MENTAL HEALTH CARE: CAN WE CREATE A NEW KERALA MODEL?

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ABSTRACT

Good mental health is a prerequisite for a prosperous society. Mental health of the population is shaped by social, cultural, economic, and political forces. Growing inequality and social recession are likely to contribute to multiple mental health problems. Though the highest attainable standard of mental health is considered as a fundamental right of every citizen in many countries, India lacks the infrastructure, resources and care pathways to provide basic mental health care. Kerala has a glorious history of high achievements in human development. However, mental health care in the state is not fit for purpose. Kerala has many factors that would enable it to develop a radically different mental health care and social support system based on the principle of collective responsibility. High quality mental health care, free at point of delivery, and universal in coverage, is possible. Care can be coordinated and provided locally, within an integrated service model that embraces public, private and voluntary sectors.

Keywords: Mental health Policy, Kerala, Alternative models

Individuals with severe mental disorders in India continue to be subjected to discrimination, abuse and social exclusion. Their plight is further complicated by poverty and poor physical health. Clinical services are almost inaccessible to majority of those who need them desperately. After 68 years of independence, our country lack infrastructure to provide basic mental health care. The recently introduced National Mental Health Policy (2014) does recognize these problems and appear to articulate the principles for a modern mental health care system.[1] However, the financial and political commitments required to overhaul the system are unclear. The observations made by the Joseph Bhore Committee (1946) regarding the pathetic state of our mental health services remains acutely relevant even today.[2] Kerala Government's mental health policy (2000) aimed to develop an integrated mental health system. None of the short term or long term objectives were realized due to total absence of planning.[3] National and state governments in past have consistently failed to translate positive

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policies into practice. The political and administrative will behind the present policy initiatives should be closely monitored by everyone with an interest in the wellbeing of our people.

Mental health problems are very common; at least one in four of us will have some mental health disorder in our life time.[4] Mental health is increasingly identified as a prerequisite for a healthy and prosperous society. The highest attainable standard of mental health is a fundamental right of every human being, as enshrined in national and international charters and treaties.[5] States must generate conditions in which everyone can be as healthy as possible. The argument for the society to assume collective responsibility for mental health care has already been won in most modern societies. Mental health care is free, need based, and universally available in such societies.

Kerala's achievement in physical health is widely celebrated. Social and political forces as well as cultural and historical factors have shaped those achievements.[6] Unfortunately, indicators of our mental health suggest that the burden of poor mental health is so much that our achievements in education, physical health and material wellbeing are under threat.[7]

If we continue to allow the severely mentally ill individuals to live on the thin margins of our social space, we risk losing the possibility of creating a society that cares for each other, respects differences, collaborates in finding solutions and values the dignity of life. It is time for us to remember that only a caring society will nurture and promote values that will protect the 'society' from withering away to 'private' individuals who care only for themselves.

All degrees of poor mental health are linked to multiple disadvantages. Those with poor mental health are more likely to have poor educational and employment outcomes. They are more likely to be using alcohol and dependence-causing substances and follow poor diet and life styles. They suffer from poor physical health and they die considerably earlier than others.[8] The burden, public and individual, of any degree of poor mental health is enormous.

GROWING INEQUALITY

Economic growth and the associated expansion of markets have increased our consumption capacity and material wellbeing. However, the reduction in absolute poverty is happening along with an alarming increase in inequality.[9,10] Effects of inequality can remain hidden under the more conspicuous changes in consumption. The corrosive effects of inequality include social dislocation, isolation and alienation. Relative deprivation can catalyze negative emotional and cognitive reactions that culminate in ill health. Socioeconomic position of the individual in the community is related to constructs of social identity, personal confidence and self-esteem. Research evidence unequivocally shows that, worldwide, inequal societies have relatively more mental health problems.[11,12]

SOCIAL RECESSION

Social commentators observe that our communities are more divided and inward looking than ever before. Individuals and families tend to live for themselves and among themselves. This social recession is part of the larger phenomenon of privatization of society.[13] Eroding social trust, increasing social isolation and poor social support are key risk factors for poor mental health. Cohesive communities with cooperative transactions, inclusive spaces

and participatory processes are more likely to enjoy better mental health as opposed to those with fragmented participation, hierarchical social spaces and competitive transactions.

CAN KERALA LEAD THE NATION?

