REVIEW ARTICLE

Decentralisation of Mental Health Services under DMHP

B K WARAICH, LOK RAJ, B S CHAVAN, R BADHAN & SN PANDA

ABSTRACT

The Bellary model of district mental health programme(DMHP) has been adopted by the government of India under the national mental health programme with the primary aim of making mental health care accessible to all by setting up psychiatric services in peripheral areas, training primary health care personnel and involving the community in promotion of mental health care. The DMHP was set up in Chandigarh in a 50 bedded Civil Hospital in a suburb of Chandigarh. This study aims to present the sociodemographic and clinical data of all cases seen in the first six months and discusses the need of decentralisation of mental health services. A total of 527 patients were seen in the first six months. 52% of the males presented with substance use disorders while a majority of the females (40%) presented with mood disorders. In patients with illness of duration more than one year, upto 51.9% had no past psychiatric treatment and 27.6% were on irregular treatment. Reasons for this are discussed. In conclusion, it was seen that decentralisation was a felt need of the community and required not only in rural but urban areas as well.

Key words: District mental health programme, decentralisation, psychiatric services, mental health care.

INTRODUCTION

Various epidemiological surveys carried out in India have found that at any given time, about 2-3% of the population suffers from seriously incapacitating mental disorders or epilepsy (Dube, 1970; Sethi 1972; Verghese 1973). Ganguli(2000) in a metaanalysis of epidemiological studies on psychiatric morbidity in India arrived at a national prevalence rate of 73/1000 population. However, most patients do not have easy access to mental health care facilities which are sorely lacking. It is estimated that there is one psychiatric bed per 32,500 population and only about 5 mental health professionals per million population.

Recognising the difficulty of making mental health care accessible to all, various models have been suggested all over the world. In Australia, many models have been proposed for delivering mental health care to the community especially in rural areas. These include "Shared Care" between general practitioners and psychiatrists and other models in which the mental health worker consulted from the GP office (Llewellyn Jones 1997). In South Africa, primary health care nurses offer psychiatric services or primary health care clinics are visited by psychiatric teams usually consisting of psychiatric nurses (Sokhela, 1999).

It has been suggested the basic mental health care i.e. detection and management of all cases with psychosis and epilepsy should be decentralised and integrated with general health care services (Carstairs, 1973; WHO 1975; Giel & Harding 1976 and Carstairs & Kapoor 1976). In India, a new direction was given to mental health care with the formulation of the National Mental Health Programme in 1982.

The WHO sponsored study "Strategies for extending mental health care" attempted to develop and evaluate low cost methods of mental health care (including training methods) in developing countries (Clement et al 1980). The Raipur Rani project

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The primary emphasis in DMHP is on making mental health care accessible to all by setting up psychiatric services in peripheral areas, training primary health care personnel and involving the community in promotion of mental health care. The programme has been envisaged mostly for rural areas wherein psychiatric facilities are not available at a close distance.

AIMS

1. To study the sociodemographic and clinical profiles of all cases seen in the first six months.
2. To discuss the effectiveness of various health education strategies.
3. To discuss justification of decentralisation and providing mental health services in a primary health care setting.

MATERIALS AND METHODS

The District Mental Health Programme was started in Mani Majra, a suburb of Chandigarh in a 50 bedded Civil Hospital catering to around 1,00,000 local population. Outpatient services commenced in November 2001and inpatient services started in January 2002. This is a retrospective study. All the patients seen in the OPD of DMHP at Civil Hospital, Mani Majra during the first six months ie November 2001 to April 2002 were included in the study. Sociodemographic and clinical details were collected from case records. Diagnoses were made according to ICD-10 criteria by the psychiatrist posted under the DMHP.

In order to create awareness in the community, multimodal awareness techniques were used including newspaper articles, pamphlet distribution, loudspeaker announcement and cable TV. Regular follow-up was ensured through field visits and telephones.

RESULTS

In the first six months, 336 (63%) males and 191 (36.2%) females utilised the psychiatric facilities provided under DMHP.

