

Mental health orientation among ASHAs: A study from Karnataka State, India

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ABSTRACT

Introduction: The high mental health treatment gap in India, necessitates mental health service delivery through the primary health care system. Accredited Social Health Activists (ASHAs) as frontline community health workers are a key member of the primary health care team. The ASHAs training needs related to mental health, require to be determined in order to accordingly tailor capacity-building programs. In this context, the present study aims to examine the ASHAs mental health orientation utilizing a factorially validated Indian tool. **Methods:** In this cross-sectional study, 91 ASHAs from a taluk of Bengaluru Urban District, responded to the self-administered Orientation towards Mental Illness (OMI) scale. Data were analysed using descriptive statistics viz. frequencies, percentages, means, and standard deviations. **Results:** The ASHAs reported an overall unfavourable mental health orientation and the specific OMI factors on which unfavourable orientation was observed were Psychosocial stress, Non-restrained behaviour, Weak cognitive control, Fidgety behaviour, Bizarre behaviour, Psychosocial manipulation, and Hypo-functioning. **Conclusion:** The findings of the study suggest that capacity-building programs for ASHAs will need to first examine their orientation to mental health and collaboratively address an unfavourable orientation when present, as it would have a bearing on ASHAs mental health service delivery in the community.

Keywords: Accredited social health activist, community health workers, mental health capacity-building, mental health orientation, primary health care

Introduction

There is a huge burden of mental illness in India, with the prevalence of mental morbidity being 10.6% and 13.7% for current and lifetime respectively.^[1] An overall treatment gap of 83% reveals a high level of unmet mental health needs.^[1] To address this high mental health treatment gap it is imperative that 'task sharing' be incorporated in mental health care through the

capacity building of community health workers from the local community.^[2,3]

Accredited Social Health Activists (ASHAs) are one such cadre of female community health workers, who are selected from the local community itself for the delivery of public health services.^[4] ASHAs thus are a key member of the primary health care team of the country. The National Health Mission of India, in its recent Operational Guidelines to incorporate mental health care as part of the comprehensive primary health care at Health and Wellness Centres, has elucidated ASHAs' roles and responsibilities, such as conducting mental health awareness and anti-stigma programs, reducing myths about mental illness, and delivering basic psychosocial care.^[5]

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In this scenario, with increased focus on delivery of mental health services through the primary health care system, it is essential to examine the knowledge, attitudes and practices with regard to mental health, of community health workers such as ASHAs, who would provide these services; as it may impact the mental health services they provide, and hence needs to be addressed through tailored capacity-building programs. The present study contributes to the emerging research on training needs of community health workers as it aims to examine the ASHAs mental health orientation utilizing a factorially validated Indian tool. The term 'orientation' in the present study refers to 'a pre-attitudinal set which is predominantly knowledge or information based.'^[6]

Subjects and Methods

Design

The present study had a cross-sectional design and was part of a larger study titled the 'ASHA ViDe Study' on the development and evaluation of a training video for ASHAs on brief psychological intervention for depression. The study was approved by the Institute Ethics Committee (No. NIMHANS/DO/99th IEC/2015; Date 23/09/2015).

Sample

The sample consisted of 91 ASHAs (age range: 22-57 years) from a taluk of Bengaluru Urban District. The sampling method was purposive. ASHAs meeting the inclusion criteria of ability to read and write Kannada and providing written informed consent were recruited.

Tools

Sociodemographic information was collected on a semi-structured proforma. Cross-sectional assessment of mental health orientation was performed using the following measure.

Orientation towards Mental Illness scale (OMI)^[7]: This tool was developed in India. It comprises 67 items that assess orientation to mental illness. Each item has a 5-point Likert scale response pattern with options of: Completely disagree (score of 1), disagree, cannot say/don't know, agree, completely agree (score of 5). The tool provides scores across 13 factors. These 13 factors are grouped under four broad domains viz.: (i) Area of causation (ii) Perception of abnormality (iii) Treatment (iv) After-effects. The tool's factorial validity has been established. Scoring the 13 factors involves summing the scores of the items within each factor. For each factor, higher scores indicate a more unfavourable orientation to mental illness. The Kannada language version of the tool was used in the present study.^[6]

Procedure

The Taluk Health Officer of one of the taluks of Bengaluru Urban District was contacted to obtain permission for recruiting ASHAs for the 'ASHA ViDe Study' from the taluk. The present study was part of a larger study, the 'ASHA ViDe Study', wherein

ASHAs were trained in brief psychological intervention for depression, primarily through the medium of a training video. ASHAs who provided written informed consent were recruited for the study. The training program was held at the Taluk Hospital in a group format with approximately 12 ASHAs in each group. This was a one-day training program with self-administered, pretest and immediate posttest measurements, which was followed by self-administered posttest measurements after a month. While the pretest-posttest measurements mainly focused on the impact of the training program on ASHAs' knowledge, attitude and practices related to depression, one of the pretest measurement (i.e. the OMI scale) focused on an objective of the 'ASHA ViDe Study' which was to examine the ASHAs orientation towards mental illness. The present study focuses on analysing and reporting the findings of this latter objective, which was obtained during pretest, from a cross-sectional assessment tool i.e. the OMI scale. The data collection was conducted in August 2017.

