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Mental Health Care by Primary Health Care Personal : A Follow-up Evaluation

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Abstract

National Mental Health Programme aims to provide mental health care through primary health care personnel. This type of care becomes accessible and acceptable to people. NIMHANS has been organising short term training programmes for PHC personnel since 1982. Follow up field visits were carried our in 1983 and in 1985 to review the mental health care activities of the trained personnel. At follow up health care work was not considered to be an additional burden and trained personnel were providing care to the mentally ill. A few constraints and difficulties regarding regular drug supply, records, monitoring and administrative support were identified.

Key words -
National Mental Health Programme,
Community mental health,
Primary health centers

The National Mental Health Programme (NMHP) focusses on the integration of mental health care with the existing primary health care services. The aim is to provide task oriented training to the medical officers and field level multipurpose workers and supervisors to carry out simple tasks of identification, referral, followup and first level management. In the country, experiment to train the health personnel have been undertaken to a number of centres [1]. The focus so far has been to identify a catchment area, train all the personnel and monitor their work by active followup by the research team. The results have shown that mental health care is possible to be provided at the primary health care (PHC) level and by the PHC personnel. However, professional and planners continue to ask the questions namely

(i) is it possible for the PHC personnel to take up mental health care?
(ii) will this work be not a burden?
(iii) is it effective within the existing PHC system?

The often unvoiced opinion is that 'it is alright as long as it is done by research centres but if it is part of the regular PHC

system it may not work'. The present paper describes the experience of NIMHANS which provides partial answers to the above doubts.

NIMHANS, Bangalore through its Community Mental Health Unit has been working on the problem of mental health care as part of PHC system since 1976. The initial years were focused on the development of training modules [2]. Following these in April 1982, regular monthly training programmes for PHC personnel was taken up at the Rural Mental Health Training Center, Sakalawara. These training programmes are of one week duration for non-physician health workers (JHA, SHA's) and of two weeks duration for the medical officers. Manuals of training have been developed as well as audio-visual aids for training [3], [4]. By the end of November 1985, more than 100 doctors and 300 health workers have participated in the training programmes. They are form centres of two Divisions of Karnataka namely Gulbaraga (about 300-700 km from Bangalore) and Mysore.

A followup visit was carried out by the authors to understand their functioning following the training.

Methodology

The followup field visits were carried out in the Gulbarga Division in April 1983 (one year often initiation of training in Gulbarga Division) and in December 1985 in Mysore Division (about 12 to 18 months after starting training for staff of this division).

The team members who are regularly involved in the training of these personnel, visited the above districts and interviewed a sample of trained health workers and doctors, using a 'guided interview schedule' specially constructed for the present evaluation. The team also randomly examined few patients under management of these trained personnel and reviewed records maintained by the health personnel. Discussions with the district head quarters and divisional head quarters and health authorities were also held. The guided interview attempted to assess

(i) the work done by (identification, management and referral of cases, health education),
(ii) the kind of problems faced by them in implementing the mental health programme (emphasis to availability and distribution of drugs),
(iii) their impressions about the training itself and
(iv) their remedial suggestions for better implementation of the programme.

The duration of the field visit was four days in April 1983 and three days in December 1985. During this evaluation a total of 30 medical facilities were visited. These included primary health centers, single doctor centers like the primary health units and the general hospitals. During the followup visits the district health authorities and divisional level officers also interacted with the staff and reviewed the programme. From the experience it has been possible to have an understanding of the problems and prospects for mental health care by primary health care personnel.

Observations

Following the training, the doctors and health workers in the centres visited had undertaken mental health care activities to varying extent. Some of the centers and personnel had done excellent work while others had done very limited amount of work.

While the work done in some of the PHC's were below our expectation there were several other PHC'S where varying types of mental health care activities were going on quite satisfactorily, in spite of many

of the difficulties. For example, in one PHC, the medical officer had kept a personal record of all the cases under his management and followup. He could tell the detailed histories of most of his patients without looking into the record. He could get few patients to the PHC form the local village in a very short time. While he was very confident in managing all kinds of epilepsies, he had doubts in the diagnosis and appropriate drug regimes for some of the psychiatric cases. He used to regularly call his psychiatric patients on appointments and spend longer time with them.

In another PHC the trained LMO had about 25 neuropsychiatric cases under her regular management. She had referred few cases to the medical college psychiatrist with detailed notes to confirm her diagnosis. We could verify some of her diagnosis and management by ourselves examining few of these cases. As the drugs were not available at the PHC, this doctor has successfully persuaded many of her patients to buy drugs from outside (fortunately Gulbarga is not very far away from this village) and had managed to get some supply of phenobarbitone from the district hospital for poor epileptics.

In some of the PHCs the trained doctors had organized mental health camps so that large scale case identification and mental health education was attempted. They felt that such efforts will benefit a large number of sick people and the regular followup of these patients could be taken up by the PHCs. Some of the health workers had put in efforts to make simple charts on their own for display at the PHCs and also systematically survey their population for cases. In some PHCs, the health workers were following up the patients and delivering the drugs (in one PHC although we could not interview the trained LMO there, we were able to find out that she had entrusted the task of followup and drug distribution with the health worker, in her absence).

