Community Mental Health

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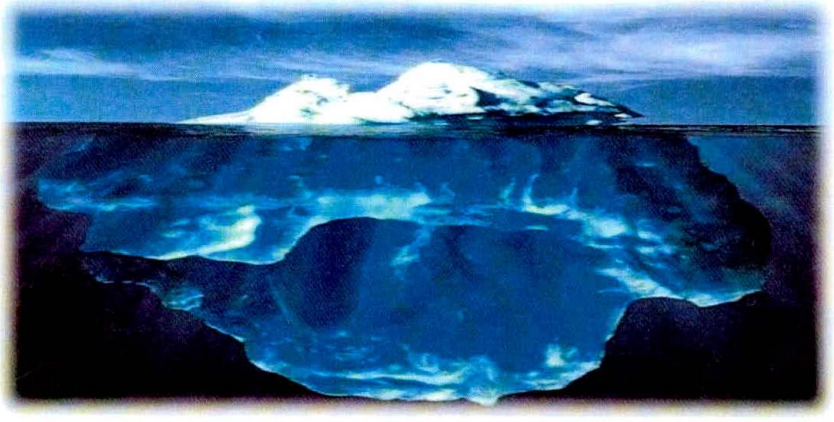
A perspective of DMHP Thiruvananthapuram

2012



DISTRICT MENTAL HEALTH PROGRAMME (DMHP)

Thiruvananthapuram

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"We believe each of us as waves and forget we are also the ocean"

Community Psychiatry

Evolution of Mental Health Care can be best described through 5 '**C**'s, namely Confinement, Caring, Curing, Chemicals, & Community. In early and medieval periods, mental patients were mostly **C**onfined or chained, as their behaviors were believed to be due to evil spirits, witchcraft or black magic. But in 18th century, these symptoms and behaviors were started to be considered as part of a disease, and thus the concept that these people need to be **C**ared for, emerged. In late 19th century attempts were made to **C**ure these symptoms, and many psychological methods were developed. But still crude methods including torturing were in vogue in different parts of the world. Using **C**hemicals to cure mental illness found success with the discovery of Chlorpromazine in 1956. Thus began the era of psychopharmacology which drastically reduced the morbidity associated with the illness. But still the benefits were narrowed to a selected few for whom these treatments were accessible and affordable. Thus came the 5th revolution in mental health namely **C**ommunity Psychiatry in 1960s.

Community psychiatry in India

WHO strongly recommended the delivery of mental health services through primary health care systems as a policy for developing countries, as most developing countries including India did not have adequate number of institutions to care for the mentally ill.

The seven reasons given by World Health Organization (WHO) for integrating mental health into primary care are: -

1. **The burden of mental disorders is great.**
   As they produce significant economic and social hardships that affect society as a whole.
2. **Mental and physical health problems are interwoven**.
   As many people suffer from both physical and mental disorders, integrated primary care services help ensure that people are treated in a holistic manner.
3. **The treatment gap for mental disorders is enormous.**
   There is a significant gap between the prevalence of mental disorders and the number of people receiving treatment and care. Primary care for mental health helps close this gap.

4. **Primary care for mental health enhances access.**
   People can access mental health services closer to their homes, thus keeping their families together and maintaining their daily activities.
5. **Primary care for mental health promotes human rights.**
   Mental health services delivered in primary care minimize stigma and discrimination and can also remove the risk of human rights violations that can occur in psychiatric hospitals.
6. **Primary care for mental health is affordable and cost effective.**
   Costs in seeking specialist care in distant locations are avoided.
7. **Primary care for mental health generates good health outcomes.**
   Especially when linked to a network of services in the community.

Over the last few decades, community psychiatry in India has made substantial advances. **National Mental Health Programme (NMHP)** was established in 1982.
Attempts to develop models of psychiatric services in the PHC setting were made nearly simultaneously at PGI, Chandigarh in 1975 and NIMHANS, Bangalore in 1976.

Aims of NMHP

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.**

Strategies adopted

1. **Integration** of mental health **with primary health care.**
2. Provision of **tertiary care institutions** for treatment of mental disorders.
3. Eradicating stigmatization of mentally ill patients and protecting their rights through **regulatory institutions** like the Central Mental Health Authority (CMHA), and State Mental Health Authority (SMHA).

District Mental Health Programme (DMHP)

DMHP was started as a component of NMHP with the following aims:

1. To provide sustainable mental health services to the community and to **integrate** these services with general health services.

2. **Early detection** of the patients within the community itself
3. To see that the patient and their relatives do not have to travel long distances to go to hospitals or nursing homes in their cities
4. To take pressure off the mental hospitals and medical colleges
5. To **reduce the stigma** attached towards mental illness through change of attitude and public education
6. To **treat and rehabilitate** mental patients discharged from the mental hospital **within the community.**

