# A Probing into Emergence of Community Mental Health Movements: An Analysis of Historic Perspective

[1] **Dr. Randhir Singh Ranta,**
Senior Research Officer, Department of Interdisciplinary Studies, Institute of Integrated Himalayan Studies (UGC Centre of Excellence), Himachal Pradesh University, Shimla-5.

**Abstract**

The healing of people with mental illnesses in society is referred to as community mental health. Individuals with psychological disorders used to be treated only in psychiatric wards or asylums in the past. The origins of community psychiatry in India are traced in this article, starting with Dr. Vidya Sagar's renowned trial of treating persons with psychological disorders and their families in shelters outside the psychiatric hospital in Amritsar. "The National Mental Health Program and the District Mental Health Program are next discussed. The significance of the United Nations Convention on the Rights of Individuals with Disabilities in influencing the creation of the present Mental Health Care Bill of 2013", is addressed. The researcher assesses some of Bill's benefits and disadvantages in light of current advances in psychiatric services in India.

***Keywords:*** District Mental Health Program, Community Mental Health, United Nations Convention on the Rights of Individuals with Disabilities, Mental Health Care Bill, Historical Perspective, The National Mental Health Program.

## 1. Introduction

The care of people with mental illnesses in community settings is known as community mental health. Public psychological healthcare facilities as well as other healthcare community programs, mainly any service outside of a custodial care mental health environment, are examples of such arrangements. The community psychiatry program began more than a century ago with the goal of rehabilitating people with mental disorders in their communities after lengthy stays in psychiatric institutions. There have also been worries about violations of people with severe mental illnesses' fundamental human rights and the negative consequences of institutionalisation. Additional advances in pharmacotherapy have aided the expansion of community mental health. It's disputed if community mental health facilities must be governed by the legal system or by mental health laws. In light of this, it's important reviewing the many kinds of mental health care accessible in the community and determining if they need any legal assistance or oversight. If so, what legal structure would be required to govern their operation? The newly adopted Mental Health Care Bill in India, with the most recent version being the Mental Health Care Bill, 2013, has a number of provisions that have the ability to influence India's public mental health care. This study evaluates these parts severely.

In India, people with mental disorders have historically been cared for in society by family and friends. Several mental hospitals or psychiatric institutions were established in India under British colonial rule, mainly for British troops and British citizens suffering from psychological disorders[1]. Following India's sovereignty in 1947, many of these clinics remained in operation, and many others were constructed during the following several years, but the number was much fewer than in the West. Many changes at India's mental hospitals have been implemented in the past three decades, including the involvement of family members of those hospitalised as well as those receiving outpatient care. The power of a united family, marriage, a close-knit society, higher acceptance of aberrant conduct in the broader community, spirituality and faith-based healing and rehabilitation all have aided to the treatment of a significant number of people with different psychological disorders in India.

- Repetitive instances of ill care of patients, geographical as well as expert solitude of establishments and personnel, inability of leadership and management, inadequate public economic ability, inadequate employee training, or rather an insufficient checking as well as verification procedures have all contributed to the gradual closure of mental hospitals around the world.
- In India, on either side, psychiatric institutions have changed by adding training facilities, increasing outpatient and community programs, and shrinking inpatient units.
- Contrary in the West, wherein it was a frequent occurrence in the second part of the twentieth century, no psychiatric hospitals in India were closed. India has made a distinctive commitment by including family in the treatment of patients receiving mental health services.

Dr. Vidya Sagar founded the Amritsar Psychiatric Clinic in the 1950s, backed by the Christian Medical College's Mental Health Centre in Vellore and the All India Institute of Mental Health in Bengaluru in the 1960s. Members of the family would be hospitalized with those suffering from psychiatric disorders as part of the patient's treatment[2]. This practice has been carried out in the majority of India's district hospital psychiatric units since the 1960s. Attempts also were undertaken in the 1970s and 1980s to better comprehend how households with a sick member functioned and what they needed.

