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PRINCIPLES OF PLANNING I (ADMINISTRATION AND ORGANIZATION)

by

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Before one can plan realistically for action on a nation-wide basis in the field of mental health, one must have authentic data in the following areas:

1. The magnitude of the problem of mental illness and mental subnormality in the country.
2. The types of mental illnesses commonly met with.
3. The number of qualified psychiatrists and para-medical professional personnel, like Clinical Psychologists, Psychiatric Social Workers, Psychiatric Nurses, etc. available.
4. Facilities for training professional personnel.
5. Facilities for prevention, treatment and rehabilitation of the mentally ill and the mentally subnormal - in the urban and rural areas.
6. Attitudes of the community to various aspects of mental illness, like etiology, treatment and rehabilitation.

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7. Level of preparedness of the community for participation in community-based services.

8. The quality and quantity of Psychiatry taught to undergraduate medical students.

9. The degree to which the laws of the land relating to admission of mentally ill patients to mental hospitals, their discharge, their civil rights, their criminal responsibility, etc. reflect current psychiatric thinking and practice.

10. Funds available for mental health services.

11. The nature and amount of help available from social welfare agencies in the cause of the mentally ill.

12. The nature and amount of on-going research in the field of mental health.

13. The degree to which the mental health services are integrated into the delivery systems for general medical and health care.

The present trend in organization of mental health services is towards dispersal of these services in the community itself and integrating them. The traditional mental hospital is losing its pride of place as the centre of all psychiatric activity and is even threatened with extinction in some places, like Saskatchewan, where it is planned "to replace all mental hospitals by 150-to-300-bed regional psychiatric units attached to general hospitals" (McKerracher, 1963). Even if it does have a place as a link in the chain of comprehensive mental health services, it is in a vastly changed form. It is more often, than not, an "open" hospital with no barriers isolating it from the community, and an active therapeutic and rehabilitation centre; and is used mainly for short-term hospitalization of patients, who

cannot be treated in the other community-based facilities. While 'Community Psychiatry' might well be considered "the third major revolution" in the history of Psychiatry (Bellak, 1964), there is no clear consensus as to its definition, scope and practice. A simple unobjectionable definition of 'Community Mental Health Service' is "any scheme of things directed to providing extramural care and treatment where it is indicated, directed to facilitating the early detection of psychiatric illness or relapse and its treatment on an informal basis, and to providing some social work service in the community for support or follow-up" (Rehin and Martin, 1963). The extramural service-facilities which form a major part of community mental health service include out-patients departments, Psychiatric departments in general hospitals, after-care clinics, day-hospitals, day-care centres, night-hospitals, sheltered workshops, half-way houses, hostels, in varying combinations. The advantages claimed for this approach to the treatment of the mentally ill are claimed to be that:

1. It causes minimum of disturbance to the occupational, familial and social life of the patient;
2. the treatment is more readily accepted by the patient and the family, as it does away in most cases with the stigma of getting admitted to a mental hospital;
3. it ensures continuity of treatment and follow-up care;
4. it provides for appropriate therapy for the varying phases of illness.

The Community Psychiatry movement has probably reached the peak of its development in the U.S.A. since the report of the Joint Commission on Mental Illness and Health (1961) and in the year 1970, a total of 245 centres were

in operation (Ozarin et al. 1971). These centres, by and large, seem to have served the purpose for which they were established, quite satisfactorily. In San Francisco, California, where the mental health services are dispensed through five community mental health centres, petitions for State hospitalization dropped by 92 per cent (3720 to 302) and commitments dropped by about 96 per cent (2882 to 108) between 1964 and 1969. At the same time the total work out-put of the entire mental health system increased as shown by the number of persons served (13,972 to 17,257), number of out-patient interviews (80,481 to 143,500) and units of day-care service (7728 to 19,425). Balancing San Francisco mentally ill patients resident in one large State hospital against net city costs shows a marked reduction of such patients (1618 to 723) in five years, with only a slight gain in country cost for its own institutional services ($285,734 to $360,470 not adjusted for inflation). Not available to be included in these comparisons is the money not spent in State hospitals as a result of reduced patient days (Stubblebine and Decker, 1971).

