

Challenges of building community mental health care in developing countries

**R. SRINIVASA MURTHY,
KISHORE KUMAR**

National Institute of Mental Health and Neurosciences, Bangalore, India

The stimulating and thought provoking paper by Thornicroft et al takes us back to the time we started psychiatric career in the early 1970s, when the issue of deinstitutionalization was in the forefront of professional discussions. During that period, while colleagues in the Western countries were thinking of developing community mental health programmes, the challenge for us in countries like India was to develop services utilizing the community resources already available. As pointed out by German (1), "The major advantage for the psychiatrist in a developing country is the very paucity of previous provision for the mentally sick. Thus, he does not have

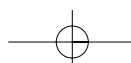
to expend his energies in frustrating attempts to dismantle an inert and cumbersome administrative infrastructure; nor does he have to concern himself with finding a method of absorbing large numbers of solidly built, prison-like mental hospitals into a more efficient and humane psychiatric programme. There is little need for him to struggle with large armies of personnel in various categories, each unwilling to change from the security of well defined roles to meet the challenge of the present and future...".

Many of us in developing countries initially seized the opportunity of "open canvas" by implementing a community based approach (2) aimed to enhance the availability of mental health manpower. This was both a matter of necessity, as there were no institutions caring for the persons with mental disorders, as

well as a choice, driven by the changes in the international scene as well as the cultural aspects of the society.

A good example, in the initial phase of development of mental health care in India, was the way family members were involved in day-to-day mental health care (3,4). Other approaches we used were the integration of mental health into general health care, and the utilization of non-specialist personnel for a wide variety of mental health tasks, including suicide prevention, disaster psychosocial care, drug dependence care, rehabilitation, care of persons with mental retardation and schizophrenia, public mental health education, and mental health care in children and in the elderly (5-8).

The challenges faced in this process, in developing countries, have been as follows:



- The need to simplify mental health care skills and continually review and innovate them, in order to suit the reality of the community needs. For care to be undertaken by health workers, teachers, volunteers, family members, there is need for simple interventions. Professionals have to develop the appropriate information in a simple format and identify the level and limits of care to be provided by these personnel. These include choosing priority mental disorders to be addressed in training, limiting the range of drugs to be used by the general practitioners, developing strong referral guidelines.
 - The availability to share the mental health caring responsibilities with non-specialists, overcoming the fear of some professionals to lose their work, identity and income. The method used by many of us was not to convert the non-specialist into a mini-psychiatrist, but to identify what is relevant, feasible and possible for the specific non-specialist to undertake.
 - The need to decrease the amount of time devoted to individual clinical care and increase the time for training of other personnel. This is a big challenge for clinicians who value caring for ill people by themselves. This change in role becomes meaningful when we recognize that training of other personnel has a multiplier effect on mental health services for the population.
 - The need to devote significant time to periodic support and supervision of the non-specialists. Reports of mental health care in developing countries have repeatedly shown the importance of support and supervision by psychiatrists to the non-specialist personnel. Fortunately, the easy and inexpensive availability of mobile phones and internet allows for distant support to the non-specialists on a continuous and interactive basis.
 - The need to acquire the skills to work with the community, education sector personnel, welfare sector personnel, voluntary organizations, and policy makers. This includes understanding the planning process, fighting for getting priority for mental health in health programmes, becoming familiar with legislations and budget procedures, and developing skills to negotiate with different stakeholders.
- As a consequence of these challenges, the psychiatrist can feel overwhelmed and experience feelings of inadequacy. However, our experience tells us that there is also considerable satisfaction, as the opportunity to take services to the people, and to contribute to a better understanding of the needs of the persons with mental disorders, can occur within a short period of time (9). In addition, these approaches have the potential to provide new insights into the caring processes (6).

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