Statistical analysis

Data were analysed using IBM SPSS Statistics, Version 27.0. Descriptive statistics viz. frequencies, percentages were computed for categorical variables, and means, standard deviations were computed for continuous variables. Figures were rounded off to the nearest two decimal places and in the case of percentages, to the nearest whole figure.

The OMI does not have cut-off scores and higher scores indicate a more unfavourable orientation.^[7] Therefore for data analysis in the present study, the mid-point score of each factor was taken as representing the average score, and the sample mean scores above or below it were considered as indicating an unfavourable or favourable orientation towards mental illness respectively, on that factor. Each factor's average score (i.e. mid-point score) was calculated by adding the maximum and minimum score for that particular factor, and dividing it by two.

Results

Out of the 100 ASHAs who participated in the study, the responses of 91 ASHAs were included in the final analysis, as 9 were incomplete data. The mean age of the ASHAs was 34 years (SD = 6.63). Majority (89%) of the ASHAs were married. Majority (85%) had an education of 10th standard or above. Their number of years of work experience as ASHAs ranged from 3 months to 10 years, with the average being 5.45 years (SD = 3.48).

The mean score of the ASHAs (n = 91) on the full OMI tool, was 203.54 (SD = 33.18, Min-Max: 121-263). This value was found to be higher than the tool's average score of 201 (Min-Max: 67-335), thus indicating an overall unfavourable orientation towards mental illness.

Table 1 shows that in the domain 'Area of causation', the ASHAs had above average scores on the factor of Psychosocial stress,

indicating the presence of unfavourable orientation on this factor. Table 2 reveals that in the domain of 'Perception of abnormality', the ASHAs had above average scores on all of its factors viz. Non-restrained behaviour, Weak cognitive control, Fidgety behaviour, and Bizarre behaviour, indicating the presence of unfavourable orientation on these factors. Table 3 indicates that in the domain of 'Treatment', the ASHAs had above-average scores on the factor of Psychosocial manipulation, indicating the presence of unfavourable orientation on this factor. Table 4 indicates that in the domain of 'After-effects', the ASHAs had above-average scores on the factor of Hypo-functioning, indicating the presence of unfavourable orientation on this factor.

Discussion

The present study revealed that the ASHAs had an overall unfavourable orientation towards mental illness. In order to discern this finding the specific factors in which the ASHAs were observed to have an unfavourable orientation will be elaborated upon.

In the domain 'Area of causation' [Table 1], the ASHAs were found to have an unfavourable orientation on the factor of Psychosocial stress. The items that comprise the factor of Psychosocial stress attribute the cause of mental illness primarily to immediate life stressors such as the death of a near relative, frustration in love, domestic unhappiness, trouble with in-laws, inability to have children. Psychosocial stressors, for example,

financial issues, family problems, as the primary cause of mental illness have been reported in other studies that have examined ASHAs perceptions on depression,^[8] and mental illness^[9] through focus group discussions.

In the domain of 'Perception of abnormality' [Table 2], the ASHAs were found to have an unfavourable orientation in all of the four factors viz. Non-restrained behaviour, Weak cognitive control, Fidgety behaviour, and Bizarre behaviour. The content of the items in these factors attributes negative characteristics to persons with mental illness. For example, items state that persons with mental illness are not at all trustworthy (Factor: Non-restrained behaviour), are incapable of taking even minor decisions (Factor: Weak cognitive control), cannot complete any activity they have undertaken (Factor: Fidgety behaviour), and speak in a way that cannot be understood (Factor: Bizarre behaviour). Similar findings were reported from a study in Gujarat State, India, wherein ASHAs and Anganwadi workers were found to perceive persons with mental illness to be 'dangerous, unpredictable, hard to talk with, and having a lower IQ'.^[10] In a similar vein, community health workers in Karnataka State, India, were reported to perceive depression and psychosis as indicating personal weakness, and persons with these illnesses as being erratic and dangerous.^[11]

The ASHAs were observed to have an unfavourable orientation on the factor of Psychosocial manipulation in the domain of 'Treatment' [Table 3]. The items in this factor imply that persons

