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Invited Perspective

Community Mental Health Services in India: The Pandemic and Beyond

Abstract

Both popular and professional narratives during the COVID pandemic have focused on the perceived mental health needs of the population. Anxiety and distress have figured high in the list of mental health problems anticipated either during the crisis or in the aftermath. Some of this has been based on previous experience of disasters, but the current pandemic is unique in that there are no modern-day comparable equivalents. A number of cross sectional studies, many from China, have reported high levels of symptoms, particularly anxiety. However, the interpretation of these is difficult as it is not clear if the reported high scores on questionnaires translate into the presence of diagnosable mental disorders. By focusing on the population effects of the pandemic, we are in danger of neglecting the needs of the existing severely mentally ill. It is also becoming increasingly clear that the pandemic could continue for months or years. Existing mental health services have been badly affected by the ongoing lockdown. Considering that the treatment gap is already wide in India and resources stretched in meeting the existing needs, we cannot afford to lose the gains we have made in meeting the needs of people with severe mental disorders. This paper describes, in the light of an example from Kerala, how we can adapt to the changed circumstances without care being significantly compromised. It could also be that these changes forced on us now, could actually make the delivery of mental healthcare even better in future. The COVID challenge also provides opportunities for reform.

Keywords: *Community mental health, COVID-19, healthcare systems, telepsychiatry*

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Introduction

*"Those who wish to build fairer societies and health systems after the pandemic ends, must learn about and prioritise the needs of people living with severe mental illness as a matter of urgency." (*Lancet Psychiatry 2020[1])

The first 6 months of the year 2020 has rapidly become an epoch-defining period. The COVID-19 pandemic[2] has truly been universal in its impact. Our lives will recover, but in many ways, life will never be the same again. Moreover, perhaps in clinical medicine and in the way, we practise psychiatry, the impact of the lockdown and economic downturn will be far-reaching.

The COVID-19 Pandemic

At the time of writing, globally, the number of people who have tested positive for the virus is approaching 5 million and deaths from COVID, 3.5 lakhs. At the best of times, the prediction of any natural phenomenon is fraught, and the pandemic is no exception. The problems of forecasting future of the pandemic are well known,[3,4] but the models have become more sophisticated.[5] It is also well known that there is probably gross under-reporting of both cases and deaths, and the actual figures may be many times more.[5] By the time this is in print, it is projected that nearly 50 million people (corrected for under reporting) worldwide would have been infected and the real as opposed to the reported death rate around 5 million.[5]

The Indian situation

In India, it is no surprise that given the size of our population, at the time of writing, <2 million people have tested positive and <40,000 people have died. Despite limited health-care resources, the numbers have remained manageable, and health-care systems mostly have not been overrun. Even though the numbers are still on the rise and the infection has by no means run its course, it is possible that we may be spared the worst-case scenario.

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The single event, which has had the maximum mental health implications, is the abrupt lockdown announced across the country on March 25, 2020. While the decisive action has possibly helped flatten the steep curve of increasing numbers of the infected, the effect of the sudden turn of events has been nothing short of catastrophic. All economic activity came to a standstill, and medical services curtailed except for emergencies and large populations stranded in different parts of the country facing starvation and hardships. It could be argued that the mental health implications of the COVID-19 pandemic are really about the lockdown than about the effects of the infection.

The Kerala response

Kerala was the first state in the country to respond to the impending crisis and the well planned and effective strategy has drawn attention from across the globe.[6,7] The earliest cases were detected toward the end of January. The well-oiled government machinery had started its response even earlier. In the subsequent weeks and months, the State health services, from the primary health centers to the tertiary hospitals, quickly initiated contingency measures. The different arms of the government, such as revenue, finance, and police, worked well in co-ordination. The other factors which helped in effective control of the situation were decisive political leadership, efficient local self-government, and compliant public. Even before the lockdown, control measures at the population level, such as social distancing and handwashing were in full swing. The result has been that the epidemic has been brought under reasonable control despite the arrival of lakhs of expatriates from hotspots abroad and within the country.

