

Community Psychiatry: Indian Viewpoint

For an average Indian citizen, concept of 'health' itself was rather a luxury than need at the dawn of independence. The medical system including training was set up and administered by the British Raj in the best traditions of colonization, which meant a predominantly urban perspective with a charitable (?) view about rural fold. It had its good points as well. In terms of its authenticity of clinical training and erection of public health institutions which were then to become pillars of modern Indian health system.

Independent India in its infancy had therefore basic health issues cut out and presented in the form of Pivotal & preliminary health problems such as immunization, malnutrition, population control etc.

Efforts of almost half a century have however not been able to tackle any one of them completely. In fact, some of them have become more complex. But, these five decades have definitely changed the complexion on Indian society. The urban-rural schism on the one hand seems to be disappearing with growing urbanization and sharing of similar dreams about lifestyles. But this process have yet not touched a sizable population of this country for whom primary health needs remain of principle importance even today.

With this scenario in mind, it will be imperative that 'Mental health needs' of this society are and will be expressed by the urban society first. Since the effective combination of factors leading to such a perceived need is working in this atmosphere. (It is my contention that a rural Indian perception of Mental Health also exists but our perspectives as mental health professionals trained by modern (read, western) scientific perspective generally fail to catch this ethos).

Thus, it will be prudent on my part to talk of an industrial city as my community and express my views about it. As mentioned above, this part of society perceives 'Mental Health' as a need because comforts as the basic physical health needs are looked after at least to some extent. The emerging middle and higher middle class (in economic terms) has started redefining itself as 'consumer' rather than 'mere recipient' of health services. Growing maladies of urban-shocks are forcing this group's attention on the needs of mental health.

So, any Indian city with a population close to a million a growing consumer culture with industrialization and urbanization setting its pace, should prove to be a fertile ground for any community mental health strategy.

So far, paucity of such experiments will tell us conclusively that the pastures are not as green as they look from the other end. The reasons lie as much with the community as they lie with the mental health professionals.

After a first hand experience of running one such project over eight years (from the point of conception of the project) one has gathered some fund of knowledge about why things do not click more often than why they should.

We as a society have this peculiar trait of admitting certain issues at a group or social level but refusing to accept them at individual or family level. Similarly, we vociferously deny existence of certain issues at the social level but may indulge in them in personal life or at least ratify them. To quote examples from mental health field: psychosexual disorders arising out of ignorance and misconceptions is an example of the first submission and the problem of child-abuse is a glaring example of the second. This inherent (read, extremely conditioned) 'double think' and 'double talk' is a major stumbling block in getting the community involved in any mental health project. Unless one understands this one will not be able to blend individual and group approaches of intervention to narrow down this dichotomy.

So the road is rough and needs dogged perseverance, which may, or may to pay at the end. Career for a mental health professional in clinic / hospital / industry / established agency / private practice / overseas; becomes for more secure and lucrative in comparison. Since mental health is less glamorous amongst all medical branches, a failed experiment may never evoke tears of sympathy and a successful one may to bring extraordinary glory. Reluctance on the part of mental health professionals to throw themselves in community based approaches is thus solidly based in day to day realities.

Unfortunately training in psychiatry is given keeping only clinical practice in mind. This is by and large true even in the most prestigious teaching schools in the country. Psychiatrist in a developing country should also be equipped with a variety of managerial, administrative and communication skills, since he has to take a role of 'manager of mental health' in community based approaches in addition to his clinical role.

The ability to lead, in a psychiatrist should not be interpreted as his / her one-up-manship over other mental health professionals. 'Prescription – power', that comes through medical training gives an unrealistic superiority notion to many clinicians who tend to look down upon the mental health professionals in disdain. Some training schools have evolved a culture of this 'elitist' viewpoint, which actually is an 'alienist' one.

Community approach means team building of various professionals and a basic requirement is respect for other professionals.

Unfortunately other mental health professionals (e.g. psychologists, counselors, social workers, special educationists) are not without their own prides & prejudices. Additionally many of them are 'trained' to be meek and submissive before their medical & psychiatric colleagues. Trainers of these mental health professionals many times lack the exposure to field-settings and actual interventions. Thus they are bound to impart knowledge which may sound solid theoretically but lacks innovation, imagination and what I call 'a spirit of application'. Thus, few mental health professionals are in a position to command or demand the respect that they deserve from the community.

Add to this two more factors... one, with rapid advances in psychopharmacology, psychiatrists will start believing more in their 'pen-power' and in other 'biological' interventions. This would strengthen the 'consulting room' approach in psychiatry.

Secondly, fund allocation from governmental and semi-governmental sources for exclusive mental health projects has yet not become an accepted practice. Mental health professionals who want to work with the community will have to raise their own funds and believe me, this can be often frustrating.

Thus mental health professionals are bound to become either trainers / teachers or interventionists / therapists whichever is easier, little realizing that by doing so they may be increasing the dichotomy in the social mind.

Effective approach of working with people involves merging of these two levels, i.e. becoming teacher to the group and therapist to the individuals within the group.

We at IPH have tried to address all such mind-boggling problems and have tried to carve our way through them. Our successes and failures will be a subject for one more essay. So let me not go into it right now.

We are evolving our viewpoint from collective experiences which we feel are far from being formidable.

Yet, devising imaginative projects and innovative activities over these years to attract presence and participation of the community has demonstrated one thing to us... keep up the urge to explore, and innovate, despite setbacks... sky is the limit – only then!