The components of DMHP

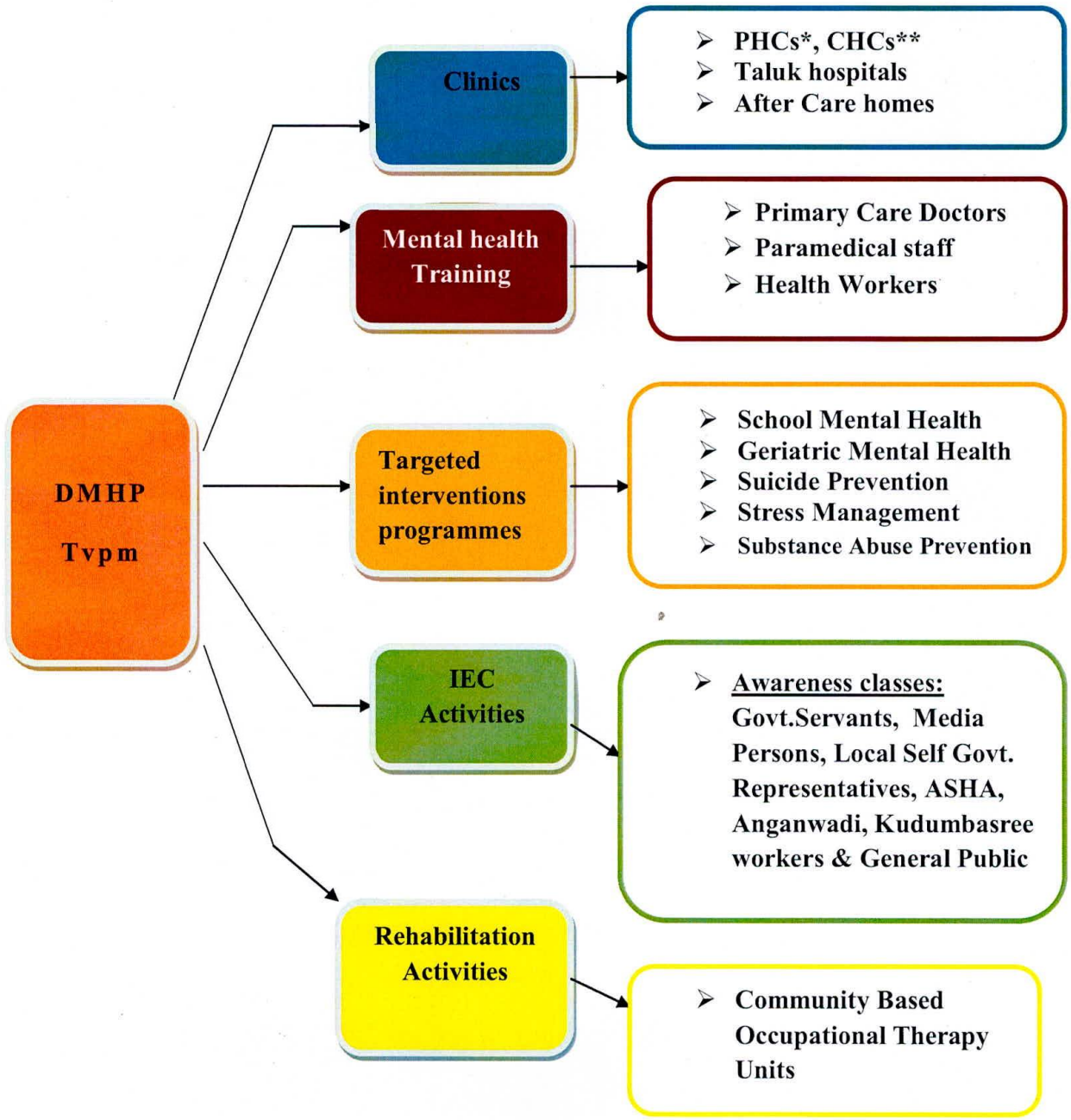
1. **Training** of medical, paramedical personnel and Health workers in mental health skills.
2. Community **Mental Health care** through existing infrastructure of the health services
3. **Information, Education and Communication** activities.
4. Community oriented **Rehabilitation** Services.

DMHP Thiruvananthapuram

- DMHP Tvpm was established in 1999 as **first in Kerala.**
- DMHP office is situated in the campus of Mental Health Center, Thiruvananthapuram, which is also the Nodal Center of the programme.
- Selected as the **most successful** and **model DMHP** in India by **WHO.**
- Total number of registered patients as on 2012 is **14,357.**

DMHP Tvpm –Staff pattern

Activities of DMHP Tvpm



*PHC- Primary Health Centre (6 sub centres, population- 30,000)

**CHC-Community Health Centre (First referral centre, population-1, 40,000)

Problems faced in Community Psychiatric Care

1. Lack of Awareness

- **Regarding symptoms**-physical symptoms of depression and anxiety disorders like body pain, aches, impaired sleep and appetite, are usually considered as that of physical illnesses (even after physical examination and investigation results are negative and assurance from physician) and repeatedly seek treatment or take analgesics and other medications by self.
- **Regarding treatment**. Most people are ignorant regarding psychiatric treatments available, mental health professionals, and where to approach. So they may prefer religious forms of treatment which are easily available. Also, misconceptions regarding psychiatric treatments especially pharmacotherapy and ECT, keeps patients away from seeking proper treatment.

These can be addressed through increasing awareness regarding mental illnesses and treatments. Conducting regular IEC Programmes in community will help in achieving this aim.

2. Resources

- Resources are limited. Number of mental health professionals especially Psychiatrists are few compared to the growing population and demand.
- Available resources are concentrated in urban areas, leaving psychiatric care scarcely accessible to majority
- Lack of mental health skills in primary health care professionals and workers
- Quacks thriving in many rural areas due to lack of qualified mental health professionals.

These can be addressed to a large extent through integration of mental health into Primary care system.

3. Stigma

There is stigma associated with mental illness, because of which people try to ignore the symptoms, or keep it to themselves. They may opt for religious forms of treatment or black magic for cure.

Stigma can be reduced by increasing awareness through IEC programmes. Integration with Primary Care will also help in the process.

4. Follow-ups

- Cost of treatment, especially when multiple drugs are needed.

- Long duration of treatment needed as in schizophrenia
- It may be difficult to bring the patients for long distances in public transport system, especially if the patient is symptomatic.

Can be addressed to a certain extent through Primary Care integration of Mental Health.

5. Other patient related factors

- **Poor drug compliance**:- mostly patients relate the treatment with that for acute physical illnesses and discontinue drugs as soon as symptomatic improvement occur.
- **Expressed emotions**;- hostility, over-involvement, and critical comments towards the patient from care givers and family members often increase relapse rates.

Repeated and regular psycho-education for patients, caregivers and other family members should be given to ensure compliance to treatment and address expressed emotions.