Mental Health Aspects of Pandemics

The history of pandemics is well recorded,[8-10] but the mental health aspects less so, with the exception of the HIV pandemic.[11-13] However, AIDS was different in that there were a lot of novel aspects, including the stigma of sexual transmission, moral interpretations, and ethical and legal aspects of testing and neuropsychiatric complications from the viral infection of the brain. We will probably never know about the mental health implications of previous pandemics because most of them occurred before we started thinking about the impact on the mental health of such events. Past pandemics might have killed more, but the sheer scale of the current containment measures, mainly the shutdown of whole economies, is unprecedented. It may be safe to propose that the mental health effects will be of the economic downturn, poverty, and disruptions to livelihoods than to the actual effects of the infection *per se.* The economy is predicted to be set back by decades and poverty to increase.[14,15] Another factor, the effects of which could be proposed as of importance to the mental health of the population, is social isolation. Again, published evidence of the mental health effects of such events appears to be scanty.

Narratives–popular and academic

It is rather extraordinary how both the popular[16] and professional narratives so easily anticipate poor mental health consequences despite lack of real evidence for the same. It could be equally easily argued, again based on little evidence, that the population is resilient and there will not be any adverse mental outcomes. However, the former far outnumber the latter.[17]

From the beginning, dire warnings have been issued that our mental health "may" deteriorate, and guidelines have sprung up from the WHO[18] to the Department of Health.[19,20] An online survey of the opinions of its members, conducted by the Indian Psychiatric Society (IPS) has unfortunately been picked up by the media and even the World Economic Forum and misreported as "cases of mental illness have risen by 20% in India since the country went into lockdown."[21-23] As is often the case, the distinction between symptoms of mental distress and a diagnosis of mental disorder has been completely lost. The many guidelines which have sprung up to focus on the popular remedies of exercise, meditation, etc., As these are only guidelines, it is understandable that an evidence base is not mandatory. These have disproportionately focused on imagined mental health needs of the population rather than on mental disorders – existing or probable.

Given that the pandemic is in its infancy, it is commendable that a number of academic publications have come out examining various mental health aspects of the pandemic. These include setting the research priorities,[24] the potential effects on the elderly,[25] the potential effects of school closures[26] and other aspects.[27-29] As in the media reports, studies confuse symptoms with syndromes. An Indo-Singaporean study[30] of COVID-19 health workers using a single questionnaire measuring symptoms, reported the prevalence figures for "psychological outcomes of Depression, Anxiety, Stress, and Post Traumatic Stress Disorder" while correlating these with physical symptoms. As with the IPS survey, there is the risk of such findings fuelling the popular narrative of COVID-19 being associated with an upsurge of psychiatric morbidity in the affected, patients, or others. Other published articles[31-33] also blur the symptom-syndrome distinction or make sweeping generalizations of mental ill-health. All the studies are cross-sectional surveys using symptom questionnaires but not diagnostic instruments and without groups.

Some of the recent literature have tried to draw on disaster-related literature, and it is not clear how such a connection has been made. For example, parallels have been drawn about the mental health fallout for the survivors of the 9/11 World Trade Centre twin tower bombings in New York and the current COVID-19 situation.[34] Comparisons between sudden, dramatic, disastrous events such as fires, earthquakes, tsunami, or other singular events and the current pandemic scenario are odious.

While many have followed the popular narrative, a notable exception has been the Lancet Psychiatry editorial,[1] which points out that the mental health needs of the already diagnosed people with severe mental illnesses should not be neglected. To quote: "There have been innumerable opinion columns and reports on the mental health effects of lockdown, and on the situation on medical wards and in primary care. However, there has been far too little space dedicated to the status of those with severe mental illness who would usually receive community support, or on the problems faced on inpatient mental health units." Across the world and more so in developing nations, the emphasis has been on "reducing the gap" and these efforts are in danger of being undermined during the current global crisis.

Maintaining Mental Healthcare during Crises

The shortcomings of the mental health service provision in India has been well documented.[35] The lifetime prevalence of mental disorders, according to a recent survey, is 13.7%.[36] We do not have enough mental health resources, both human and material, to cater to our massive population. However, even with the constraints under which we work, large numbers of people are helped by the existing facilities in the government, private, and voluntary sectors. It is these large numbers of people with often severe mental illnesses who are at risk of disruption of services due to the current lockdown. The effects of this disruption will only come to light later after normality returns to our lives. Hence, an argument can be made that this should be the priority for mental health providers across the world, including India.