Table I shows that males were significantly younger than the females. A significant number of the females were illiterate. 62.8% of the females were housewives while a majority of the males (46.2%) were skilled/ semiskilled workers. As compared to the males, significantly more females were married.

Majority (89% males and 91.6% females) were from an urban background belonging to nuclear families.

Fifty two percent of the males presented with substance use disorders. On the whole, 6.8% were diagnosed as suffering from Schizophrenia, schizotypal and delusional disorders.

Nearly half (40.3%) of the females in our study suffered from mood disorders and 29.7% from anxiety and somatoform disorders as compared to 8.3% and 9.8% in males. 5.76% of the females suffered from epilepsy while only 0.60 % of the males presented with epilepsy.

The duration of illness on first contact was more than one year in upto 60% of the patients. 30.56% of the schizophrenics, 33.64% patients with mood disorders, 40.2% of patients with anxiety, somatoform and stress related disorders and 61.2% of epileptic patients had illness duration of more than one year on first contact.

In patients with illness of more than one year, only 20.48% were on regular medication prior to their visit to DMHP while 28% were taking treatment irregularly and upto 51.9% had no psychiatric treatment at all in the past.

Reasons for not seeking treatment included lack of recognition of psychiatric illness , going to faith healers, lack of awareness about mental health services, going to general practitioners with somatic problems, distance and treatment cost. Inspite of there being three big government hospitals in the city, 37.6% of the people reported not taking treatment because of the distance from the hospital and the cost of treatment. Drop out rate during the study period was 38% after the first visit.

TABLE I : Socio-demographic variables

	Male (n=336)	Female(n=191)	
Variables	**No. (%)**	**No. (%)**	
Age			
0-19	53(15.8)	34(17.8)	
20-29	95(28.3)	33(17.3)	χ^2= 74.
30-39	102(30.4)	52(27.2)	d.f.=4
40-49	56(16.6)	39(20.4)	p<0.01
>50	30(8.9)	93(17.2)	
Education			
Illiterate	67(19.9)	67(35.1)	
Primary	74(22.9)	40(21.0)	χ^2= 60.8
Middle	61(18.2)	24(12.6)	d.f.=4
Intermediate	91(27.1)	36(18.8)	p<0.01
Graduate/Postgraduate	43(12.8)	24(12.5)	
Occupation			
Skilled	42(12.3)	13(6.8)	
Unskilled	56(16.6)	15(7.8)	χ^2=305.54
Semiskilled	114(33.9)	05(2.6)	d.f.=8
Student	25(7.4)	23(12.0)	p<0.01
Housewife	–	120(62.8)	
Professional	07(12.1)	02(1.5)	
Business	23(6.8)	01(0.5)	
Unemployed	43(12.8)	09(4.7)	
Other	26(7.7)	03(1.57)	

DISCUSSION

Approximately half (52%) of the males presented with substance use disorders.

TABLE II : Sociodemographic Variables (contd)

Marital Status			
Married	227(67.4)	149(78.0)	χ^2=12.5
Single	107(31.8)	37(19.4)	d.f.=2
Other	02(0.6)	05(2.6)	p<0.01
Locality			
Urban	300(89.3)	175(91.6)	χ^2=0.748
Rural	36(10.7)	16(8.4)	d.f.=1 N.S.
Family			
Nuclear	228(67.8)	145(75.9)	χ^2=3.8
Joint	108(32.1)	46(24.1)	d.f.=1 N.S.
Income			
<1500	158(47.0)	85(47.7)	χ^2= 0.637
1500-3000	64(19.0)	33(17.3)	d.f.=3 N.S.
5000-	49(14.6)	26(13.6)	
>15000	03(1.07)	03(1.6)	