5. Attitude of General public

Even though health is defined as physical, mental and social wellbeing, majority considers physical wellbeing as the only criteria for health. People tend to seek treatment for even minor physical ailments while a severe mental stress or illness is kept to themselves without seeking any help, even though the stress created by the latter is far greater. This attitude of general public may be due to a combination of factors like stigma, lack of awareness, and lack of easy accessibility to treatments. But this forms the leading limitation in the concept of psychological wellbeing to all, as we assume that **five sixth of those requiring psychiatric intervention** (constituted mostly by depressive disorders, anxiety disorders, OCDs and somatoform disorders) **still remain untreated in the community**.

Strategies adopted by DMHP Tvpm

As a unit of National Mental Health Programme, DMHP works within the framework of NMHP guidelines. Being a national programme, it allows enough flexibility for regional variation in strategies to be adopted (especially the Revised NMHP guidelines). For example, while providing funds in a head like IEC, it suggests measures like school mental health, stress management etc. The strategies to be adopted in each head and subheads can be decided by the concerned DMHPs depending on the regional requirements. This may vary from state to state, between districts or even within a district.

Strategies adopted in each (IEC, Training, Clinics & Rehabilitation)

Targeted interventions - help in channelizing the awareness activities to selected target groups. So they become more effective and ensures easy follow up of actions.

Resource Persons-With 22 clinics, 8 aftercare homes and Training programmes in hand, its impractical for DMHP Team to conduct awareness programmes in the entire community. NMHP guidelines give us scope for creating resource persons for IEC programmes. DMHP Tvpm created resource persons for each Targeted interventions by conducting Training for Trainers (TOT). They are given remuneration for the number of classes they conduct.

Another scope provided in NMHP guidelines is tie up with Psychology or sociology departments of colleges in the district. Even though no tie-ups have been made with any departments, students (mostly MSW) of Sociology departments of Kerala University and Loyola College of Social Sciences undergo community psychiatry training in DMHP Tvpm as part of their fieldwork. They form a workforce as most of them continue their work as voluntary trainees or resource persons even after their placement. With this workforce in hand DMHP Tvpm implemented targeted interventions which include:-

i. **School Mental Health Project (Thaliru)**: Aims at the holistic development of mental health of school children. Through awareness classes, distribution of booklets, posters, leaflets, counselling sessions and other psychiatric services, DMHP makes sure that the aim is being achieved. (Utilizing the lack of co-ordinated services, several unqualified people have gained access in this area, posing as mental health professionals, which has brought in more severity to the basic problems of school mental health.)

For creating a link between DMHP and schools in the district, 64 School Counsellors, and 38 School JPHNs were trained in school mental health issues and incorporated into this programme. 'Thaliru' focuses on 5 aspects of school mental health namely

a) Behavioural and emotional problems
b) Substance abuse
c) Suicide prevention
d) Stress management
e) Life skill education

Once awareness classes are conducted, cases requiring counselling are identified following which counselling camps are conducted in the school with regular follow ups. Those

requiring pharmacotherapy are referred to the nearest DMHP clinics. Till date the programme has covered 26 schools and 7,208 students in the district.

ii. **Geriatric mental health (Thanal):** Through this project, DMHP conducts camps in community or Old age homes. Screening is done for dementia (MMSE), depression, anxiety disorders and adjustment disorders. Awareness classes are given and counselling sessions are conducted for the necessary. Those who need further treatment are referred to nearby DMHP clinics.

iii. **Substance abuse (Mukthi) and Suicide prevention (Jeevaraksha)**: In these projects DMHP enlisted the support of NSS (National Service Scheme) Volunteers from different colleges of the district. A seminar and street play writing competition were conducted in first phase to help them understand the gravity of the situation and different aspects of the problem in society. In the next phase these volunteers perform street plays, distribute leaflets, conduct awareness class in colleges and help identify those in need.

iv. The same volunteers or students from Sociology or Psychology departments will be managing **'Bodhana', the Stress management** units DMHP plans to start in **colleges** across the district.

In addition to this DMHP has started stress management programme in **Government Offices** in the district. Awareness classes and interactive sessions will be followed by counselling sessions for those in need.

Other Target groups:

LSG members- DMHP Tvpm conducts mental health awareness programme for Elected representatives of LSG- Grama, Block and Jilla Panchayats, Municipalities and Corporation. It focuses on 5 components:-

1. Importance of mental health in public health scenario
2. Problems faced in mental health especially community mental health
3. Common symptoms and disorders
4. Removing misconceptions regarding psychiatric treatments
5. Pension schemes and other benefits available to psychiatric patients.
6. About the help they can provide in rehabilitation of these patients, especially with regard to Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS).

ASHA, Anganwadi, and Kudumbasree workers: form a suitable link for mental health awareness and activities to reach the grass root level. For this, DMHP started a programme for these workers. Resource persons were created, and they conduct awareness classes and

interactive sessions in batches of 50-100. These workers in turn arrange classes in the community. This ensures an even distribution and maximum outreach in the community.

Residence Associations and Youth Clubs: forms another mode to reach the community. Through awareness classes, counselling sessions, street plays, painting competitions and other activities based on mental health, the aim is being achieved.

NGOs: DMHP Tvpm has tie ups with NGOs like Sacred Heart Charity, Providence Home, Mahila Samakhya Society, BUDS (of Kudumbasree) and SSREE Foundation for rehabilitation and occupational therapy of the mentally ill patients.

Posters and Leaflets: Taking a cue from other health programmes (Immunization program, RNTCP, Family planning etc),which owe a part of its success to wide campaign through posters and leaflets, DMHP Tvpm prepared 7 sets of posters and leaflets and is distributing these to be displayed in Hospitals, Govt. Offices and Public places. Themes include:

1. Reduction of Stigma associated with mental illness.
2. Common signs and symptoms, in particular the somatic symptoms.
3. Treatments available and removing misconceptions regarding it.
4. Alcohol abuse
5. Stress management in school children.
6. Substance abuse in school children
7. Life skills to be developed.

