been 10, 8 and 12, the discharges 16, 8 and 7 respectively.

These innovative approaches in rehabilitation have been taken keeping in view the needs of the patients, the cultural and social set up and the economic restraints.

4.

Community Mental Health Services for Rural and Urban Populations

It has been emphasised in the beginning that the available man power in the field of mental health to cater to the needs of the vast population in India is too meagre. The seminar on Organisation and Future Needs of Mental Health Services held under the auspices of WHO in 1971 emphasised this fact and it was noted that the health care services in India can mainly be delivered through Primary Health Centres (P.H.C.). Though the primary health centres were not fully developed at that time, the potentiality and importance of these primary health centres were recognised and they resolved that as

soon as possible, an opportunity should be taken to provide mental health care at these centres through multidisciplinary team and by the use of available staff, such as Government Medical Officer, Nurse, Family Planning Workers and Basic Health Workers who have got suitable training. The basic idea is to integrate mental health care into the general health services meaning there by that the mental health component should be incorporated into the work of primary health worker and the medical officers at the primary health centres.

This decentralisation of mental health can be made available to the community through General Medical Centres available at that level. The average primary health centre doctor in India is a medical graduate from one of the medical centres in the country and has very limited knowledge of psychiatry. The multipurpose health workers and health supervisors working in the primary health centres have no knowledge of mental health, though Srivastava Committee had recommended to include the training of mental health for these base line workers and a chapter has been included. These basic health workers also called as multipurpose workers rarely recognise any mental health problem and advise the public to go to doctors. Even though some of the psychiatric patients are taken to ;primary health centre doctors, the doctor invariably refers the case to one of the mental hospitals. A WHO seminar on "Community Action for Mental Health Care" held at Bangalore in 1973, urged for the organisation of a pilot project at different levels of care in order to evolve an efficient system of integrated services.

In 1976, NIMHANS launched community Psychiatry programme under the leadership of Dr. R L Kapur [10], [11]. The aim of the programme has been to develop suitable training programmes for the doctors and multi-purpose workers, so that these personnel can provide basic mental health care in the respective catchment areas. Fortunately, Government of Karnataka, gave full support and agreed to depute all the primary health centre doctors and multi-purpose workers as and when the training programme is arranged.

The objectives of training multi-purpose workers are as follows:

1. Early recognition of all epileptics and psychotics in the community (who live in their catchment areas).
2. Referral of the identified patients to the primary health centre.
3. Regular follow up of such patients in the community with feed backs given to the doctor at the PHC.
4. Education and motivation of the family members & neighbours of the patients to look after the patients in a human and practical manner.
5. Management of psychiatric emergencies like acute excitement when no doctor is available.

The objectives of training the primary health centre doctors are as follows:

1. Diagnose and manage epilepsy and different forms of psychosis - both acute and chronic.
2. Refer difficult cases for specialist opinion to district hospital and receive them back for further follow up.
3. Supervise and guide the multipurpose workers.

Therefore, before launching the training programme, the unit took up the feasibility studies to formulate the training procedures and develop a manual. The feasibility study was conducted in about a population of 76,000 spread over 120 villages. Epileptics and psychotics were identified in these villages by a simple method of asking, a few questions to any 3 to 5 persons of the adult populations of the village [12]. Patients thus identified were managed in their own home setting with follow ups at the rural centre which is situated about 20 kms. from NIMHANS.

The number of patients detected and managed during this study is as follows - Schizophrenics (51),

Affective disorders (27), Acute psychoses (13) and Epilepsy (268) [13], [14].
The duration of the illness before they were detected is given in Table III.

Table III - Duration of illness before detection

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Many of these epileptics and psychotics were chronically ill for several years. Almost all these patients consulted traditional healers as indicated in Table IV.

Table IV - Consultation of various agencies by patients

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*Traditional healers

Although 50 per cent of the patients had consulted allopathic doctor, most of them were on some treatment and had moderate to severe disability as indicated in Tables V and VI.

Table V - Severity of disability in schizophrenic patients - No. of patients - 31

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Table VI

Table VI

While detection of epileptics and psychotics was rather easy, convincing the family members to accept the long term medication and regular follow up needed constant efforts. Frequently, the improved patients became live examples to motivate other patients in the same village and near-by villages to take their medications regularly and thus changed the attitude of the community. It was noted that only 4 per cent of the detected cases needed hospitalisation for a very short period during the course of two years.