TABLE III : Diagnostic Break up of the sample

Diagnosis	Male (n=336) N(%)	Female(n=191) N(%)	
F00-10	03(0.89)	03(1.57)	χ^2=189.85
F10-19	175(52.0)	04(2.09)	d.f.=12
F20-29	23(6.8)	13(6.8)	p<0.01
F30-39	28(8.3)	77(40.3)	
F40-49	33(9.8)	49(29.7)	
F50-59	08(2.38)	02(1.04)	
F60-69	02(0.59)	01(0.52)	
F70-79	24(7.14)	08(4.19)	
F80-89	03(0.89)	03(1.57)	
F90-99	09(2.67)	05(2.61)	
Deferred	13(3.86)	05(2.6)	
Epilepsy	02(0.60)	11(5.76)	
Others	13(3.76)	10(5.80)	

TABLE IV: Duration of Illness (Excluding substance abuse and others)

	0-3 Months No. (%)	3-6 Months No.(%)	6-12 Months No. (%)	> 1 year No. (%)
1 visit				
N=117(38.1%)	36(30.7)	19(16.1)	10(8.5)	52(44.4)
	> 1 visit			
N=194(61.9%)	73(23.4)	54(17.4)	26(8.4)	158(50.8)

Table V : Prior Psychiatric Consultation (Patients With Illness >1 year)

N=210	N(%)
On regular medication	43(20.48%)
Under irregular treatment	58(27.62%)
No prior treatment	109(51.9%)

This high proportion may be due to the presence of a motor vehicle repair market in the vicinity where the incidence of opioid and alcohol abuse is high. 6.8% were diagnosed as suffering from Schizophrenia, schizotypal and delusional disorders. 40.3% of the females in our study suffered from mood disorders and 29.7% from anxiety and somatoform disorders as compared to 8.3% and 9.8% in males. 5.76% of the females suffered from epilepsy while only 0.60 % of the males presented with epilepsy. A large number of women were referred from other clinics in our study and it has been seen that in general practice sex ratio of depressed patients rises to 3:1 or even 4:1 (Porter, 1970; Dunn & Skuse,1981; Sireling,1985; Blacker and Clare,1987).

In Sakalwara, Karnataka from 1977 to 1980, a total of 376 patients were seen and of these 13.76% (51/376) were schizophrenics, 71% (268/376) were epileptics and 7.7% had acute Psychosis and 7.18% manic depressive psychosis. The Raipur Rani study reported schizophrenia in 11%, MDP in 18%, epilepsy in 13.8%, anxiety neuroses in 22% and depressive neuroses in 21% (Wig & Murthy, 1980).

In our study, 52.7% of the schizophrenics, 33.64% patients with mood disorders, 40.2% of patients with anxiety, somatoform and stress related disorders and 61.2% of epileptic patients had illness of duration more than one year on first contact. The Raipur Rani study found that 2.6% schizophrenics, 7.8% manic depressive psychosis patients, 13.25% epileptics and 4.9% neurosis patients had illness of more than 6 months duration at first contact. In the Sakalwara project 96% of the schizophrenics had illness of duration more than two years before detection.

Slighdy more than a half 51.9% of the patients with illness of duration more than one year had had no prior psychiatric treatment. Of these, 22% of all patients with schizophrenia, schizotypal and related disorders had had no previous treatment at all and 36.15 were taking irregular treatment. However upto 85% of the epileptics were on regular treatment. In the Sakalwara experience, upto 46.7% of epileptics had not undergone any prior treatment and 23% schizophrenics had no history of prior

TABLE VI : Reasons for not taking Psychiatric treatment earlier (n=109)

Reasons for not taking Psychiatric Treatment earlier (in pts with illness more than one year)	No(%)
1. Lack of recognition of psychiatric illness by family members.	7 (6.42%)
2. Went to other specialities (Physicians, Orthopaedician etc) with physical complaints predominating.	28 (25.69%)
3. Lack of knowledge about mental health services	12 (11.01%)
4. Did not seek treatment because of distance and cost involved.	41 (37.61%)
5. Others: Stigma regarding psychiatric illness, misconceptions such as psychiatric treatment only being for "mad" people	21 (19.27%)

psychiatric treatment. One would expect that with time (Sakalwara findings are from 1977 to 1980) and in an urban area, treatment seeking would have improved but while most of the epileptics were taking prior treatment, a significant number of the schizophrenics were on either no treatment or were on irregular or inadequate treatment.