In some PHCs where medical officers had not put in major efforts at identification and management of cases, the usual reasons were, 'there are no drugs here', 'our health workers did not bring any cases' 'there was no pressure from the DHO', 'we were not asked to send returns regarding the performance of this programme', 'the pressure from authorities is so heavily on programmes like malaria and family planning, so much so that the other programmes get neglected', 'people are still not convinced about medical treatment for these illness, they don't listen to us, they still go to temples' etc. Health workers who had done limited amount of work, too complained more or less similarly, regarding the absence of any pressure from authorities for implementation of this programme, the unwillingness of people to come to the PHC for their illnesses and their (health workers) inability to successfully launch health education efforts due to lack of materials(like charts etc.) and support.

There appeared to be problems because of the small number of health workers trained from each PHC. Population coverage wise, they accounted only for a small percentage of the total population of the PHC. In some PHCs the trained doctors talked to all the health workers to identify, refer and followup cases and impart mental health education. Many of the cases presently being managed by the doctors, were identified by themselves from their daily clinics.

None of the health care personnel interviewed felt that their load had increased because of this programme, while many feared that as the number of cases identified and managed increases, the work load too might increase. All of them said that the training programme at NIMHANS had improved their knowledge and attitude towards mental illness and many of them particularly doctors wanted the training to be of a longer duration - of even a month.

Non availability of drugs, and inability to convince people about medical treatment for their illnesses were reported by several people as hindrances to the implementation of the programme. The following were some of the frequently voiced suggestions of the functioning of the programme.

(1) Train more number of health workers
(2) Provide adequate regular drugs
(3) Make mental health education materials like posters etc. freely available at the PHCs for health workers
(4) Introduce a reporting system and regular pressure from DHO
(5) Make more frequent visits by NIMHANS team
(6) Hold mental health camps yearly
(7) Hold refresher training for the trained personnel.

Interestingly, one health worker pleaded for an 'additional risk allowance' for doing this work as he claimed that 'the nature of this work involved certain amount of risk while dealing with the patients'.

The district health authorities were strongly of the opinion that regular reporting system should be introduced for the mental health programme and it should be discussed at monthly meetings both at the PHC level as well as district level. They envisaged continuous and effective role of NIMHANS to implement the programme by monitoring. In general, they perceived 'mental health care' as a relevant programme similar to other health programmes and their ideas on implementation of this programme were very similar to the other programmes like tuberculosis and leprosy.

Of the various activities envisaged for the different levels of health personnel, the component of identification by the health workers and treatment by the doctors are more satisfactory. Areas like regular follow up, public education and community participation have received least importance. As yet except in the general hospital settings inpatient treatment of mentally ill has not been undertaken.

In the two followup visits the most important limitation has been the failure of the PHC personnel to keep a record of their work for review and reporting. From our observations, besides the provision of drugs the introduction of a system of reporting and monitoring is most urgently needed.

Discussion

The overall results of this evaluation exercise has been quite rewarding. The effect of the 3 years long training for batches of PHC personnel has been in general positive and useful. For the first time, in the country the efforts at delivery of mental health services, through the primary health centres have moved from a 'micro level project' status to a 'macro' level 'programme'. It is no more a pilot project involving one or two PHC s and a few PHC doctors and health workers but a major programme involving two health divisions (i.e. 9 district and many PHCs and personnel) and the health services department of a state in the country. This is certainly a major step forward in the delivery of mental health services and planning of a 'national mental health plan'. The evaluation exercise was undertaken with the full co-operation of a Divisional Joint Directors of Health Services of the Government of Karnataka, and the respective district health officers and ADHOs. The training programme has sensitized not only the trained workers but also the health administrators to the problems of mentally ill in peripheral areas.

The more specific effects of the training has not been as satisfactory, as the number of cases identified and on regular management is not very large. But this evaluation points to several simple and remediable flaws in the programme as it exists today. The programme, to become more successful, should involve all hierarchical levels of the health care machinery and it should not be broadly

dissimilar from other presently operating programmes. Hence inputs by way of training or orientation should include not only PHC medical officers and health workers but Directors, DHOs, ADHOs, PHU-MOS, Health supervisors and CHVs. The programme cannot be expected to function in an ideal situation of everybody taking responsibility and doing their tasks. The work of various categories of personnel should be recorded in a simple and recording and reporting system and regularly, checked at each level like PHC, District, Division etc.

The health workers should be supported by way of additional input for mental health education - by providing posters etc. Better education can improve the case detection and regular followup. These skills will have to be imparted at the time of training to a greater extent. The doctors should have more of practical training and the aspects of diagnosis and management of psychotics will have to be emphasised during the training as many doctors expressed a lack of adequate confidence in this area. Organizationally, regular supply of necessary drugs at the PHCs and supervision of the work of the trained staff will have to be streamlined. The 'Newsletter from NIMHANS' has gone a long way in maintaining a useful contact between the trainers and the trained.

The progress of the NMHP has been presented elsewhere [5]. Of the many developments, the most important one is to consider coverage of one district for mental health care. Such an approach will allow for all personnel and components of an administrative unit to be involved. The initial experience of Bellary District programme demonstrates the feasibility of training personnel at a district level, having a district team for monitoring and use of simple record system for reporting on a regular basis. The current report highlights the importance and utility of followup visits on a regular basis to understand the practical problems in implementing the programme in the peripheral health facilities.

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