In an attempt to evaluate the effectiveness of the community care service, Grad and Sainsbury (1963) studied two patient-populations treated by community care service and hospital care, respectively, and concluded that:

1. The community psychiatric service diminished hospital admission rate in all groups of patients;
2. more families of patients in the community service found the disposal recommended more appropriate to their needs than in the hospital service,
3. the more one was able to keep the patient in the community the more likely he was to keep his job.

While there seems to be consensus among specialists that an integrated community mental health service is probably the most satisfactory way of dispensing mental health services, there is no agreement about the most satisfactory model of such a service, which is only to be expected, as the model suitable for a particular community will be determined mostly by locally prevalent socio-cultural and economic factors, the resources available, the attitude and preparedness of the community for participation in community-based programmes, etc. In addition to the American model of comprehensive community mental health centres, we have several other models, namely the model of Balanced hospital community (McKeown, 1958) and the model involving the mental hospital and the extramural services in an integrated fashion (Macmillan, 1963), the Russian model of neuropsychiatric dispensaries (Bhaskaran, 1972), the home-care programmes prevalent in the Netherlands, etc. To evolve a model most suitable for a particular community, it is necessary to have at one's reach, in addition to technical expertise a knowledge of the local factors and the other determinants already mentioned. It must also be remembered that for any community care programme to succeed it is essential that:

1. There is a community of goals among the members of the various participating professional disciplines;
2. there is a clear understanding of the roles of participating personnel and that the whole team functions in a well-knit and integrated fashion;
3. there is optimal participation by the community in the programme;
4. adequate community-based supportive services are evolved to an appreciable extent before the programme is launched.

Having considered the various models of mental health services to choose from, we may next consider the goals in mental health planning.

In the field of organization of mental health services, these goals are broadly:

1. Providing optimal and effective direct and indirect services to the community, that resources in terms of funds and professional personnel would permit, and this, in a way that would least interfere with the familial, social and occupational life of the patients.
2. Evolving the most satisfactory and at the same time economical delivery system to dispense mental health services to the poorly served rural population.
3. Training adequate numbers of professional personnel.
4. Imparting the needed psychiatric orientation to members of other help-giving professions, like general practitioners, School teachers, Social Workers, Public Health Nurses, Health Visitors, Village Level Workers, etc., whose active collaboration is very necessary for operating community-based programmes satisfactorily.
5. Preparing the community for active participation in community mental health programmes.
6. Making legislation concerned with admission of patients in mental hospitals and other discharge and their rights more humane and more in tune with the current psychiatric thinking and practice.
7. Evaluation of the efficacy and adequacy of the different kinds of services.

To realize the goals, it is necessary to have a machinery for planning and execution of the plans. The organizational set-up for drawing up plans and administering the services will naturally vary from one country to another depending on the system prevalent for the delivery of medical and health services, the availability of professional personnel and funds, etc. As a concrete illustrative case we may consider the set-up for a developing country, like India, where medical care is primarily a State subject and the Central Government, through the Union Ministry of Health, gives only advice on health and allied matters, co-ordinates health programmes and policies, supplies technical information and equipment, and provides financial and other assistance towards health measures. Thus, it mainly guides, assists and co-ordinates while State Health Ministries implement the relevant programmes and policies. The suggested organization is schematically represented in Figs. 1 and 2. (Appendix).

Figure 1 represents the organization at the Central Government level. The Commissioner for Mental Health will have mainly an advisory role, though he will also undertake pilot projects and be responsible for planning and operating evaluation services. He will be guided in formulating policy by an "expert's panel" comprising Child Psychiatrist, Psychoanalyst, General Hospital Psychiatrist, Social Scientists, etc., and also by a broad-based Mental Health Advisory Committee representing various professional disciplines concerned with mental health, representatives of the National Psychiatric Society and the National Medical Association, Legislators, Finance Ministry Officials, Social Workers, Directors of Health of State Governments, Deans of Medical Colleges and community leaders. The Commissioner will have close

liaison with officials of the other departments of Health Ministry, especially the departments dealing with rural health service, health education, medical rehabilitation and budgeting and also with bodies, like National Council for Medical Research and National Medical Council, which lays down standards and curricular requirements for undergraduate and post-graduate medical training. It may be seen that the Commissioner for Mental Health must have close liaison with several bodies. The "expert's panel" is suggested with the idea of making available to the Commissioner the expertise of personnel engaged in the practice of sub-specialties of Psychiatry and of social scientists. This panel is meant to help the Commissioner in the technical aspects of mental health planning.