These have helped in extending our campaign throughout.

Street Play: For the past few years DMHP Tvpm is using the appeal and minimalism of Street Play as a tool for mental health promotion. It has been conducted in 58 locations in the district and focuses on awareness regarding symptoms, common illnesses, treatments available, stigma and misconceptions in mental health. Information leaflets are distributed after each play. It has been found to a very effective tool as it draws large crowds and huge response in the form of clearing doubts directly and through phone calls.

Mass media: The extensive range of mass media is regularly utilized in the form of Mental Health Articles in Newspapers, and Talk shows in Doordarshan, and Radio Health. This further helps in mental health awareness campaign to reach a wider population.

Primary Care Integration

From its onset in 1999, DMHP Tvpm has been conducting clinics directly in selected PHCs, CHCs & Thaluk hospitals. During the initial periods clinics were conducted every two weeks, and later on, as number of clinics increased, they were conducted monthly.

Table- Clinical attendance (%) at DMHP clinics in January 2012

Clinics (N)	Schiz	BPAD	Epil*	Dep	Dem*	ADS	Anx. dis	Others
Poovar (139)	46	32	2	7	0	1	1	4
Vakkom (96)	41	37	6	4	0	1	0	5
Kanyakulangara (81)	49	27	10	4	0	0	0	3
Aryanadu (73)	43	18	16	7	1	0	0	1
Pallichal (38)	47	24	8	0	0	0	0	0
Vellarada (123)	37	27	19	7	1	1	0	6
Puthanthope (63)	38	29	10	11	2	2	0	5
Kilimanoor (51)	47	31	6	10	0	0	0	4
Malayankeezhu (134)	41	16	16	8	1	1	0	1
Kattakkada (101)	41	28	16	4	1	0	1	5
Neyyatinkara (163)	57	31	5	1	0	1	0	1
Kesavapuram (146)	40	39	5	5	1	1	0	6
Vamanapuram (93)	40	31	8	4	0	1	0	9
Vellanadu (41)	17	24	46	2	0	2	0	0
Vilappil (65)	52	22	15	2	0	0	3	3
Vizhinjam (71)	41	20	23	1	0	0	0	4
Vithura (70)	41	27	11	6	3	0	0	4
Perumkadavila (74)	35	41	16	0	1	0	0	3
Kallara (171)	32	44	7	6	2	1	0	3
Mangalapuram (86)	40	37	5	5	1	2	1	5
Palode (90)	40	33	8	8	0	0	0	4
AshaBhavan(F)(63)	51	48	0	2	0	0	0	0
AshaBhav (M)(57)	72	23	2	0	2	0	0	0
Total (2089)	**42**	**31**	**10**	**5**	**1**	**1**	**0**	**4**

There has been a steady increase in the number of patients and is about 2000 per month now. This amounts to about 100-180 patients per clinic. But the availability of only a single Psychiatrist began affecting the quality of care given. Moreover, the other components of DMHP namely IEC activities, training programmes, rehabilitation work etc. were also affected. It was the case till 2010. Also, the National Mental Health Programme meeting of Nodal Officers of Southern states at NIMHANS in July 2011 gave emphasis on the need for integrating mental health with primary care. It was in these circumstances that DMHP Tvpm decided to start the process of Primary Care Integration in August 2011.This was to be done in 3 phases.

PHASE I (Initiation)

1. **Training** for Doctors, Nurses, Pharmacists, Health workers, and ASHA workers of hospitals where DMHP conducts clinics (22 in number)
2. Trained doctors to conduct **Psychiatry OP** in each hospital.
3. **Psychiatric drugs** to be dispersed by concerned trained pharmacist of each institution.
4. **Case sheets** to be prepared for each patient to be kept in concerned PHCs & CHCs.

PHASE II (Consolidation)

1. Consolidation of the integration process
2. Assigning follow-up cases to weekly psychiatry OP conducted by trained primary care doctors.
3. Preparation of Case taking Performa and Treatment protocol for Doctors.
4. Preparation of Case detection forms and Follow up form for Health workers.
5. Preparation of Posters and Leaflets on signs and symptoms of mental illness and treatments available, to be distributed and displayed in Primary care institutions across the district.

PHASE III (Extension)

1. Extending the integration process to all other PHCs & CHCs in the district.
2. Doctors, Pharmacists, Nurses and Health workers in these institutions to be trained in primary mental health care.
3. Weekly Psychiatry O.P to be conducted in all PHCs & CHCs by trained doctors.
4. Follow-up cases in the first 22 clinics (of Phase -I) to be re-assigned to their nearest PHCs or CHCs.
5. This will reduce the number of follow-up cases in each institution to 10-50 (from the current 100-180 patients)
6. DMHP team will conduct clinics in 22 CHCs.

7. New cases and follow-up cases which are symptomatic to be referred by primary care doctors to nearest DMHP clinic. After regular follow-ups, once these patients become stable, they will be referred back to the doctor of concerned PHCs.
8. Mental Health Awareness and orientation regarding primary care integration to be given to all staff members of PHCs, CHCs and also to elected representatives of Local Self Governments.

Training in Mental Health

Doctors: Training in mental health skills were imparted to 48 **primary care doctors** in three batches. **Training modules** were prepared focusing on familiarization of psychiatric symptoms, identification of common psychiatric illnesses in primary care, its management, and psychopharmacology.

They were also given awareness regarding their role in community mental health. For Doctors, DMHP Tvpm conducts an initial **Five day** training programme followed by **Two day Review trainings** every 6 months.