## 2. People with mental illnesses are a particularly vulnerable Population

### *2.1 What makes sets susceptible?*

Some people are more susceptible than others. Societal variables, as well as the surroundings in which people live, contribute to their susceptibility. Distressed populations have similar difficulties in terms of economic and social position, social assistance, and living circumstances, such as:

- Inequality as well as prejudice;
- Assault and aggression;
- Limitations on the exercise of human and civil rights;
- Not being able to fully participate in the community;
- Wellbeing and medical services are more difficult to get;

- Limited accessibility to disaster assistance services;
- There aren't enough academic possibilities;
- Separation from sources of earnings and employment prospects;
- Increasing incapacity and mortality at a younger age.

Such variables may combine over time, resulting in increasing marginalisation, dwindling assets, and increased susceptibility[3]. Sensitivity must not be mistaken with incompetence, and vulnerable populations should not be thought of as helpless victims. There must be methods to strengthen disadvantaged populations so that they may fully engage in the community.

***2.2 Psychiatric patients are stigmatised and discriminated against.***

Prejudice on the grounds of impairment is prohibited, and people with disabilities are guaranteed equitable constitutional safeguard on all bases. Article 5 of the Agreement on the "Rights of Persons with Disabilities of the UN". The prejudice attached to psychiatric illnesses stems mostly from prevalent misunderstandings about their origins and character. Mental illnesses are often misunderstood throughout the globe as indications of human vulnerability or as the result of paranormal powers. Individuals who suffer from mental illnesses are often stereotyped as being sluggish, weak, stupid, hard, and unlikely to make choices. Regardless of the reality that they are much more inclined to be victims than perpetrators of domestic violence, they are also believed to be aggressive. The ramifications are significant. Mental health problems are often attributed to ownership by bad forces or retribution for unethical actions, which leads to detrimental treatment methods. Inequality and alienation from communal life are prevalent in residence, schooling, work, and social and familial connections[4]. As a result, substantial social and economic hardship develops over time. When it is assumed that healing from mental illnesses is impossible, efforts are diverted from giving care and support to those who need it. Rather, individuals with mental illnesses are neglected or incarcerated in long-term psychiatric facilities or jails, where they are often denied appropriate treatment and subjected to abuses, aggravating their diseases. The belief that a character flaw is widespread, not only among 'normal' individuals.

***2.3 Victims of violence and torture are people with serious mental illnesses.***

Patients at psychiatric hospitals are also subjected to assault and assault by the same healthcare professionals who are supposed to be treating and caring for them. Other kinds of torture are also prevalent, such as housing circumstances that are unsanitary and cruel, as well as damaging and humiliating treatment practices. Individuals may be incarcerated against their own will in facilities for months or even years.

***2.4 Individuals with psychological health problems have challenges in exercising their civic and political rights.***

Numerous laws in India limit the civil rights of individuals with mental illnesses. As someone of "inferior intelligence" or having an extended psychological problem may be reasons for dissolution or divorce under Hindu 52, 53, and Parsi 54 legislation, as well as the Divorce Act of 187255. Marriage is prohibited for individuals with mental health problems "of this kind of type or with such a degree as to render them unsuitable for marriage as well as the generation of children," according to the Special Marriage Act of 1954. Individuals who have been found to be of unsoundness of mind by a court of competent jurisdiction may be barred from registering to vote.

***2.5 Psychiatric patients are not permitted to fully engage in society.***

Involvement entails not just the freedom to vote and run for office, but also the ability to engage successfully and completely in the activities of public affairs. Everyone has the right to engage in government issues, no matter how impoverished or disadvantaged they are. Involvement allows for the development of a vibrant civilized society that can offer everyone a representation, even marginalised groups, as well as drive national change [5]. Individuals with mental illnesses do not engage effectively in policy decision-making procedures in the majority of nations.

***2.6 Individuals with psychiatric illnesses have limited access to medical and social assistance.***

Although mental illnesses are common, a significant percentage of those who are afflicted do not get care or treatment. 75 percent to 85 percent of individuals with serious psychological health problems in poor and middle-income nations do not have accessibility to required mental health care. Between 35 percent and 50 percent of individuals with serious mental illnesses in high-income nations do not get the care they need. Individuals with serious mental illnesses are also less prone to get care for physiological illnesses.