The feasibility study in the rural setting helped to formulate training programme and develop Manuals [15], [16], [17]. These manuals were tested in two primary health centres. As a result of this and repeated revisions - two separate manuals on instructions in basic mental health care for multipurpose workers and primary health centre doctors have been developed. As a result of this, a regular training programme for the primary health centre doctors and multipurpose workers has been started from April 1982 at Sakalawara. So far six batches have been trained. Most important aspect of any pilot project is the feasibility of replication at different centres by different personalities. Accordingly the Indian Council of Medical Research, is presently engaged in multi-centre projects to evaluate the usefulness of the training programme developed at NIMHANS.

Four centres were selected in different parts of the country - Calcutta in the East, Patiala in the North, Baroda in the West and Bangalore in the South. The questions being asked in this project are:

a) Can a M.P.W. after training, actually detect psychotics and epileptics in the community and to what extent?
b) Can P.H.C. doctors manage cases through multipurpose workers?
c) Can the attitude of the community be changed towards mental patients through such programmes? and

d) What is the cost involved?

In a similar community based work done at Chandigarh (India) as part of WHO Project titled "Strategies for Extending Mental Health Care" (1975-81) it has been shown that it is possible to integrate mental health with general health services by choosing priorities and developing proper training programmes for the health personnel [18], [19], [20], [21].

The Community Mental Health Unit at NIMHANS has developed a regular out-patient services at K.C. General Hospital, Bangalore since 1977 and has developed active liaison with general practitioners in the surrounding areas. The main aim here is to train the general practitioners and develop various methods of training programmes. Most of the general practitioners in the country have very poor knowledge of psychiatry. Recent studies in India have shown that about 30 per cent of the clients of general practitioners suffer from some type of emotional problems. This is true of semi urban and rural areas too. The Mental Health Unit at K.C. General Hospital has been providing regular consulting services to the general practitioners in addition to running outpatient services. Linked with this ongoing programme, different types of training programmes have been designed and conducted for general practitioners. The training programmes have been designed, depending upon the background and interest of general practitioners as
(1) long duration
(2) medium duration
(3) Short duration.

Long duration course consists of one to two hour sessions per month for 2 years, medium duration course consists of one to three sessions per week for 3 months and short duration course consists of one to three sessions per week for 3 months and short duration course consists of 4 to 6 sessions of total about 12 hrs, over a period of 2/3 days. The first two are meant for urban general practitioners in cities and big towns, while the third course is primarily meant for general practitioners in semi urban areas. Lectures and discussions with audio visual aids, discussion of trainee doctors, own case material, practical clinical training with live situations at the out-patient or a mental health camp etc., are the main methods of training [22], [23], [24].

Involvement of IMA and training of semi-urban doctors: With the help of local Indian Medical Association and voluntary organisations like Rotary Club and Lions Club, Mental health camps are organised at Taluk levels. As the mental health camps without proper follow up will be of very little use for the psychiatric or epileptic patient, we have made it as an experiment and made it a point to see that the local IMA is involved and the members of this Association who are the general practitioners or the doctors working in the Government hospitals are given training at least for 2 days before the camp. After this intensive training, a camp is conducted on the 3rd day, where these trained doctors are involved in diagnosis and management of the patients. These doctors are trained to follow up the patients. To facilitate better follow up, one of the psychiatrists from NIMHANS would visit once a month to provide consultation to the general practitioners and to see how the follow up is going on. So far two such intensive training programmes were held at Kollegal and Ramanagaram for doctors and the patients treated were as follows: At Kollegal 20 doctors received training and 291 patients were seen in the camps. Similarly at Ramanagaram, 15 doctors were trained and 145 cases were seen in camps.

5.

Training of School Teachers and Lay Volunteers

In developing countries like India, child psychiatry services are most poorly developed and the mental health problems of children are neglected. Hardly any school provides counselling services. NIMHANS has been attempting to create referral and counselling resources in the community, in the hospital & clinics. This is done by training school teachers and lay volunteers.

A general training programme on child mental health for all categories of school teachers and a more intensive programme for the interested and suitable teachers on counselling have been developed and evaluated [25], [26], [27], [28].

A manual providing guidelines for school teachers has also been developed. Presently two programmes of training of lay volunteers in mental health are going on. The main aim of training these categories of non professionals is to make them identify emotional, personality and other mental disorders, to educate and motivate the people and offer simple counselling.