Resource personnel for Training Programmes of DMHP

- Dr. Veena G Thilak, Retired Consultant Psychiatrist, Mental Health Center, Tvpm.
- Dr. Vidhukumar, Addnl. Prof. in Psychiatry, Medical College Hospital, Tvpm.
- Dr. Jayaprakash, Psychiatrist, Mental Health Center, Tvpm.
- Dr. Indu V Nair, Psychiatrist, Mental Health Center, Tvpm
- Dr. Jayaprakash KP, Associate Prof in Psychiatry, Medical College Hospital, Tvpm
- Dr. Anish NRK, Psychiatrist, Mental Health Center, Tvpm.
- Dr. Sheena G Soman, Psychiatrist, Mental Health Center, Tvpm.
- Dr. Arun V, Psychiatrist, Mental Health Center, Tvpm.
- Dr. Arun B Nair, Asst. Prof in Psychiatry, Medical College Hospital, Tvpm.
- Mr. Ajith R, Clinical psychologist, Mental Health Center, Tvpm.
- Ms. Nanda, Psychiatric Social Worker, Mental Health Center, Tvpm.
- Ms. Sandhya Sony, Psychiatric Social Worker , Mental Health Center, Tvpm.
- Dr. Kiran PS, Nodal Officer, DMHP, Tvpm.
- Ms. Amrutha R, Clinical psychologist, DMHP, Tvpm.
- Mr. Vinod MD, Psychiatric Social Worker, DMHP, Tvpm.

Role of Primary Care Doctors in Community Mental Health

As primary care givers, delivering mental health care through primary care doctors, makes it more accessible and affordable and also reduces stigma to a certain extent as they are treated by general care physician.

Doctors in PHCs & CHCs can play an active role in Primary Mental Health Care by:-

- Patient care – treat psychiatric patients in weekly clinics or along with general O.P. [During Training, most Primary Care Doctors expressed reservations regarding examining psychiatric patients in general O.P, as number of General cases are very high and mostly only a single doctor is available to manage. Also psychiatric patients may have to wait in long queues of general care patients to be examined. This is also the case with Pharmacists who have to dispense multiple psychotropic drugs for one month to each patient. Hence weekly clinics are preferred in all PHCs. Another advantage with weekly clinic is that the detailed case sheets prepared by DMHP team for each patient can be referred to by doctors, and also Psychiatric O.P register provided by DMHP can be maintained].

  Doctors can examine follow-up cases and can adjust dosage of drugs if patient is symptomatic, and can refer them to DMHP Clinic if there is no improvement. They should enquire about side effects of drugs if any, improvements made, whether patient is going for work or household jobs etc.

  They can also examine new psychiatric cases or can refer them to DMHP Clinic. It is preferable for primary care doctors to attend DMHP Clinic so that they can get an overview of psychiatric diagnosis, first line psychiatric drugs and can also clear doubts about the cases they referred.

- Case detection & Psycho-education– As general care physicians, they can detect psycho-somatic, somatoform, dissociative-conversion disorders, and physical symptoms of anxiety disorders and can give individual psycho-education regarding the psychological factors in the causation of these symptoms and disorders.

- Awareness Classes –mental health topics can be included in the awareness classes they conduct in community. Focus should be on causes of mental illness, common symptoms, treatments available, whom to approach, need for regular follow-ups and treatment compliance.

- **Supervision** – can enquire about the number of cases identified and referred by health workers. In addition they can be asked to follow up drop out cases if any. One trained JHI can be entrusted with co-ordination of community mental health activities. Number of cases attending the primary care clinics are to be reported to DMHP by month end.

Other Health Professionals -Training was imparted to 34 **Pharmacists** and 39 **Staff Nurses**, focusing on psychopharmacology. They were familiarized with psychiatric drugs and their common trade names. DMHP will provide drugs to pharmacists of PHCs & CHCs, to be dispensed to psychiatric patients in their clinics.

Table: Training for Health professionals

Date	Participants	No. of participants
06.08.11	JPHN & JHI	30
29.09.11	JPHN & JHI	32
30.09.11	JPHN & JHI	35
07.11.11	LHI	21
26.11.11	HI	24
20.01.12 to 21.01.12	Pharmacists	24
27. 01.12 to 30.01.12	Doctors	18
23.02.12 to 28.01.12	Doctors	21
31.07.12	Pharmacists & Staff Nurse	27
20.08.12	Pharmacists & Staff Nurse	22
16.10.12 to 20.10.12	Doctors	8

As part of its efforts to bring mental health care to community, **Health Workers** (JHI, JPHN, HI, & LHI) were given mental health training. 142 Health Workers were trained in 5 batches. They were taught about common psychiatric illnesses, epilepsy, mental retardation, dementia, identification of common symptoms, referral and follow up of mentally ill.

They were given information about Expressed Emotions in caregivers, and ways to reduce it through psycho-education.

DMHP Tvpm has included **ASHA workers** in the process of referral and follow - up of mentally ill patients. Awareness classes of 2 hours duration were intended to alleviate the misconceptions regarding mental illness, inform them of the treatments available for mental illnesses, and about primary care integration and their role in it. 626 ASHA workers have been included in the process till date.

Table:-Awareness programme for ASHA Workers.

Date	Place	No. of participants
06.09.11	R.H.C Vakkom	69
26.09.11	P.H.C Perumkadavila	21
03.10.11	C.H.C Aryanadu	27
07.10.11	P.H.C Pallichal	12
12.10.11	P.H.C Mulakkalathukavu	30
24.11.11	C.H.C Palode	42
08.12.11	P.H.C Malayankeezhu	30
15.12.11	C.H.C Vellarada	23
23.12.11	C.H.C Vithura	32
27.12.11	C.H.C Kallara	28
28.12.11	P.H.C Mangalapuram	33
02.01.12	C.H.C Poovar	31
04.01.12	C.H.C Kanyakulangara	27
16.01.12	C.H.C Kattakada	38
13.02.12	C.H.C Vellarada	27
15.02.12	P.H.C Vamanapuram	47
20.03.12	C.H.C Kesavapuram	79

Role of Health Workers in Community Mental Health

Active involvement of Health Workers is essential for successful implementation of community mental health programme. They can play active role in:-

1. Case detection – As health personal who are in constant touch with community, and conducting house visits, they help detect untreated psychiatric cases in the community. Cases thus detected should be promptly referred to Medical Officers of concerned PHCs or CHCs.