The Mental Health Advisory Committee is the main policy-making body and therefore must include in its membership all those key persons concerned in one way or another with policy making and/or its implementations.

Liaison with other departments of Ministry of Health is necessary for effective integration of mental health services into the existing systems of medical and health care. The research and evaluation unit is a very important component of the organization. It is meant to launch pilot projects to evaluate the efficacy and adequacy of the existing and the newly introduced services and also carry out a cost-benefit analysis of the services. It will also be the function of the Research Unit to gather essential epidemiological and other data which will help in formulation of realistic plans for the future. He will also have liaison with Ministries of Education and Social Welfare.

He will be in closest touch with the Deputy Directors of Mental Health Services for the various State Governments, who are charged with the responsibility for the delivery of mental health services, to the people in their respective States.

In formulating plans for action, the Deputy Director of Mental Health Services of the State Government will be guided by the State Mental Health Council, comprising Psychiatrists, Clinical Psychologists, Psychiatric Social Workers, Public Health and Community Development Officials, representatives of social service agencies and voluntary organizations, local community leaders and general practitioners. Unlike the Mental Health Advisory Committee at the centre which has mainly an advisory role in the matter of policy-formulation, the Mental Health Council at the State Government level will be more action-oriented in its approach. The Council will constitute the forum for discussion of ways and means of implementing the various schemes formulated in consultation with the mental health directorate at the centre, keeping in mind the specific needs and resources of the State, and for clearly delineating the role of the various individuals and agencies concerned with programme-implementation. The Council will meet at least twice a year to :

(1) discuss the various problems in implementation of programmes derived from actual field-experience and methods of resolving them,

(2) review the over-all effectiveness of the programmes,

(3) organize educational programmes through communication media, mental health exhibitions, etc.

(4) to find out ways and means of actively involving the various sections

of the community in the programmes, so that it becomes increasingly possible to operate diversified community-based services,

(5) to draw up concrete projects for research on the regional problems in the field of Mental Health.

The delivery system for the services will consist of mental hospitals, general hospital psychiatric departments, other specialized institutions in the State and Community Psychiatrists with their team-mates, namely Clinical Psychologists, Psychiatric Social Workers and Psychiatric Nurses, who will be charged with the specific responsibility of operating the community-based direct and indirect services. They will concentrate specifically on providing mental health services to the poorly rural areas either through mobile service-programmes or basing themselves in District Hospitals. By designating them as Community Psychiatrists from the start, it is hoped that they will be helped to develop an identity of their own and devote their whole time and effort towards community mental health service. They will, however, work in close collaboration with the personnel of other established services, like the mental hospitals and psychiatric departments of general hospitals on the one hand and the personnel of the Public Health Departments, Social Workers and the community leaders on the other hand.

The creation of the posts of Commissioner for Mental Health and of Deputy Directors of Mental Health Services is crucial for the development of a comprehensive net-work of mental health services, and the success of any planning will, to a large extent if not entirely, depend on the administrative and technical competence of these officials. Men occupying these posts must be people with years of experience in clinical psychiatry and able and

mature administrators with leadership qualities of a high order. They should be able "Social System Clinicians", to use the term coined by Greenblatt (1957), "capable of objectively analysing their organizations, identifying where communication blocks exist - where tensions and anxieties between individuals and groups may have restricted free communication and paralysed expression or limited creative out-put - and by specific techniques free this energy into productive channels". They should have high energy and drive, physical endurance, the ability to appraise people without sentiment, the capacity to encourage and tolerate change, great resiliency and flexibility, creativity, determination, steadfastness, and a high frustration-tolerance. As important as technical competence as an essential qualification are a facility in public relations and the ability to get things done. It will be the prime duty of these officials to help in realizing the goals in Mental Health planning through clearly formulated workable short-range, and long-range objectives, taking into consideration the prevailing local conditions, and again determining the order of priorities among these objectives. In the developing countries with vast unmet needs and limited resources in terms of funds and professional personnel, setting up priorities in objectives is an inevitable prerequisite and will require a great deal of thought.

