CBR for Inclusion of People with Mental Illness

Bharat Rajendra Joshi*[1]

ABSTRACT

In 2004, a Mental Health Pilot Project was implemented in Gujarat State, India, for the rehabilitation of persons with mental disorders in community settings, along the lines of the CBR model. The state government, in collaboration with the Royal Netherlands Embassy, selected the Blind People's Association (BPA) to design and implement the programme. Working closely with NGOs and local communities, this private-public partnership established referral links with government hospitals to provide medicines and counselling to affected persons. At the end of 18 months, 1206 people (diagnosed with schizophrenia, mania, depression and epilepsy) had accessed psychiatric services on a regular basis, and 272 people had recovered and resumed their earlier occupations. As a result of the pilot project, it may be concluded that rehabilitation of people with mental illness is possible outside of hospital settings.

Key words: mental health, CBR

INTRODUCTION

Persons with severe mental disorders such as schizophrenia, mania and depression are often neglected by members of their family, community and state governments in India. In fact, the mental health sector has not been given priority in any state health budget in India.

The government of Gujarat initiated the mental health support programme (MHSP) to strengthen community based mental health care in the state in 2004. The programme was supported by the Royal Netherlands Embassy and coordinated by the Indian Institute of Management, Ahmedabad. Partnerships were developed with non governmental organisations (NGOs), and 14 pilot projects were designed and implemented in 8 districts of Gujarat, targeting vulnerable people mainly in remote and inaccessible areas.

At the time when the pilot project was initiated, there were 4 mental health hospitals and 10 medical colleges with services related to mental illness in the

* **Corresponding Author:** Project Manager for CBR and Mental Health, Blind People's Association, Vastrapur, Ahmedabad, India. Email:cbrrollout@gmail.com

state. According to a WHO report (2006), the mental health hospitals in the state had a total of 1.34 beds per 100,000 population. At least 1 psychotropic medicine of each therapeutic class was available in all the mental hospitals. Though there were physicians in all the primary healthcare centres, at primary health care levels they did not prescribe psychiatric drugs.

The WHO report (2006) mentioned that the total number of human resources working in mental health facilities or in private practice per 100,000 population was 1.44. The breakdown, according to professions, was : 0.41 psychiatrists, 0.06 other medical doctors (not specialised in psychiatry), 0.44 nurses, 0.19 psychologists, 0.20 social workers, 0.02 occupational therapists, and 0.12 other health or mental health workers (including auxilliary staff, non-doctor/non-physician primary healthcare workers, health assistants, medical assistants, professional and paraprofessional psycho-social counsellors) per 100,000 population.

At the same time, the number of persons with mental disorders in the state is growing. WHO's world mental health report (2001) suggests that the prevalence of severe mental disorders worldwide is 0.2% - 0.4%. The estimated current population of Gujarat state is 60 million and, according to the prevalence rate suggested by WHO (2001), 240,000 could be persons with mental disorders.

Based on these facts and figures, it was evident that the mental health sector required a strategy which could provide community based mental health services within the available resources, in addition to addressing human rights issues, reducing stigma attached to mental illness and enhancing the quality of life.

INTEGRATION OF PERSONS WITH MENTAL DISORDERS INTO CBR

The Blind People's Association (BPA), a NGO, was selected to design and implement the MHSP as it had extensive experience in the implementation of Community Based Rehabilitation (CBR) programmes for persons with different types of disability. BPA developed a pilot project to rehabilitate persons with severe mental disorders and called it "Integration of Persons with Mental Disorders into CBR Model".

CBR Implementation Process

The project was implemented in 5 blocks of Gujarat state for 18 months (May 2004 to December 2005). It was designed for people with severe mental disorders such as schizophrenia, bipolar affective mood disorder and depression. BPA utilised CBR as the strategy to integrate and rehabilitate persons with mental disorders in the community. The process followed is described in the following sections.

Identification of local partners: It was necessary to identify competent partners to implement the CBR programmes as this was the first time BPA was working for persons with mental disorders. Hence, BPA selected partner organisations that had experience in conducting CBR programmes. The 4 local partners chosen had been in the field of disability and CBR for the previous 10 years or more. These implementing agencies had a strong presence in the community and maintained good relations with government departments from village to district levels.

Capacity development for project staff: Forty five days of rigorous training was organised for field workers, supervisors and coordinators. As part of the training programme, they were placed in mental health hospitals and in the psychiatric wards of government hospitals to gain practical experience.