Mental Health Action Trust Model

The Mental Health Action Trust (MHAT) is a registered Charitable Trust based in Northern Kerala, India which has been at the forefront of the community psychiatry movement in Kerala for more than a decade. MHAT takes care of, at any point in time, >2500 extremely poor, severely ill people with enduring mental illnesses in an entire community-based model. The care is long term and is provided free of cost, in partnership with about 50 autonomous community based organizations (CBO). The ownership of the local services is with the CBO. MHAT provides professional input (both medical and psychosocial), sets standards and decides on the systems to be in place for efficient delivery of good quality care. In the community, >1000 volunteers spread across 50 centers provides the day-to-day care and communicates with MHAT.[37]

An oft-quoted phrase during the ongoing COVID-19 pandemic is that unusual (or desperate) times call for unusual (or desperate) measures. However, in our community mental health program, we have been able to steer clear of desperate measures and still continue to provide quality services. This is because, over the last few years, we had gradually steered towards increasing the use of technology in our services due to economic reasons. As our services grew, in cash strapped situation, we had to constantly innovate. Several of these innovations were to place ourselves squarely in the voluntary sector, working with partner CBOs. The dependency on high paid professionals was reduced, and technology introduced to increase efficiency.

Adapting to the pandemic

Before the pandemic, the MHAT teams traveled out to the 50 clinics across the State, 6 days a week. Anticipating a total lockdown, we drew up contingency plans so that when it actually happened, we were well prepared to deal with potential disruption in services. Almost overnight, we shifted to running a virtual service with the ceasing of all travel and face to face contact with service users.

Several key aspects of the MHAT model helped ensure a smooth transition to a model of remote delivery of clinical services.

A decentralized, devolved pattern of working with empowered local communities

The CBOs are autonomous and empowered to take ownership of the local service. This is important for sustainability and growth. A franchise model will not encourage similar ownership and commitment. Thus, in crisis situations, it is easy to provide guidance, which is quickly translated into action by the partner CBOs.

Involvement of >1000 unpaid volunteers who run the community service

As these people have volunteered and have grown with the system, they take individual ownership and more importantly, find local solutions to problems. They also enjoy the confidence of local authorities and therefore found it possible to keep the service going during the lockdown. They ensured that people got quality, comprehensive service even they could not move outside of their homes. Medicines were delivered at home, and the supply of essential materials by the authorities was facilitated.

The task sharing model

Task sharing essentially involves people with less professional qualifications delivering services which would otherwise have been delivered by people with higher qualifications. Training and continuous supervision are essential for this process.

Effective use of telepsychiatry

Over the years, MHAT has been increasingly using various aspects of technology such as mobile phones, videoconferencing, and electronic databases, which generate e-prescriptions. This has been supplemented with a custom made application which will eventually

replace the current database and an application to monitor medication adherence. All of these made the transition to a remote way of working smooth. Monitoring for relapses is possible because of this.

Outcomes

Two months into a new way of working, the experience has been surprisingly positive. Clinicians in MHAT run virtual clinics with telephone contacts replacing direct face to face contact. Sometimes these are conference calls involving the community level mental health workers of MHAT as well as the volunteers outside of MHAT. Prescriptions for medications are generated by the database and E-mailed to CBOs. Whenever there has been difficulty with the procurement of medications, MHAT has stepped in and procured medicines centrally from distributors. Transfer of medicines across districts was facilitated by the Fire and rescue services of the Government of Kerala, who had set up a system for such a need as courier services were not operating. Medications are supplied at home to the vast majority of patients, thus obviating the need for them to come out of their houses. All three groups of people involved, clinicians (professionals), and community mental health workers (non-professionals) employed by MHAT and volunteers of local partners offer support remotely, and the MHAT workers provide limited psychosocial interventions also. People requiring consultations and psychotherapy are encouraged to seek these through our website, where exists a facility to book virtual appointments.