***2.7 Individuals with psychological illnesses do not have access to emergency assistance.***

Individuals with psychological illnesses sometimes have their problems exacerbated as a result of the strain of an emergency. Health professionals may move or die during crises, further complicating the issue and depriving individuals with mental health problems of pre-existing healthcare and social assistance programs. Individuals in establishments, such as mental hospitals, are more likely to be left, while others may be neglected by their own families [6]. Emergency aid programs are often insufficient to meet the particular requirements of individuals with mental health problems, and in other instances, those with pre-existing mental health problems are expressly excluded from obtaining assistance.

***2.8 Individuals with personality disorders have fewer educational chances and worse academic results.***

Despite the fact that education is widely acknowledged as a critical component of socioeconomic growth, most individuals with mental illnesses encounter significant obstacles to enrolling in school. Children with mental health issues are discriminated against, and their absence further marginalises an already vulnerable population. Notwithstanding this, individuals with mental illnesses or intellectual disabilities are institutionalised in institutions that do not provide educational chances in many low- and middle-income nations.

### *2.9 Psychiatric patients are refused work and other chances to earn money.*

Mental health problems are linked to the greatest levels of unemployment among all causes of impairment: often between 70 percent in terms and 90 percent. There are significant differences in unemployment rates between individuals with mental illnesses, people with physical disabilities, as well as the general public. According to studies, the overwhelming majority of individuals with mental illnesses want to work, 128 but are unable to do so due to stigma, prejudice, and a lack of professional expertise[7]. Inequality against individuals with schizophrenia who are looking for work is significant and constant across nations with different socioeconomic levels.

### *2.10 Individuals with psychological illnesses suffer from significant handicap and die young.*

People with mental health issues are at an increased risk of premature mortality and impairment as a consequence of extended contact with the previous economic and social variables that contribute to susceptibility. The significant treatment gap – between both the prevalence of mental disorders on the one extreme as well as the number of individuals getting care and treatment on the other – only adds to the difficulty. Mental health problems represent 13 percent of the worldwide illness burden and 31 percent of all years spent disabled. Anxiety is expected to be the single largest cause of global illness burden by 2030, “surpassing heart disease, stroke, traffic accidents, and HIV/AIDS”.

## 3. Mental health policy and service guidance package:

The present national and community environment includes a growing burden of mental illnesses, insufficient resources and financing for psychological health, and possibilities to improve this condition via recent advances in psychological disorder treatment. Health-care reform, as well as socioeconomic and political developments, have significant consequences for psychological health. Authorities have a critical role in maintaining the mental wellbeing of their citizens in this scenario[8]. Rapid innovations in the understanding and dealing with mental illnesses imply that if proper action is done today, the aim of enhancing community mental health may be achieved. "The Mental Health Policy and Service Guidance Package" is designed to assist nations in addressing mental health problems. The package includes practical advice for nations to use in developing policies, planning services, financing those services, improving the quality of current services, facilitating psychiatric advocacy, and developing relevant legislation.

### *3.1 Policy, Guidelines, and Programs for Psychological Health*

A specific mental wellness policy is a crucial and effective instrument for a ministry of health's mental health department. Policy, if correctly designed and executed via policy and strategies, may have a big effect on individuals' mental health.

### *3.2 Funding for Psychological Health*

Funding is a crucial component of establishing a sustainable mental health care system. It is the framework that allows plans and policies to be put into action by allocating resources.

### *3.3 Civil Rights as well as Psychological Health Legislation*

Psychological health law is critical for safeguarding the rights of individuals with mental illnesses, who are a particularly vulnerable group in society. This module provides step-by-step instructions for drafting mental health laws. The module starts by outlining the actions that must be completed before legislation can be drafted.