Door-to-door survey: This was the first time a door-to-door survey was conducted to identify persons with severe mental disorders. BPA worked closely with the psychiatric department of B.J. Medical College and the Mental Health Hospital (both in the city of Ahmedabad) to develop a simple survey form and symptoms checklist. The survey was undertaken in 461 villages of 5 blocks covering a population of 900,000. Through the survey, 1597 people with mental illness were identified: 703 (400 male and 303 female) with schizophrenia, 538 (355 male and 183 female) with depression, and 356 (277 male and 79 female) with manic disorder.

Single-window services through Medical and Disability Certification camps: Although the majority of the people with mental disorders identified lived in rural areas, most of the project areas did not have psychiatric services at either block or district levels. The mental health services were available only in city based hospitals under the District Mental Health Programme and at Medical College hospitals. It was difficult for family members to convey persons with severe mental illness to the city, due to lack of transportation, fears that they would run away as well as their violent behaviour. It was very challenging to mobilise people identified with mental illness to travel outside their district for diagnosis, treatment and certification purposes.

BPA therefore mooted the idea of single-window services for diagnosis, free treatment and certification through medical and certification camps to be conducted in collaboration with concerned government authorities. The successful outcome of previous CBR programmes during which disability certification camps were conducted, indicated that camps could also be organised for people with mental disorders. BPA requested the concerned authorities to depute a team of psychiatrists with adequate staff and medicines to the camps. The local implementing agencies mobilised people with mental disorders to attend and, with the help of the local community, made arrangements for refreshments and toilet facilities.

The Mental Health Care Pilots in Gujarat Report (Bhat et al, 2007) noted that the camp approach made services accessible and was a cheaper option for the clients as it reduced transportation and other opportunity costs. Of the total identified 1597 persons with mental disorders, 858 came to camps and 759 persons suspected of having mental disorders were given medication.

The reasons for the low attendance at camps (i.e. only 858 persons from among 1597 identified) were many. This was the first time that diagnosis, treatment and certification camps had been organised at the grassroots level. It was found that people were very reluctant to disclose information about the illness of their family members as they believed the family would get a negative image; hence, they did not attend public camps. Secondly, there were people who were violent and very aggressive, so it was very difficult to mobilise them to visit the camps. However, the psychiatric team had made house visits and provided treatment there. Thirdly, there were some families who had already spent huge amounts on treatment without seeing any result. They felt that free psychiatric treatment camps would not be effective and therefore it would be a waste of time and money to attend them.

Disability Certification

BPA worked very closely with the Gujarat government's department of Social Justice and Empowerment to advocate that mental illness should be considered a disability. Special training programmes were also organised for district social defence officers, in coordination with the government's Department of Health, the Hospital for Mental Health and Psychiatric Department of B.J. Medical College and Civil Hospital, Ahmedabad. As result, persons with severe mental illness whose disability is above 40%, are entitled to avail of free transportation, pension

and other benefits under different government schemes, like other persons with disabilities in Gujarat.

A major achievement of the medical camp programme was that 365 persons were given disability certificates. The Indian Disability Evaluation and Assessment Scale (IDEAS) (Indian Psychiatric Society, 2002) was the yardstick for disability certification of persons with severe mental disorders and only those who matched the given criteria were issued certificates by the deputed government psychiatrist.

Of the 1597 people identified, only 365 people (23%) with severe mental disorders were issued disability certificates in the camps. Of these, 47 were for mania, 12 for depression and 306 for schizophrenia. People with mild depression, epilepsy and other common mental disorders that are not certified were treated and given medication.

Psychiatric services at local level

The outpatient services of the hospitals at nearby cities recorded an increase in the number of clients after the CBR on Mental Health pilot project was initiated. The Mental Health Care Pilots in Gujarat Report (Bhat et al, 2007) states that the number of clients who attended these services increased to about 90-112 persons per week. Psychiatric services are now available in all these districts along with the necessary medicines.

As part of the pilot project, BPA had also organised various training programmes on mental illness for medical officers at primary health centres and District Health Officials, in partnership and with the support of the Mental Health Hospital Ahmedabad, and B.J. Medical College and Civil Hospital, Ahmedabad. A state level workshop for Psychiatrists (practising in the government hospital) on Indian Disability Evaluation and Assessment Scale was also organised at BPA, with the support of the Department of Health and Family Welfare, Mental Health Cell, the Mental Health Hospital, Ahmedabad and B.J. Medical College, Ahmedabad. As result of this, people with mental illness can get disability certificates from Civil Hospitals where psychiatrist services are available.