Table 1: Area of causation

Factor No.	Factor (Min-Max score)	Factor average (midpoint) score	Min-Max score (n=91)	M	SD
1	Folk belief (12-60)	36	12-48	28.31	8.53
2	Psychosocial stress (13-65)	39	21-62	43.73	8.18
3	Organic causation (4-20)	12	6-16	11.81	2.07

Table 2: Perception of abnormality

Factor No.	Factor (Min-Max score)	Factor average (midpoint) score	Min-Max score (n=91)	M	SD
4	Non-restrained behaviour (6-30)	18	9-30	18.69	4.47
5	Weak cognitive control (3-15)	9	3-15	9.82	2.47
6	Fidgety behaviour (2-10)	6	2-10	6.75	1.98
7	Bizarre behaviour (3-15)	9	5-15	10.22	2.05

Table 3: Treatment

Factor No.	Factor (Min-Max score)	Factor average (midpoint) score	Min-Max score (n=91)	M	SD
8	Folk therapy (5-25)	15	5-22	14.62	3.33
9	Psychosocial manipulation (3-15)	9	3-15	11.04	2.27
10	Physical methods of treatment (2-10)	6	2-10	5.31	2.23

Table 4: After-effects

Factor No.	Factor (Min-Max score)	Factor average (midpoint) score	Min-Max score (n=91)	M	SD
11	Hopelessness (6-30)	18	7-26	17.74	4.07
12	Hypo-functioning (4-20)	12	4-20	13.62	2.99
13	Rejection of the mentally ill (4-20)	12	4-20	11.89	3.40

with mental illness can be cured by recommending hobbies to them, that to treat them the most important thing is to teach them how to control their emotions, and that if help is given to get their domestic problems solved they usually recover. These thus focus on the manipulation of psychological and social factors for treating mental illness. The finding in this factor is in line with the ASHAs emphasis on psychosocial stress [Table 1] as a cause for mental illness. Similar findings were reported in a study of community health workers, in Karnataka State, India, where it was found that they strongly endorsed psychosocial interventions such as physical activity and distraction for recovery from mental illness.^[11]

In the domain of 'After-effects' [Table 4], the ASHAs were found to have an unfavourable orientation on the factor of Hypo-functioning. The content of the items attributes reduced capacity in various areas for those who have had mental illness. For e.g. items indicate that persons who have had mental illness will be sexually weak, will have difficulty cooperating with others, would lose a lot of weight. In accordance with these findings, self-help group members in a rural part of Karnataka State, India, were found to have the opinion that persons who have had mental illness will not be able to function as earlier.^[12]

It is to be noted that the ASHAs in the present study have not endorsed the culture-specific factors of Folk belief [Table 1] and Folk therapy [Table 3] as reflected by their below-average scores on both these factors. This could possibly be due to them already being trained in the delivery of public health services and consequently assimilating the biomedical model.

As per the recent Operational Guidelines of the National Health Mission of India, ASHAs' roles and responsibilities, would include conducting mental health awareness and anti-stigma programs, addressing myths and misconceptions about mental illness in the community, delivering basic psychosocial care, and providing follow-up care in the community.^[5] It is apparent that for the ASHAs to adequately perform their roles and responsibilities, the capacity-building programs will need to first address their own orientation toward mental health.

The findings of our study indicate that capacity building programs for ASHAs would need to focus on myths and misconceptions about mental illness, a sensitive engagement with mental illness related cultural beliefs and practices of the community, and with regard to the broad categories of mental and substance use disorders – an integrated biopsychosocial understanding of causation, key signs and symptoms, effects on various domains of functioning, biopsychosocial treatment options, and prognosis.

The limitations of the study are with regard to the generalizability of findings due to its non-probability purposive sampling. The implications of the study are that capacity-building programs for ASHAs will need to first examine their orientation to mental health and collaboratively address an unfavourable orientation

when present, as it would have a bearing on ASHAs mental health care practices in the community. Further research could focus on the kind of teaching methodology that could be utilized to adequately address unfavourable orientation towards mental health in community health workers.

Conclusion

This study indicates that ASHAs have an overall unfavourable mental health orientation. The specific factors of the OMI tool, on which their unfavourable orientation towards mental illness was observed were viz., Psychosocial stress, Non-restrained behaviour, weak cognitive control, Fidgety behaviour, Bizarre behaviour, Psychosocial manipulation, and Hypo-functioning. Given ASHAs key role as frontline health workers in the community, and the present impetus of the National Health Mission to include them in mental health service delivery; it is imperative that suitable capacity-building methods be employed to engender in them, a favourable orientation towards mental health.

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Conflicts of interest

There are no conflicts of interest.

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