### *3.4 Human Rights and Mental Health Legislation*

Mental health advocacy is a novel idea that aims to reduce stigma and prejudice while also supporting the human rights of individuals with mental illnesses. It entails a variety of activities targeted at overcoming significant structural and behavioural obstacles to population-level good mental health outcomes.

### *3.5 Improving Mental Health Quality*

Quality evaluates if treatments improve the chances of attaining targeted psychological wellbeing and if they satisfy existing evidence-based practice standards[9]. All psychological healthcare systems must prioritise excellence because it guarantees that individuals with mental illnesses get the treatment they need because their problems including life quality improve.

### *3.6 Organization of Mental Health Services*

Appropriate strategies are made feasible by mental health care. The manner these services are structured has a significant impact on their efficacy and the eventual achievement of national mental health policy aims and priorities. The present types of mental health care organisation seen throughout the globe are described and analysed in this module.

### *3.7 Psychiatric Health Service Delivery Planning and Budgeting*

The goal of this module is to provide a clear and logical planning approach for evaluating and planning mental health services for local populations. The module intends to offer nations with such a set of budgeting and planning tools to assist in the implementation of mental health care in local regions by using practical examples continuously.

## 4. Historical Perspective

It is essential to take a historical context to comprehend the roots of the present impact of mental illnesses, as well as patterns in treatment and care. This elucidates the causes for past restructuring attempts' failures and highlights the vast differences in how services have grown in rich and developing nations[10]. Spiritual or religious interpretations have impacted how people with mental disorders are treated in various societies for millennia. In the early 17th century, logical explanations of insanity as a medical illness started to emerge. Throughout North America and Europe between 1600 and 1700, a growing number of destitute people with mental disorders were imprisoned in public prisons, labour camps, poorhouses, medical facilities, and individual mental hospitals. Traditional ideas of insanity therapy did not encourage empathy or patience, instead suggesting that the damaged physical state was caused by an excess of emotion, necessitating punishment. Throughout the first part of the 18th century, the widespread view of mentally ill people as incurable subhumans encouraged inhumane living conditions and the use of physical restraints in prisons[11]. The need for reformation of such institutions coincided with an increase in humanitarian problems in the 18th century, and many hospitals adopted moral treatment programs. The effectiveness of moral therapy led to the construction of numerous asylums in Europe and the United States.

The dismissing of mental hospitals on compassionate grounds began in the 1950s, resulting in the leading to the expansion of the community support progression as well as a procedure of limiting the number of patients with chronic conditions in mental hospitals, shrinking and closure some, and continuing to develop alternative solutions in the form of psychiatric services. Deinstitutionalization is the term for this procedure. A significant transition from hospital-based to community-based systems has occurred in many nations across the globe. Deinstitutionalization, on the other hand, is more than the bureaucratic discharge of patients; it is a multi-step process that should result in the establishment of a network of options outside of psychiatric facilities. Regrettably, deinstitutionalization in many affluent nations has not been followed by the establishment of suitable community services. In so many emerging nations, mental health care of the Western type started with the establishment of mental institutions by the state or colonial forces in the late nineteenth or early twentieth centuries[12]. G generally, psychiatric ward systems in underdeveloped nations have been less extensive in their treatment of people than in developed ones. Numerous developing nations have been successful in upgrading basic mental hospital services and establishing new psychiatry units in district medical centers, as well as integrating basic mental health care with healthcare by educating primary care professionals in 3 mental health.

Psychological treatments, on the other hand, are usually limited in most developing nations, serve a tiny percentage of the populace, and suffer from a severe lack of qualified human capital and also adequate institutional settings. There are reasons to believe that the care of people with mental illnesses will significantly enhance in the twenty-first century. Additional insight into the social roots of mental illnesses including anxiety and depression have been provided by advancements in the social sciences[13]. The problems that emerge from early childhood trauma and adult mental illness are being studied via developmental research. For a variety of mental illnesses, clinicians now have accessibility to more

efficient psychotropic medicines. Psychological health treatments have been shown to be helpful in hastening and maintaining healing from severe mental disorders like anxiety and depression, and also chronic diseases like schizophrenia.