2. Follow-up – For dropout cases, health workers as part of their home visits can persuade and educate the patients and family members to ensure regular follow ups and drug compliance.

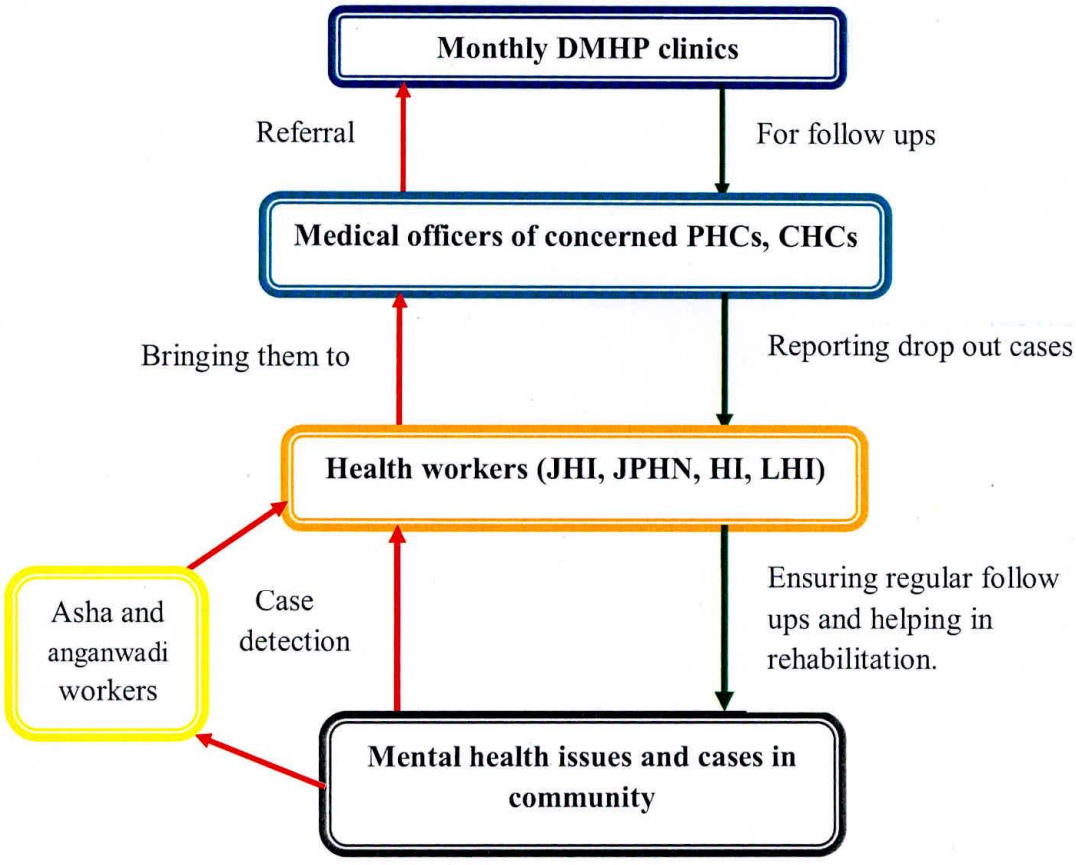
3. Awareness classes – Health workers should include mental health topics in the awareness classes they conduct in community. Also, they can arrange for DMHP team members and resource persons to take mental health classes in community.

4. Reporting – just as they report Communicable disease to District Medical Office, total number of mental health cases seen in one month in the hospital is to be reported to staff nurse of DMHP by month end.

Present Status

Now **weekly Psychiatric clinics** are conducted in Government Hospitals under DMHP Thiruvananthapuram. Of the 4 weekly clinics every month, one clinic is directly conducted by DMHP while other 3 are conducted by trained medical officers of the concerned institution. DMHP clinics examine new cases and those referred by Medical Officers conducting the other three clinics. Psychotropic medicines are provided to the respective pharmacists, to be supplied to the patients. A register for the Psychiatry OP is also provided by DMHP. The programme ensures that the patients are monitored regularly and all medications given free of cost.

Functional levels of Primary Care under DMHP Tvpm



Prepared by DMHP Tvpm 2011

Community based Rehabilitation - Occupational therapy Units at primary care settings

Rehabilitation and mainstreaming of patients with severe psychiatric illness are key issues while focusing quality health care to all. There are many patients under treatment for mental illness who do not have active illness and are in remission. These patients need not be in hospital but should be cared for at home so that they can slowly be brought to the mainstream. But very often, after being discharged, these patients end up being a burden on their families. Unemployment and rejection could drive them to alcohol or drugs; they could miss medication and finally end up in hospital again.

Occupational therapy helps them to build their self-esteem, confidence and also help them to come into the main stream of life like any other individual.

Objectives

- To rehabilitate the patients who are under treatment but in remission.
- To provide occupational opportunities so that the patients can be gainfully employed.
- Help patients acquire the skills to care for themselves.
- To impart basic skill so that the dignity and self-worth of the individual can be sustained through receiving remuneration for the skilled work done.

This is best achieved by establishing occupational therapy units in Primary Care Settings. DMHP Tvpm started the first community based Occupational Therapy unit in Kerala at PHC Mangalapuram, Tvpm on19th march 2012. Similar units are being planned to be started in 3 other zones of the district at Primary Level.