A similar attempt to train lay volunteers is also in progress in the Bangalore City, in association with voluntary agencies.

6.

Domiciliary Care Programme

Treatment of schizophrenic patients through a visiting nurse was taken up as a research study to understand the burden on the family, the social functioning, as well as the recovery of the patient. The first onset schizophrenic patients were taken and after initial assessment in the hospital, the patient was managed at home by a visiting nurse. This group of patients were compared with a matched control group who underwent regular hospital treatment. They were followed up after a period of six months and assessed at 8 different points of time on clinical severity, social functioning and burden on the family.

The home care group consistently did better on all the three parameters, after the first month. The differences were more marked on the parameters of burden on the family and social functioning [29], [30], [31]. As a result of these studies the urban centre continues to offer domiciliary care, assisted by a visiting nurse.

7.

NIMHANS Extension Services - "Satellite" Clinics

Extension services of neuro psychiatric clinics were started with the help of local people in four taluk headquarters. These headquarters are situated varying from 60 to 120 km. from Bangalore. The multidisciplinary team of consultants (clinical and para clinical) and the residents attend these services once a month on a fixed day (eg., 1st Monday of the month). The importance of these services is the involvement of local people. It was made very clear from the beginning that these clinics should be sustained by the support of local voluntary organisations, as well as philanthropists. Accordingly, in

each place either the Rotary Club or the Lions' Club or both have joined together to organise these camps regularly, to publicise and provide information to rural population. They also take the responsibility to provide hospitality to the visiting team and free medication for a month for the deserved patients who are attending these services.

It is made sure that at least one month's requirements of drug is provided. These centres cater to about 80 to 100 thousand population. Now the patients who could not have utilised the facilities at NIMHANS due to distance are able to attend to these services and get the benefits, closer to their home.

Number of patients seen and followed up: About 50 new patients with neurological and psychiatric disorders attend the clinics and the follow up cases are more than the new patients. It is gratifying to note that these clinics are becoming more and more popular and thereby more and more people are getting the benefit now. There are some more requests from different parts of the state for starting similar clinics. We feel that about 85 per cent of the neurological and psychiatric disorders can be treated and followed up on this way once a month effectively. They do not require more attention than this. This is being evaluated now. If this approach is found appropriate, we feel that every district psychiatrist or neurologist should be able to run, once a month, clinic in different parts of the district so that many more patients can be benefitted by this type of service.

8.

Self-help Groups of Parents

The problem of providing meaningful services to the mental retardation has not received to-date serious consideration. As a result, the large majority of the retarded persons lie with families and the major source of help are the parents. The lack of resources and unlikelihood of any major effort to develop institutions for the mentally retarded calls for developing approaches appropriate to the Indian needs. The role of parents assumes special importance in India. It is in this context that the ongoing innovative work at NIMHANS assumes significance for wider planning.

During the last few years two major approaches have been adopted by the mental retardation unit. On every Thursday two separate parental groups are organised for

(i) training the retarded in self-help skills applicable to children above 2 years of age and

(ii) training in sensory motor development for children below 2 years of age.

Each group has 10-15 parent units at any given time. In addition individual parents are counselled on Fridays on appointment basis.

At the ward level 7-8 retarded persons are admitted along with parents in the children's ward for assessment, counselling, speech and behaviour training and physiotherapy. The average duration of admission is about 4 to 6 weeks. These efforts at the hospital level both in out-patient and in-patient level has resulted in parents being confident to care for their retarded children. This has also resulted in them not looking for institutional help as the primary method of care.

At the community level, our approach that is less dependent on professionals is being supported. This was the direct follow up of the workshop on 'self-help groups' held at NIMHANS in Dec. 1981. Since Jan. 1982, at Bangalore, with the initiative and commitment of one of the parents, a weekly get-together of 15-20 parents is functioning. These parents come to the house of a parent and spend the

Sunday mornings together. These get-togethers have been supported by NIMHANS staff. The experience of the last one year has convinced us of the utility of this approach. The self help groups of parents are valuable in providing mutual support, sharing of experiences, group learning and mobilisation of resources in the community. What has been gratifying is the coming together of parents irrespective of the social class and caste groups. The benefits seen in this area are more meaningful life for the retarded and a greater confidence in parents to carry on with their special responsibility. It is gratifying to note that two other centres outside Bangalore have taken up this philosophy and working well. This effort to bring back the parents and children to the centre of care programmes has larger implications for the country. We also know of similarly functioning groups of parents at Chandigarh, Delhi and Madras. This programme needs support so that it spreads far and wide.