## 5. Conclusion

Mental Health Care Bill has a number of problems. Nevertheless, if it becomes law, it is intended to safeguard the rights of mentally ill individuals, preventing their abuse and exploitation. This is especially important in the Indian setting, given the low socioeconomic position of the population and the lack of public knowledge of the mental illness. The revised mental health legislation will also be compliant with the United Nations Convention on the Rights of Persons with Disabilities [14]. Nevertheless, given the disadvantages, it is possible that it will legitimise and bureaucratize much of the treatment method, making it inconvenient for sufferers, relatives, and treating physicians, and stifling the public mental health initiative.

In a constantly shifting public and private economy, the public psychological state is fighting for survival. Several of the former federally funded community psychiatric health clinics have been renamed community behavioural health care organisations, or CBHOs, with the main goal of integrating psychological health, addiction, and primary care services. The continued public health catastrophe of severely mentally ill homeless individuals or in jail contrasts with the effectiveness of recovery oriented methods combined with monitored accommodation. If Dorothea Dix returned to America now, she would be astounded. “We remain stuck in our worries about the locus of care, mistaking it with the basic humanity, efficacy, and quality of treatment,” writes Geller[15]. Because the majority of care will be provided in the outpatient setting, a major problem for community psychological health in the twenty-first century will be to address the problem of individuals who refuse treatment, become ostracised, and impoverished. We must depend on mental health programs and regulations with sufficient financial support for community treatment rather than recreating asylums or finding a miracle cure or treatment for schizophrenia as well as other severe mental disorders. If managed care is a transitory aberration in mental health policy, which is, Barton's dictum "service precedes the money" is critical. We still have to figure out how to establish objectives, distribute resources, and guarantee that those in need get high-quality scientific as well as compassionate treatment.

## REFERENCE

1. McHugo G, Drake R, Whitley R. Fidelity outcomes in the National Implementing Evidence-Based Practices Project. *Psychiatr Serv.* 2007;58:1279–1284.

2. Swain K, Whitley R, McHugo G. The sustainability of evidence-based practices in routine mental health agencies. *Commun Ment Health J.* 2010;46:119–129.

3. Mojtabai R, Fochtmann L, Chang S. Unmet need for mental health care in schizophrenia: an overview of literature and new data from a first-admission study. *Schizophr Bull.* 2009;35:679–695.

4. Jacobs P, Dewa C, Lesage A, editors. *The cost of mental health and substance abuse in Canada.* Alberta: Institute of Health Economics; 2010.

5. Culhane D. The costs of homelessness: a perspective from the United States. *Eur J Homelessness.* 2008;2:97–114.

6. Larimer M, Malone D, Garner M. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA.* 2009;301:1349–1357.

7. Drake R, Bond G, Essock S. Implementing evidence-based practices for people with schizophrenia. *Schizophr Bull.* 2009;35:704–713.

8. Rapp C, Etzel-Wise D, Marty D. Evidence-based practice implementation strategies: results of a qualitative study. *Commun Ment Health J.* 2008;44:213–224.

9. Swain K, Whitley R, McHugo G. The sustainability of evidence-based practices in routine mental health agencies. *Commun Ment Health J.* 2010;46:119–129.

10. Corrigan P, Mueser K, Bond G, editors. *The principles and practice of psychiatric rehabilitation.* New York: Guilford; 2008.

11. Frank R, Goldman H, McGuire T. Trends in mental health cost growth: an expanded role for management? *Health Affairs.* 2009;28:649–659.

12. Centers for Medicare and Medicaid Services. *National health care expenditures data.* Baltimore: Centers for Medicare and Medicaid Services; 2010.

13. Thornicroft G, Alem A, Dos Santos RA. WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. *World Psychiatry.* 2010;9:67–77.

14. Maj M. The WPA Action Plan 2008-2011. *World Psychiatry.* 2008;7:129–130.

15. emrau M, Barley E, Law A. Lessons learned in developing community mental health care in Europe. *World Psychiatry.* 2011;10:217–225.