The initial survey carried out in the Raipur Rani study to identify severe mental disorders found that nearly 2% of the local population had major mental disorders and of these half had not received any psychiatric treatment. Reasons given were fears of going to distant big treatment centres, expenditure on drugs, loss of earnings and transport (Wig 1981). In DMHP, Chandigarh, a large number of patients (57.5%) sought psychiatric treatment for the first time. Reasons given for not seeking psychiatric treatment earlier included lack of recognition of psychiatric illness and awareness about mental health services, distance and fear of cost involved, seeking treatment from other specialities for predominant physical complaints etc.

A significant number (62%) continued follow up after the first visit. In General Psychiatric Clinics, 20-57% of the patients failed to return after the 1st visit and 31-56% attended not more than four times (Dodd, 1971). More than one third of the mentally ill persons do not keep up the psychiatric appointment after brief evaluation and another third drop out after detailed initial evaluation leaving only a third to utilise the presently limited existing psychiatric facilities (Srinivas Murthy et al, 1974, 1977). Nagpal (1970) found that the distance to be covered between the patient's house and the treatment centre played a decisive role in the follow up of patients with tuberculosis. The zone of effective influence does not exceed four square road miles around the treatment centre. This could be a reason for the high retention rate of DMHP for patients who had either dropped out of other treatment centres or had never sought psychiatric treatment earlier. Other cogent reasons may be the availability of free medicines and a method of active follow up of patients who drop out of treatment.

A large number of female patients in our study suffered from mood, anxiety and somatoform disorders. More females were likely to be referred (42% of the females were referred as compared to 13.3% of the males) from other clinics. High referral from other clinics supports the finding that 15-20% of patients attending primary care settings suffer from psychological symptoms. A number of studies have found that Indians with depression prefer the somatic language (Sethi, 1978; Ponnudurai, 1981; Kulhara and Varma, 1985; Mahatme, 1989; Gada, 1982; Rao, 1989 and Chadda 1993). Teja and Narang (1970) suggested that the high rate of hypochondriasis seen in Indian depressives reflected illness behaviour. Again some of these patients may have been presenting to other outpatient clinics for lack of recourse to psychiatric facilities in the vicinity.

Thus, as is evident, seeking of psychiatric care is not only lacking in rural areas but people living in urban and suburban areas as well. A strong case is there for decentralization of psychiatric services and upgradation of mental health facilities in generalhealth care settings including training of general duty medical officers and general practitioners as well. The DMHP makes some attempt in this direction by imparting training to primary health workers. However scope of refresher courses as well as training of new entrants at the Primary health care level needs to be incorporated. Decentralisation of psychiatric services will also further the cause of psychiatry by destigmatising seeking of mental health care which is a major holding back factor for psychiatric patients in developing countries. As seen in this study, patients who had not taken psychiatric treatment earlier for various reasons came for regular follow-up to this center due to it's proximity, availability of medicine and perhaps a gradual acceptance of psychiatric treatment once it is available at their doorstep.

As the programme continues, the pattern of help seeking may diversify as the awareness of the services available spreads and publicity of psychiatric disorders by field visits, newspaper articles, cable television, distribution of pamphlets etc dispels long held myths among the local populace. Catching and treating psychiatric disorders early would then become possible.

CONCLUSIONS

1. Even in a small city with adequate psychiatric facilities, a large number of patients are not seeking help. We need to reach them through active community outreach programmes under the DMHP.
2. Patients come regularly for treatment once they become aware of the regular availability of psychiatric services in their close proximity.
3. Decentralisation of psychiatric services and integration with general health care is the felt need of the country and is required not only in rural areas but semi-urban areas and suburbs of cities.

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