# Development of community Psychology

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**By**
**Dr. Priyanka Kumari**
**Assistant Professor**
**Institute of Psychological Research and Service**
**Patna University**
**Contact No.7654991023;**
**E-mail- drpriyankakumari1483@gmail.com**

# Development of Community Psychology in India

- In 1975, the World Health Organization strongly recommended the delivery of mental health services through primary health care system as a policy for the developing countries. In India, attempts to develop models of psychiatric services in the PHC ( primary health centre) setting were made nearly simultaneously at *PGI, Chandigarh in 1975 ( Raipur Rani block of Ambala district, Haryana) and NIMHANS, Bangalore in 1976 ( Sakalwara in Karnataka).* The basic model of community mental health was defined by Gerald Caplan in 1967.

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- The predominant characteristics of community psychiatry are:

  1. Responsibility to a population for mental health care delivery.

  2. Treatment close to the patient in com munity based centres.

  3. Multi-disciplinary team approach.

  4. Providing continuity of care.

  5. Emphasis on prevention as well as treatment.

  6. Avoidance of unnecessary hospitalisation.

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- **NATIONAL MENTAL HEALTH PROGRAMME (INDIA)**

  Mental health is an integral component of health, which is defined as a positive state of well-being (physical, mental and social) and not merely an absence of illness. With this aim in mind, an expert group was formed in 1980. The final draft was submitted to the Central Council of Health and Family Welfare (the highest policy making body for health in the country) on 18-20 August 1982, which recommended its implementation. The National Mental Health Programme (NMHP) appeared almost simultaneously with the National Health Policy (1993).

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- The objectives of NMHP are:

  1. To ensure availability and accessibility of *minimum mental health care for all* in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.

  2. To encourage *application of mental health knowledge* in general health care and in social development.

  3. To promote *community participation* in the mental health service development and to stimulate efforts towards self-help in the community.

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Three aims are specified in the NMHP in planning mental health services for the country:

1. Prevention and treatment of mental and neurological disorders and their associated disabilities.

2. Use of mental health technology to improve general health services.

3. Application of mental health principles in total national development to improve quality of life.

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- The mental health care service was envisaged to include three components or sub programmes, namely treatment, rehabilitation and prevention.

  **I. Treatment Subprogramme**: Multiple levels were planned.

  A. *Village and subcentre level:* Multi-purpose workers (MPW) and health supervisors (HS), under the supervision of medical officer (MO), to be trained for:

  i. Management of psychiatric emergencies.

  ii. Administration and supervision of maintenance treatment for chronic psychiatric disorders.

  iii. Diagnosis and management of grand mal epilepsy, especially in children.

  iv. Liaison with local school teacher and parents regarding mental retardation and behaviour problems in children.

  v. Counselling in problems related to alcohol and drug abuse.

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- B. *Primary health centre (PHC)*: MO, aided by HS, to be trained for:

  i. Supervision of MPW's performance

  ii. Elementary diagnosis

  iii. Treatment of functional psychosis

  iv. Treatment of uncomplicated cases of psychiatric disorders associated with physical diseases

  v. Management of uncomplicated psycho social problems

  vi. Epidemiological surveillance of mental morbidity.

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- C. *District hospital:* It was recognized that there should be at least 1 psychiatrist attached to every district hospital as an integral part of the district health services. The district hospital should have 30-50 psychiatric beds. The psychiatrist in a district hospital was envisaged to devote only a part of his time in clinical care and greater part in training and supervision of non-specialist health workers.

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D. *Mental hospitals and teaching psychiatric units:*

The major activities of these higher centres of psychiatric care include:

i. Help in care of 'difficult' cases.

ii. Teaching.

iii. Specialised facilities such as occupational therapy units, psychotherapy, counselling and behaviour therapy

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- **2. Rehabilitation Subprogramme:** The components of this sub programme include maintenance treatment of epileptics and psychotics at the community levels and development of rehabilitation centres at both the district level and the higher referral centres.

  **3. Prevention Subprogramme:** The prevention component is to be community-based, with the initial focus on prevention and control of alcohol-related problems. Later, problems such as addictions, juvenile delinquency and acute adjustment problems such as suicidal attempts are to be addressed.