Another activity that was initiated was the training of Anganwadi staff of the integrated child development scheme. To date more than 3 batches of 20 Anganwadis each, have received this training in early identification and early intervention.

Differences between the West and East in Developing Mental Health Services

The community mental health services was developed in the West to provide alternate care for the mentally ill outside the hospital. This was evolved out of well established mental health service infrastructure. It was an approach to extend the range of services beyond the institutional setting. In other words, the movement was from the centre to the periphery. On the other hand, with the meagre facilities of poor manpower as well as meagre number of beds, the community services in India have to be viewed differently. The attempt to extend services has to be an attempt to provide meaningful service in the community as a primary method of organisation. The approach is a periphery to centre one. This desire to achieve meaningful services within a reasonable period of time, within the constraints of limited trained personnel and facilities, and limited commitment of financial supports, has lead to the number of novel experiments at this Institute as outlined above.

National Mental Health Planning

The new approaches that have been developed have been bold and innovative. They have also raised the possibility of providing basic mental health services within a reasonable period of time, considering the available personnel and other constraints. These innovatives have been appreciated by the Indian Council of Medical Research and other governmental agencies. A national mental health plan has been drawn up recently. This national plan has been approved by the Central Council of Health Ministers which was presided by the Union Minister of Health and attended by all the health ministers from different parts of the country. In principle, this plan envisages and emphasises the principles of decentralisation and deprofessionalisation. A number of training programmes for psychiatrists to become trainers in the new approach are in progress. This will help in training the primary health centre doctors and paramedical professionals. The national mental health plan also stresses the importance of increasing the undergraduate medical training in terms of mental health components, so that the doctors that come out of the medical colleges shall have the basic knowledge

of the mental health problems.

It is most important that the professionals should accept the principle of deprofessionalisation and decentralisation. At the same time, they should actively involve in various experimental approaches and be ready for change of roles, attitudes and responsibilities. It is often difficult for professionals to accept deprofessionalisation. In many areas it has not been accepted, however, considering the importance of mental health, problems and available resources, it is very important that this approach has to be accepted and bold attempts are made. This also requires reorientation of training programmes both for professionals and para-medical professionals. The involvement of general public for accepting these approaches and changing their time tested methods and attitudes can only occur through public education. The involvement of the public can bring about a great amount of resources and force the willingness of the planners and professionals to consider the urgent need and act on them to provide sufficient care in treating the mental health problems and also providing preventive and promotive aspects. So the mental health field is still a virgin area and there is an unique opportunity to avoid professionalisation and institutionalisation.

Many of the pitfalls of planning mental health services experienced by the West by too many institutions and professional rivalries can be avoided if all the professionals and the public participate collectively.

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1.Dube K C, A study of prevalence and bio-social variables in mental illness in a rural and an urban community in Uttar Pradesh, India
Acta Psychiatrica Scandinavica Page: 46: 327-359, 1970
2.Varghese A, Beig A, Senseman L A, Rao S S S and Benjamin, A social and psychiatric study of a representative group of families in Vellore town
Indian Journal of Medical Research Page: 61: 608-620, 1973
3.Nandi D N, Ajmany S, Ganguly H, Banerjee G, Boral H C, Ghosh A and Sarkar S, Psychiatric disorders in rural community in West Bengal. An epidemiological study
Indian Journal of Psychiatry Page: 17: 87-96, 1975
4.Carstairs G M, Psychiatric problems of developing countries
British Journal of Psychiatry Page: 123: 513-522, 1973
5.Narayanan H S, Padma Embar and Narayana Reddy G N, Review of treatment in family ward
Indian Journal of Psychiatry Page: 14: 123-126, 1972
6.Narayanan H S, Experience with group and family therapy in India
International Journal of Group Psychotherapy Page: 32: 517-519, 1977
7.Bhatti R S, Janakiramaiah N, Channabasavanna S M, Family psychiatric ward treatment in India
Family Process Page: 19: 193-200, 1980
8.Bhatti R S, Janakiramaiah N, Channabasavanna S M & Shobha Devi, Description and quantification of multiple family group interaction
Indian Journal of Psychiatry Page: 22: 51-55, 1980