In addition to this, patients not going for work are given psycho-education and enrolled in MNREGS. For this DMHP makes regular contacts with Local Self Government representatives and officials of their concerned Panchayat. For the past 2-3 years DMHP Tvpm has obtained help from many Panchayat members for registering our patients in this scheme, and we feel that the work is well suited to our patients as it is done in groups and under supervision. Once they get registered they can re-join work even if there is relapse and hospital admissions and so it provides a constant source of income. Now most of our patients with working capacity (without any prior job) is employed in this scheme.

As on November 2012 we have completed the Phase –II of Integration process, and is entering the final phase.

Phase –II

Integration process has been consolidated. Training for 39 staff nurses and 10 pharmacists were conducted in August& September. Third batch of Doctors Training was conducted from 16th to 20th October. Posters and leaflets on mental health awareness, Case detection and follow-up forms for health workers have been prepared and released. A book on mental health care for primary care doctors including treatment protocol is under preparation, to be distributed by November 2012. DMHP is also starting a monthly magazine on mental health awareness and activities to be distributed among doctors, paramedical staff and health workers in the district.

Case sheets

Case sheets have been prepared for each patient by interviewing the patient and family, and kept in concerned PHCs and CHCs for the purpose of verification and follow up by the medical officers. A soft copy of each will be kept in DMHP. Till now, 2026 case sheets have been prepared and kept in concerned PHCs & CHCs for this purpose.

Future Plan (Phase-III)

For integration of mental health into primary care to become complete, doctors, pharmacists and health workers in all PHCs and CHCs should be involved in the process. Starting in November 2012 (Phase-III), DMHP is starting training to Health Professionals in all PHCs and CHCs in the district. By this, Psychiatry Clinics can be conducted in every PHCs and CHCs in the district by the trained doctors, under supervision of DMHP Tvpm. Symptomatic cases and new cases can be referred to DMHP in nearest CHCs, for which DMHP will be conducting monthly clinics in 22 CHCs across the district. This makes sure that patients have to travel least distance to get mental health care, so it becomes most accessible and affordable to them. Case detection and follow-ups by health workers will cover the entire district, so most of the undetected and untreated mentally ill patients can be brought to treatment. DMHP Tvpm has also included Local Self Government officials and elected representatives in this process by conducting awareness programmes for them, which will make it more effective.

Suggestions and Recommendations

Successful implementation of programmes in community requires certain rules and enforcements.

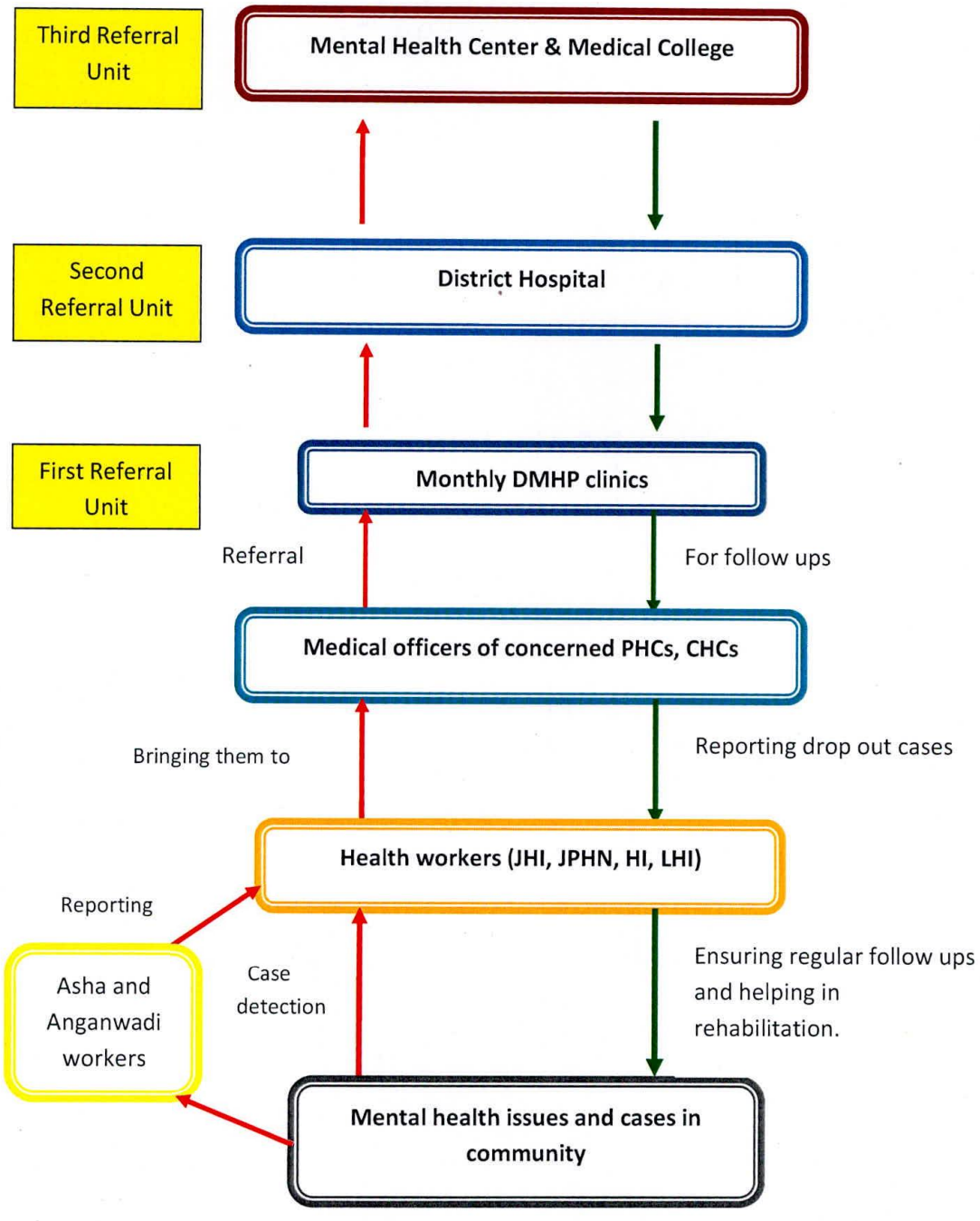
1. **Mental health training** should be made compulsory for Doctors, pharmacists and health workers in PHCs, and CHCs, as less than 50% of those called, attend the training process. It would be better if a list of 25 doctors were given from DMO office to DMHPs after each Medical Officers Conference (5^{th} working day every month).
2. **Weekly Psychiatric Clinics** should be conducted in every PHC and CHC by the trained doctors. This is essential because even after training is given, there is no rule that they need to see psychiatry cases or conduct weekly psychiatry clinics.
3. It should be made mandatory for Health workers to **report** mental health cases, drop out cases, and relapses in monthly meetings. Also total number of cases attended the weekly clinics should be reported to DMHPs by month end.
4. A scheme similar to DOTS (for TB) should be implemented to **ensure treatment compliance** which will minimise drop out cases and relapses.
5. As in general health care different **levels of care** should be implemented in mental health. DMHPs should be the first **referral units**, District Hospitals the second referral units, while Mental Health Centres and Medical Colleges should be made the third referral units. This requires strengthening of Psychiatry Units at District Hospitals, but ensures that only the needed cases reach Medical Colleges and Mental Hospitals.
6. It should be made mandatory for Casualty Medical Officers of Taluk and District Hospitals to undergo training in **emergency psychiatric managements**. This will limit referrals to only those requiring restraining or expert evaluation to mental hospitals.
7. **ASHA workers** should be incorporated into community mental health activities and provisions should be made to provide remuneration to the worker for bringing untreated cases.
8. **MNREGS work** is well suited to our patients as it is done in groups and under supervision. Once they get registered they can re-join work even if there is relapse and hospital admissions and so it provides a constant source of income. So it will be better if preference is given for mentally ill patients in MNREGS.