The task of creating a fit-for-purpose mental health service is unimaginably mammoth. However, Kerala has many factors to its advantage. We have relatively higher number of mental health professionals per population compared with most other Indian States. There are more medical colleges with psychiatry and allied departments. Private mental health provision is strong. Distribution and access are not hugely limited by geographical factors. The public is literate and often aware of the importance mental wellbeing. Appetite for quality care is increasing. The voluntary sector is very active. State-run hospitals, despite their historical, cultural and financial limitations, show a certain degree of desire to absorb modern notions of care. The District Mental Health Program is attempting to widen its scope and coverage.

Along with all the above positive factors, Kerala is unique in having social and political forces that can comprehend the complex dynamics between social, political and economic realities and individual mental wellbeing. They also have the rich experience of converting progressive ideas into social movements of sufficient momentum that can overcome the obstacles on the road to success.

CREATION OF INTEGRATED STATE MENTAL HEALTH SERVICES

Principles that guide the policy are more crucial than service structures and finer financial models. There are, and there will be, very different ways of achieving a goal, but it is the collective agreement on the principles and priorities that will generate the context for successful implementation of any intervention. Against the kind of background detailed thus far, this author would now like to suggest certain key principles and priorities that can shape a modern mental health service in Kerala, with the hope that this will generate wider debates:

1. CLINICAL CARE THAT IS FREE AT POINT OF DELIVERY

Most modern societies agree that health care should not be provided based on the patient's purchasing power. Clinical care should become a legally protected social right, with the state as the agent responsible for it. This does not mean that all clinical care should be delivered by the public sector. The public, private and third sectors can work in an integrated system with mixed financial models comprising tax based funding, social / community insurance and private insurance. Essential and universal mental health care can be defined and operationalized with tax funding. Additional care can be funded using social insurance models where the state subsidizes those who cannot afford them. Patient can retain the option to choose between sectors / providers. Service providers in all sectors would have to adhere to standards in terms of quality of clinical care. The integration of all mental health services across sectors can be a learning model that can help us consider broader health care reforms in future.

2. CARE THAT MATCH IDENTIFIED CLINICAL NEEDS

Clinical care should match the identified needs of the individual. Professionals carrying out assessments should provide

clear recommendations of treatment. They should also identify services that provide such treatments and offer choice to the individual. Unmet needs require recording and review to ensure that provisions are made within the local healthcare system. The state should have overall responsibility to ensure that such needs are met with in agreed time frames, working with various stake holders (private and public).

3. CARE THAT PROTECTS DIGNITY AND PROMOTE AUTONOMY

Patients should be treated as equal partners in the treatment process. Dignity of the individual should always be upheld. They should receive care in least restrictive environments. Stigma of mental disorder in society and lack of collaborative culture in clinical environments damage dignity and esteem of patients.

4. CLINICAL AND SOCIAL CARE THAT IS DELIVERED CLOSER TO HOME

When unwell, most of us would want to be closer to our near and dear. This might be more important when suffering from mental illness. Unfortunately, our public mental hospitals are huge institutions far away from majority of those who need them. The geographical separation, the custodial nature of such hospitals, and the fact these hospitals often become social dumping grounds for the mentally ill escalate the levels of stigma. Local services that promote community participation and integration are more effective in their treatments and more likely to reduce stigma.

5. ACCEPTING CARE OF MENTALLY ILL AS SHARED LOCAL SOCIAL RESPONSIBILITY

Mental health is a social product. If we agree that society should take the overall responsibility to provide mental health care, this duty would rest with the state government and the local bodies. Social care, i.e. providing appropriate care at home, providing placements in residential facilities etc., are also an important part of mental health care. Local bodies are best placed to understand such needs. State should pass on significant proportions of funds to enable local bodies to perform this essential and fundamental function. Local bodies should be responsible and accountable for ensuring that mental and social care needs are delivered to the standards defined by the state government. There should be a speedy mechanism to make local funding decisions, with options for appeal. Vigilant monitoring systems are also needed at appropriate levels to ensure fairness and transparency. Local bodies should provide day care facilities to those with chronic and severe mental disorders. They should appoint community psychiatric nurses to work along with doctors in state and private sectors to coordinate care of the mentally ill.