There must be free two-way communication between the Commissioner for Mental Health and the Deputy Directors of State Mental Health Services. The annual reports of their activities from the State officials will serve as a feed back to the Commissioner and help him in subsequent planning. In addition, meetings between the Commissioner and the State officials through regional meetings will help the Commissioner in studying the operation of the

schemes first hand, and appraising himself of the needs and problems peculiar to the states in the Region.

For the smooth functioning of the Mental Health planning machinery, the working relationship between the Commissioner and the State Mental Health Directors should be most harmonious characterized by mutual respect and feeling of participation in partnership in a co-ordinated venture towards achieving an agreed set of goals. A deep sense of commitment to the cause of improving the lot of the mentally ill in the community will help in focussing attention on tackling the numerous problems at hand and in realizing the need to work in collaborative partnership for this purpose, eschewing considerations of personal prestige, position in the hierarchy and power struggle.

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Figure 1

ORGANIZATION OF MENTAL HEALTH DEPARTMENT AT THE CENTRAL GOVERNMENT LEVEL

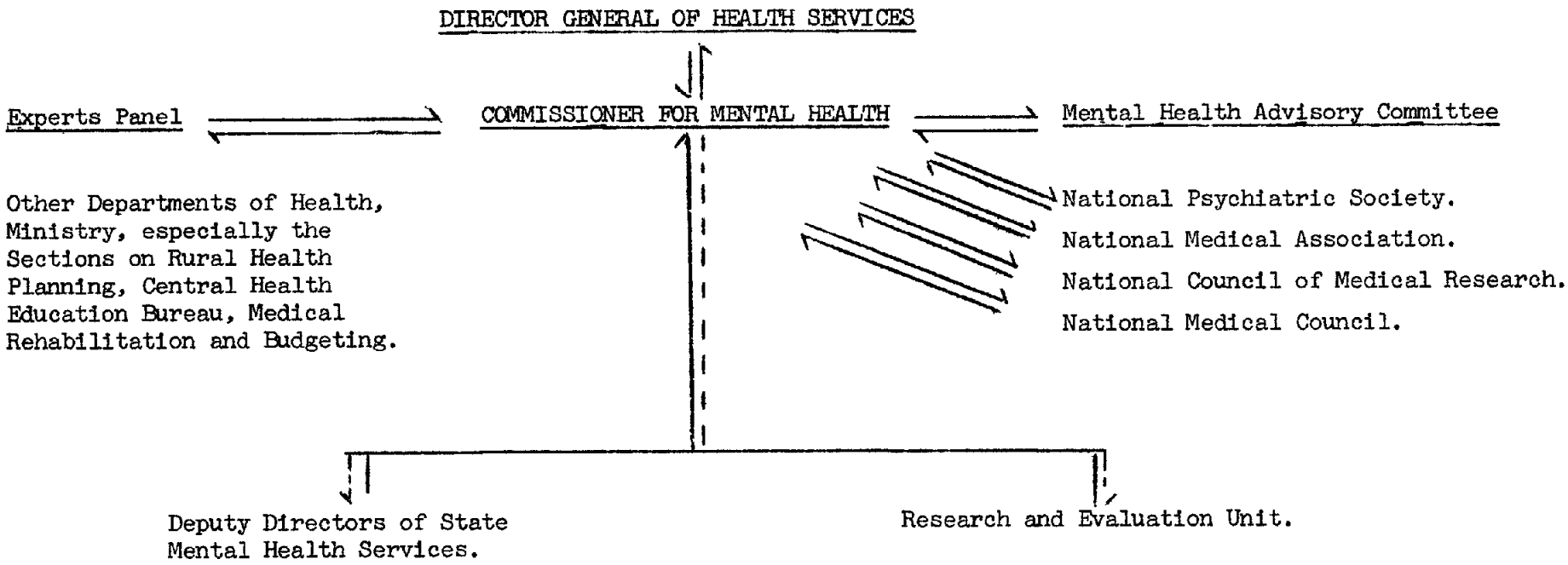

Figure 2

ORGANIZATION OF MENTAL HEALTH DEPARTMENT AT THE STATE GOVERNMENT LEVEL