Training and feedback

Within MHAT, on an almost daily basis, training sessions are provided for staff. From the beginning, we have recognized the importance of training in our task-sharing model and the lockdown has given us an opportunity to intensify it. For the wider public also sessions are provided all through video conferencing. The latter includes talks, interactive sessions, quiz sessions, and sharing of recovery stories. In all this, experts from outside of MHAT and from even as far the United Kingdom are involved.

We have also been holding video conferences with our community partners, who have been divided into eight zones. Feedback is sought through this and also a daily review of activities within MHAT. 2 conclusions emerge from these:

1. Relapse rates have been surprisingly low with the overwhelming majority of patients remaining stable
2. An opinion is also emerging that, counterintuitively, our large cohort of patients is doing *even better* than before. This is due to the high levels of motivation during this time of crisis, particularly amongst the volunteers who, fearing a relapse, have been even more supportive and attentive than before.

Discussion

Conventionally, medical services have depended on the direct face-to-face contact between service providers and clients. This is, of course, of paramount importance as clinical medicine and psychosocial services are extensions of a basic human contract of trust, concern, and love between a person in need and people who are sanctioned by the society to meet that need. However, this may need re-examining after the world recovers. Can at least some of these contacts be virtual? In other spheres of human activity, we have moved to more remote ways of working. Many of the traditional ways of working and commerce, such as banking, have moved to the internet. In general, medicine, for the above-mentioned reasons, has shied away from delivering consultations and care over the internet except as a necessity when resources are scarce. This applied to MHAT also, as, over the years of our existence, we had moved increasingly to the use of technology, including videoconferencing, telephonic consultations, and depending on a database to coordinate services. However, public support and legal acceptance had lagged behind. The pandemic seems to be changing all that. On the same day that the national lockdown was announced, the Indian Medical Council, the apex regulatory body for medical services brought out guidelines,[38] the most crucial of which was clarifying the legality of electronic prescriptions.

Anecdotally, there are reports of Psychiatrists in the private and NGO sectors of successfully moving to a Telepsychiatry model, and published reports should soon emerge. The challenges for "rapid virtualization" of systems are beginning to be elucidated.[39,40] Based on our experience, we feel that various health-care systems, including governmental, can transform into virtual ways of working or develop hybrid systems with a mixture of in-person and remote consultations. For this to happen, we need the following:

1. Clear guidelines to be developed detailing who needs in-person consultations (psychiatric emergencies, complex presentations, presence of co-morbidities, adverse family situations, etc.) and the large numbers who do not require it (routine follow-up, mild symptoms, etc.)
2. Training to be provided, including about the recent changes to the law[38] and awareness of telepsychiatry etiquette, precautions to be observed, etc.
3. Provisions to be made for basic infrastructures such as laptops and phones and for ensuring data availability. We do not feel that standalone, elaborate telemedicine infrastructure is required. Existing platforms, free or paid, are enough, but at least at the provider's end, the key is to ensure that internet data does not run out, especially as the day progresses
4. While the above can be quickly put in place, long term systemic changes also need to be thought of. Developing a cadre of empowered grass-root level mental health workers should be a priority. The missing element of "care" in our biomedical system of care is probably more important than we realize now. This can

only be provided by the local community represented by trained mental health workers

5. Finally, we need to think about setting up electronic patient databases so that we can develop systems of providing aftercare. Early picking up of relapses, identifying dropouts, and improving treatment adherence can all begin to happen only if we have systems for those.

Conclusions

During these unusual times, an unusual model seems to have found its fit. What we have learnt is that in a volunteer-led model with high levels of motivation, it is possible to keep a large cohort of people with severe mental illness stable and well looked after even during times of lockdown. Of course, this was made possible by the systematic use of already existing technology. The transition to a virtual service has not only been smooth, but it is even possible that it has increased overall quality. This may not be generalizable immediately, as it can be said that we benefitted from a way of working which we had established over a decade, in the voluntary sector. However, as outlined above, we do feel it is possible to generalize from our experience. The will to do so must come from within the profession first.

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Conflicts of interest

There are no conflicts of interest.

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