Each local body should have a mental health officer who would play a key role in local panels that take clinical and social care decisions. Local doctors, in state or private sector, who have completed the necessary training, can take on this administrative role, in addition to their normal work responsibilities, on a sessional contract with the local body. Local bodies should have contracts with local psychiatrists to provide emergency community assessments. All those who require mental health care need to be registered with a local general

practitioner or family doctor of their choice. The designated doctor would be responsible for prescription continuity, physical health assessments and referral to psychiatric facilities as needed. These doctors would receive ongoing training to effectively manage most mental disorders locally. They would work closely with community psychiatric nurses and mental health officer of the local body. The principle of collective responsibility needs to be translated into statutory provisions within care pathways.

6. REFORM AND RESTRUCTURE STATE MENTAL HOSPITALS

Despite spirited efforts by clinical professionals, public mental hospitals remain as custodial centers at least in the public perception. It amplifies the notion that the mentally ill need to be kept away from local communities and mainstream life. Living in such institutions deskill people and limit their scope of recovery. It is true that the majority of inmates in these institutions are remaining there due to lack of alternate clinical services, accommodation, or families to go back. Provision of food, shelter and medicine should not be a justification for maintaining the status quo as people are deprived of their possibilities in life. It is also important to note that the majority inmates of such institutions are from poorer socioeconomic status. It is high time we thought about providing services closer to home, encouraging integration with local services through involvement of local communities.

Individuals with both mental illness and criminal behaviors require secure services, and at present Kerala have no such facility. The current public mental hospitals could reshape into high secure and medium secure state forensic psychiatry facilities. Public mental hospitals need to reinvent themselves to take on different responsibilities and roles. They probably should aim to become specialist regional services providing assessment and treatment for the most complex patients who cannot be managed at primary or secondary levels. They could lead on policy, planning, training and delivery of services in the region.

7. INTEGRATION OF MENTAL HEALTH CARE TO PRIMARY CARE

Mental health services require elaborate coordination between physical health care, social services, police, families and local bodies. It is ideal to have identified primary care or family doctors with whom patients get registered. This doctor, either from the government sector or private sector, should be the contact point for all services including where emergency psychiatry assessments are required to be carried out in community settings. Patients who receive treatment from secondary or tertiary services would be coming back, with treatment recommendations, to their local registered doctor. This doctor would be responsible for referring the patient for appropriate social care, for liaising with local body for funding approval, and for securing recommended treatments that are not locally available. Expansion of District Mental Health Program (DMHP) will increase the access to mental health services in the government sector at primary care level. However, both the social and clinical care needs of the vast majority of people would only be met by a wider integration with the private sector or independent general practitioners.

8. WIDER AVAILABILITY OF PSYCHOLOGICAL THERAPIES TO REDUCE THE BURDEN OF COMMON MENTAL HEALTH PROBLEMS

It is well recognized that most mental health problems are of mild to moderate severity and that a good proportion of them can be managed by various psychological therapies of low intensity.[14] Such interventions are likely to be of immense benefit to large population groups. Appropriately trained and supervised therapists can reduce distress and suffering with brief and short term interventions. It is possible that large numbers of low intensity counselors (for example, 10,000 volunteers to cover the state) can be trained in a short period of time. Retired professionals and others with sufficient background education and related experience are potential recruits to provide this voluntary service.

9. CREATING CONFIDENTIAL DATA COLLECTION SYSTEMS

Suicide rate in Kerala continue to be much higher than the national average. The social, economic and psychological impact of suicide on individuals and families are enormous. We have currently no systems to collect all relevant information of each suicide, so as to generate a deeper understanding of their causes, circumstances and triggers. Many preventive opportunities are likely to be missed. Experience of many countries shows that confidential data collection systems are able to guide and shape interventions that ultimately help to reduce suicide.[15] We should set up a confidential enquiry program with a responsibility to collect all necessary information regarding each suicide in the state. The information thus collected would form the backbone of our policies and intervention programs to reduce suicide. With right infrastructure and resources, this system would be a model to all other Indian states.

10. INITIATIVE TO ENHANCE RESEARCH CAPABILITY AND TRAINING CAPACITY IN MENTAL HEALTH

Advances in clinical or social care cannot be achieved without an embedded culture of research. Mental health, more than other clinical areas, requires deeper understanding of local context. Nature, expression and response to treatment of mental disorders are shaped by various local factors. This makes it essential that the state sets up its own mental health research program. Such a program should declare its priority areas and invite research tenders to compete for grants. The Health Department should also have plans to roll out regular and mandatory clinical audits across the service. There should be a statutory responsibility to provide minimum data sets by each service provider in the state. Such information will help to identify unmet needs, gaps in services, and priorities for intervention.