9.Bhatti R S, Janakiramaiah N & Channabasavanna S M, Group interaction as a method of family therapy
International Journal of Group Psychotherapy Page: 32: 103-144, 1982
10.Kapur R L, *Community psychiatry unit at NIMHANS (unpublished observations) NIMHANS, Bangalore*1977
11.Kapur R L, Mental health care in rural India. A study of existing patterns and their implications for future policy
British Journal of Psychiatry Page: 127: 286-293, 1975
12.Issac M K & Kapur R L, A Cost effectiveness analysis of three different methods of psychiatric case finding in the general population
British Journal of Psychiatry Page: 137: 540-546, 1980
13.Chandrashekar C R, Issac M K, Kapur R L & Parthasarathy R, Management of priority mental disorders in the community
Indian Journal of Psychiatry Page: 23: 174-178, 1981
14.Issac M K, Kapur R L, Chandrasekhar C R, Parthasarathy R & Prema T P, Management of schizophrenics in the community an experimental report
Indian Journal of Psychological Medicine Page: 4; 23-27, 1981
15.Kalyanasundaram S, Issac M K & Kapur R L, Introducing elements of psychiatry into primary health centre in South India
Indian Journal of Psychological Medicine Page: 3: 91-104, 1980
16.Kapur M, Kshama & Kapur R L, A brief orientation course for basic health workers on psychiatric problems in rural areas
Indian Journal of Psychological Medicine Page: 2: 69-73, 1980
17.Issac M K, Kapur R L, Chandrashekar C R, Kapur M & Parthasarathy R, Mental health delivery through rural primary care-development and evaluation of a pilot training programme
*Indian Journal of Psychiatry (in press)*1983
18.Srinivasamurthy R, Kapur R & Wig N N, Mentally ill in a rural community. Some initial experiences in case identification and management
Indian Journal of Psychiatry Page: 20: 1-7, 1980
19.Wig N N, Srinivasa Murthy R, Mani M & Arpan D, Psychiatric services through peripheral health centres
Indian Journal of Psychiatry Page: 22; 311-316,
20.Wig N N, Srinivasamurthy R & Mani M, Reaching the unreached-II
Indian Journal of Psychological Medicine Page: 4: 47-52, 1981
21.Wig N N, Srinivasamurthy R & Harding T W, A model for rural psychiatric services - Rapur rani experience
Indian Journal of Psychiatry Page: 23: 275-290, 1981
22.Shamasunder C, Kapur R L, Sundaram U K, Pai S & Nagarathana G N, Involvement of the general practitioners in urban mental health care
Journal of Indian Medical Association Page: 72: 320-313, 1978
23.Shamasunder C, Sundaram U K, Kalyanasundaram S, Pai S & Kapur R L, Training of general practitioners in mental health. A two year experience
Indian Journal of Psychological Medicine Page: 3: 85-89, 1980
24.Shamsunder C, Kapur R L, Issac M K & Sundaram U K, Orientation course in psychiatry for general practitioners
Journal of Indian Medical Association (in press)
25.Kapur M & Cariapa I, Evaluation of training programme for school teachers in student counselling

Indian Journal of Psychiatry Page: 20: 289-291, 1978
26.Kapur M & Cariappa I, Orientation course for school teachers on emotional problems of school children
Indian Journal of Clinical Psychology Page: 6: 75-80, 1979
27.Kapur M & Cariapa I, Training in counselling of school teachers
International Journal Advance Counselling Page: 2: 109-115, 1979
28.Kapur M, Cariapa I & Parthasarathy R, Evaluation of an orientation course for teachers on emotional problems amongst school children
Indian Journal of Clinical Psychology Page: 7: 103-107, 1980
29.Pai S, A comparative study of 1st admission schizophrenics treated at home and in the hospital
Ph. D. thesis submitted to Bangalore University (unpublished), Bangalore 1980
30.Pai S & Kapur R L, Impact of treatment intervention on the relationship between dimension of clinical pathology, social dysfunction and burden on family of psychiatric patient
Psychological Medicine (in press) 1982
31.Pai S & Kapur R L, The burden on the family of a psychiatric patient - Development of an interview schedule
British Journal of Psychiatry Page: 138: 332-335, 1982