  The other approaches designed to achieve the objectives of the NMHP include:

  • Integration of basic mental health care into general health services.

  • Mental health training of general medical doctors and paramedical health workers.

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- A plan of action was outlined in 1982, with the first opportunity to develop it in the 7th-five-year plan starting from 1985, with a plan allocation of Rs. 100 lakhs (10 million). A National Mental Health Advisory Group (NMHAG) was formed in August 1988 and a Mental Health Cell was opened in the Ministry of Health and Family Welfare under a Central Mental Health Authority (MHA).

  Various activities were planned under the action plan for implementation of national mental health programme in the 7th-five-year plan, such as community mental health programmes at primary health care level in states and union territories; training of existing PHC personnel for mental health care delivery; development of a state level Mental Health Advisory Committee and state level programme officer; establishment of Regional Centers of community mental health; formation of National Advisory Group on Mental Health; development of task forces for mental hospitals and mental health education for undergraduate medical students; involvement of voluntary agencies in mental health care; identification of priority areas (child mental health, public mental health education and drug dependence); mental health training of at least 1 doctor at every district hospital during the next 5 years; establishment of a department of psychiatry in all medical colleges and strengthening the existing ones; and provision of at least 3-4 essential psychotropic drugs in adequate quantity, at the PHC level.

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- The District Mental Health Programme (DMHP) was started in 1995 as a component of NMHP. The prototype of the District Mental Health Programme was the Bellary District Programme (in Karnataka, 320 km from Bangalore). Started in 1985, it caters to a population of 1.5 million. District hospital psychiatry units have been opened in every district of Kerala and Tamil Nadu.
- Following the implementation of National Mental Health Programme in India 1982, other neighbouring countries soon followed the example by drawing national programmes for mental health (Sri Lanka 1982; Bangladesh 1982; Pakistan 1986; Nepal 1987).

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- The emphasis of NMHP-1982 was primarily on the rural sector. It is being realized that the urban mental health needs also need to be addressed under the ambit of NMHP.
- During the 11th-five-year plan, an allocation of Rs 1000 crore (Rs 10 billion) has been made for the NMHP. The current focus (2009) is on establishing centres of excellence in mental health, increasing intake capacity and starting postgraduate courses in psychiatry, modernisation of mental hospitals and up gradation of medical college psychiatry departments, focus on non-government organisations (NGOs) and public sector partnerships, media campaign to address stigma, a focus on research, and several other measures.

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- The revised National Health Policy (NHP-2002) has been released in 2002. Its focus on mental health "envisages a network of decentralised mental health services for ameliorating the more common categories of disorders". At the same time the NMHP 10th five-year plan was launched, with a plan to extend the DMHP to 100 districts. It also emphasizes the need to broaden the scope of existing curriculum for undergraduate training in psychiatry and to give more exposure to psychiatry in undergraduate years and internship. An essential list of psychotropic drugs was also being prepared.

## Community Psychology

- Considers the individual in social context
- Advocates social change
- Collaborates with citizens to enhance their strengths
- Not the expert

## Clinical Psychology

- Focus on the individual in isolation
- Improve lives through individual adaptation
- Medical model, deficiencies
- Expert role

## Community Psychology

- Attends to forces in outside world
- Looks to the peculiarities of social position and context
- Values social action; real world observation – in context

## Social Psychology

- Individual interpretations and perceptions of the environment
- Identifies universal properties of human nature that make them susceptible to social influence
- Theoretical understanding; experimental observations

## Community Psychology

- Focuses on community, organizational level
- Research/theory discipline

## Social Work

- One-on-one services to people in need
- Alleviate poverty by promoting personal change among poor people
- Intervene at the individual or family level
- A profession; has a practice

Both focus on individual in society, values, social justice, enhance strengths, attention to marginalized people

## Community Psychology

- Socially constructed environment and social problems
- Emphasis on
- Partner with mental health practitioners, social service providers, educators, community activists, policy makers

## Environmental Psychology

- Physical environment: crowding, noise, resource conservation
- Emphasis on experimental methods
- Partner with resource managers, community planners, architects

Both focus on settings with the goal of improving the quality of people's lives. Value interdisciplinary approaches to research and practice