Training requirements to initiate, implement and sustain a universal mental health care system should not be underestimated. Training of 'approved' doctors (who carry out emergency community assessments), mental health officers (local body administrative role), community nurses, social workers, and counselors would require the participation of every mental health professional in the state. Without dedicated resources, it would be impossible to achieve the standards we aspire. The state should create a Mental Health Learning Centre and every willing psychiatrist in the state should be encouraged to join the faculty, offering different levels of expertise. They should be offered honorary titles and sessional contracts to deliver the teaching, training,

and learning that are essential to run a modern service.

11. CREATE ELDERLY-FRIENDLY SERVICES

We are, on average, living longer than people in most other parts of India. The majority of elderly are looked after by very caring relatives. Society needs to create and strengthen supports available to these carers. It is also true that some elderly are mistreated and neglected by family members. Local bodies should have statutory responsibility and clearly defined roles to ensure that rights and dignity of the elderly are not violated in any setting at any time. Vulnerability assessments and safeguarding procedures should be integrated to the role of local bodies. Assessment panels with local experts from medical, legal, police, and social care areas should be set up at local body level.

Society needs to decide on how to provide care to elderly individuals with conditions like dementia. Trained support workers could provide some aspect of care at home. The elderly who cannot live at home, due to nature of illness or home conditions, need to have residential social care options locally. These services can be made means tested (i.e. assets of the individual taken in to consideration to fund such placements). The private, state, and voluntary sectors can be encouraged to provide these services within the agreed frameworks. All such care homes should meet minimum standards and should be encouraged to be part of a quality network supported by professional bodies.

12. PROVIDE FAMILIES THE ESSENTIAL SUPPORT TO CARE FOR THE ILL

Society should recognize the selfless care that families provide on a daily basis to those with severe mental disorders. They suffer silently in isolation. The enormous emotional labor can be too much, for too many. The carer role needs to be deeply appreciated and supported. Carers should be eligible for allowance depending on the nature and degree of the disorder and the functional disability. Local bodies should have the freedom to part-fund their day care centers from the carer allowance fund provided by the state government.

13. POLICIES WITH A WIDER PREVENTIVE FOCUS

Social policies that enhance social cohesion, improve inclusiveness, promote work satisfaction, and encourage social mobility and equal opportunity are likely to have a large positive influence on public mental health. Preventing discrimination in all walks of life is another key area to consider. Discrimination can lead to, or contribute to, social withdrawal and disengagement as well as antisocial behavior and violence. Social policies that address widening inequality, marginalization, and discrimination are crucial to achieve better public mental health.

14. ACCEPTING THE NEED FOR FUNDING PARITY WITH PHYSICAL HEALTH

Mental health problems account for up to one third of all morbidity in the society.[16] In spite of this, spending on mental health services remains negligible. Political parties and policy makers would have to consider the corrosive effect of such discrimination on social values. The benefits of access to appropriate clinical and social care to the wider economy is considered substantial in countries where it is studied.[17] People with severe mental disorders die 15-20 years earlier than those who do not have mental illness.[8] Those with mental disorders live

under multiple burdens of poor mental, physical, and social health. Funding and resources need to match the burden of these disorders. Mental health needs to be given equal priority to physical health, and a fresh look at how we fund different streams of healthcare in the state is urgently required.

CONCLUSION

Good mental health is a fundamental requirement for social progress. The social, personal and economic impacts of mental health problems are enormous. Current service models have failed to address these growing problems. Kerala has unique problems as well as exciting possibilities. High quality mental health care, free at point of delivery, and universal in coverage, is possible. Care can be coordinated and provided locally, within an integrated service model that embraces public, private and voluntary sectors. Care pathways, if funded adequately and implemented true to the spirit, can keep patients' and their carers' best interests and choices at all levels. Strong political will and dedicated involvement of professionals, local bodies and NGOs are necessary to begin the process that can radically alter the heath care landscape of Kerala. It is a challenge that invites passionate involvement of all who care about Kerala, its people and their dreams.

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