Inclusion and rehabilitation of people with mental illness in the community

During the pilot project, it was found that people were reluctant to disclose the names of their family members who had mental illness. They feared that names would be revealed to other community members and people would stigmatise

them. Hence, the first priority for the inclusion of people with mental illness was to create awareness in the community. It was necessary to share correct information about mental illness with members of the local community, to ensure their participation and involvement.

The pilot project developed a strategy to address the problem of stigma and reduce it through awareness creation at the local community level, as well as for capacity development among government and local administration officers on mental health issues.

BPA organised mental health awareness rallies through networking with other organisations in 5 project locations. The local implementing organisations managed to mobilise different organisations such as Lions Club, Rotary Club, Indian Red Cross, colleges, schools, and religious institutions. People with mental illness and caretakers participated in these rallies.

The CBR pilot projects experimented with a unique idea to raise awareness about mental health. Locations were selected where religious and cultural fairs were organised on a particular day. A display stall was set up and leaflets, posters and other materials (which were developed in local languages) pertaining to mental health were distributed.

Street plays and puppet shows on mental health with scripts written in the local language, addressed issues related to mental illness and the role of the community. Volunteers from schools and colleges were identified and given training in street play performance, communication and body language. Trained volunteers then performed street plays at public places like bus stops, railway stations, vegetable markets and religious places, as well as at the local government meetings.

BPA developed slogans for wall painting which aimed to disseminate positive messages on mental illness and on the role of community members in rehabilitation of people with mental illness.

Based on the stakeholder analysis done by BPA, different modules were created for capacity development for different stakeholders. Caretakers were imparted basic skills to manage family members with mental illness. Various capacity development programmes were organised for local government leaders, child development services workers, health workers, doctors and other medical staff.

BPA also worked very closely with traditional healers. These practitioners are often the first contact point in the community when people seem abnormal or

display any behaviour changes. BPA convinced them to participate in the capacity development programme and to undertake referrals.

In addition, the CBR pilot project designed home-based training for people with disabilities. Field workers visited people with disabilities at home and gave them training in activities of daily life, behaviour modification and social and communication skills. As a result family members were involved in the activities, continued with the follow-up, and the acceptance of persons with mental illness and their participation in domestic and community work gradually increased.

At a later stage, people who had recovered were involved in vocational and livelihood programmes. Efforts were made to encourage family members and local community to include them in agricultural activities and local trades. 237 people returned to their earlier occupations like agricultural labour, animal husbandry, and running shops and stalls. The women resumed participation in domestic chores. There were 14 people who started new businesses with financial contributions from family members and the pilot project.

CONCLUSION

The pilot projects proved that people with mental illness could be rehabilitated within community settings. The CBR-Pilot project changed not only the lives of people with mental illness but also the attitudes of community members towards mental illness. The biggest gains were post-treatment rehabilitation, changed attitudes towards the mentally ill and evidence that the illness is treatable and that people could be respected and productive citizens in the community without having to be in mental hospitals.

The process followed in the pilot project also established that the CBR strategy can be effective if the roles of each individual/agency/ institutions are well-defined; and, if there are well-designed capacity development programmes for various stakeholders. The involvement of members of the family, community and caretakers at each level, and strong networking with government departments and local organisations also helped in achieving the aim of the CBR projects.

REFERENCES

Bhat R, Kumar Maheshwari S, Rao K, Bakshi R (2007). Mental health care pilots in Gujarat: Process, outcomes and learning. Indian Institute of Management, Ahmedabad. Available from: http://gujhealth.gov.in/medi_servi/pdf/MHPilotsInGujarat.pdf

Indian Psychiatric Society (2002). IDEAS (Indian Disability Evaluation and Assessment Scale) – A scale for measuring and quantifying disability in mental disorders. Rehabilitation Committee of Indian Psychiatric Society. Available from: http://www.silverinnings.com/docs/Health%20n%20Fitness/Mental/IDEAS.pdf

World Health Organisation (2001). The world health report: 2001: Mental health: new understanding, new hope. World Health Organisation, Geneva. Available from: https://apps.who.int/whr/2001/main/en/00library_cat_info.htm

World Health Organisation (2006). WHO-AIMS report on mental health system in India. WHO and Ministry of Health, Gandhinagar, India. Available from: http://www.who.int/mental_health/gujarat_who_aims_report.pdf