9. **Targeted intervention** programmes of mental health should be implemented through Primary care settings, which include:
    i. School Mental Health,
    ii. Geriatric Mental Health,
    iii. Substance abuse prevention,
    iv. Suicide prevention,
    v. Stress management, and
    vi. Community based rehabilitation
10. **General cadre doctor** (preferably with Public health training) should be posted in each DMHP through NRHM. The functions will be:
    i. To assist the Nodal Officer in the supervision of clinics, which are to be extended to all the PHCs, CHCs and After Care Homes under public sector in the district.
    ii. Liaison with the offices of the District Medical Officer (DMO office) and District Program Manager (DPM office) for conducting mental health training to Doctors and Health workers in health services.
    iii. To assist the Nodal Officer in implementation of specific target programmes at primary care level.
    iv. Research on the effectiveness of clinics, targeted interventions and mental health training programmes in order to make any modifications if indicated.
11. **Research**- funding should be allocated for research purpose particularly with regard to the requirement in the community and the activities being implemented therein.
12. The DMHPs presently functioning as attached units to District hospitals, Mental Hospitals or Medical Colleges often produce administrative delay and difficulty in implementing the program effectively. This has resulted in the program becoming ineffective or stagnant in many districts. It would be better if DMHPs could be made **independent units of community mental health** in each district similar to the district units of other National Programs such as the RNTCP. Overall Supervision should be by the State Nodal Officer of NMHP. This makes the movement of files faster and the implementation of the program more effective.

13. DMHP should function as a **supervisory body** for Community Mental health in each district as stated as one of the aims of NMHP, and not merely as a treatment team as it presently operates in some districts.

14. **Rehabilitation assistants** should be posted in each DMHP to coordinate the community based rehabilitation and occupational therapy units.

Proposed Model: Levels of Mental Health Care



Prepared by DMHP Tvpm 2011

Acknowledgements

DMHP Tvpm likes to express its sincere gratitude to the support & guidance provided by Dr. PK Jameela, Director of Health Services; Dr. D Raju, Secretary, State Mental Health Authority; Dr. Prabhachandran Nair, Addl. DHS; Dr. SunilKumar, Superintendent, Mental health Centre, Tvpm; Psychiatrists of MHC, Tvpm; faculty of Dept. Of Psychiarty, Medical College, Tvpm and Indian Psychiatric Society (IPS).

Also we would like to thank the Clinical Psychologists, Psychiatric Social Workers and all the supporting staff of MHC, Tvpm.

Success of community mental health activities is largely owed to the dedicated and sincere efforts from:-

Ms. Amrutha R, Clinical Psychologist, who co-ordinates the IEC programmes and also helped in preparing more than 2000 case sheets within 4 months as part of primary care integration.

Mr. Vinod MD, Psychiatric Social worker, who organizes and coordinates the Training Programmes for Doctors, Pharmacists, Nurses and Health workers, and does liaison work with various departments.

Mr.Santhosh R, Psychiatric Nurse, who helped in designing and printing of Posters and leaflets, organising street plays and also in assigning patients to weekly psychiatry clinics of concerned PHCs & CHCs.

Ms. Megha BS and Mr. Padmarajan, staff members of DMHP assist us earnestly to attain the goal.

MSW trainees and MSc Psychiatry Nursing trainees also help us in our effort.

These strategies adopted by DMHP Thiruvananthapuram have been proved to be effective in mainstreaming many of the undetected and undiagnosed mentally ill patients in the community. It has also helped in ensuring better treatment compliance as Psychiatric care and medicines become easily accessible and affordable to them. We hope that this community initiative will bring about an absolute change in the entire mental health scenario.

Dr. Kiran PS

Nodal Officer

DMHP, Tvpm