KERALA STATE MENTAL HEALTH AUTHORITY

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# NEWS LETTER

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## Door step delivery of Mental Health Care

The latter half of 20th century witnessed a revolution in the management of the mentally ill. As the continuation of the deinstitutionalization programme, rehabilitation gained position in the first line management of psychiatric disorders. Bennet (1978) defined rehabilitation as the "process of helping a physically or psychiatrically disabled person to make the best use of his residual abilities in order to function at an optional level in as normal a social context as possible". Schizophrenia is diagnosed in 60-80 percent of the long stay patient population (Nikapota-1981). On the contrary when a psychiatric disorder is sufficiently chronic with prolonged hospitalization patient show less distinct psychopathologies and developed what Barton called institutional neurosis. People were sent back to their home villages because there were not enough place in hospitals. Ultimately they become drop out in the treatment programmes. So treating the patient at their homes is a novel idea emerging across the world.

Surveys show around 15 per thousand is the prevalence rate of major mental illness in Kerala. This roughly is the rate all over the world. Schizophrenia, mood disorder, profound mental retardation, and severe personality problems constitute an overwhelming

## *From Editors desk*

Dear Readers,

This newsletter, the official publication of Kerala State Mental Health Authority, is published to bring to the notice of the readers the latest trends and developments in the field of mental health. “Mental Health in Primary Care: Enhancing Treatment And Promoting Mental Health’ is the theme for World Mental Health Day 2009. This edition includes a report on the observation of the day to highlight the importance of the theme. This news letter can be published successfully only with your valuable suggestions and contributions. Please contribute articles to be published in this news letter .Articles may be sent to the Secretary, Kerala State Mental Health Authority, Red Cross Road, Thiruvananthapuram - 35

Sincerely,
Dr.D.Raju
Secretary

majority of these cases, For Kerala’s plus three Crores population the total number is an astounding 450,000 ! With the presence of over four hundred qualified psychiatrists spread to the whole of the state it is reasonable to presume that at least one third of these persons achieve satisfactory improvement and are able to have a dignified life in the society. But what about the remaining 300,000? Among them there are many severely ill persons. Their need for care, support and treatment is an issue no civilized society could ignore. And this is a huge challenge facing present day psychiatry in Kerala. (James T Antony 2003).Protection laws are increasing but it doesn’t protect the helpless poor mentally ill.

The Erwady fire was a Florence lamp for mental health care of Indian Society. The asylum fire at Ramanathapuram district of Tamil Nadu, was an eye opener for the Indian burocracy and judiciary. A commendable initiative has been taken by the apex court, to put a beginning to the new chapter on mental health care in our country. Most of the patients landed up in this asylum are those who have been abandoned by their family. The pernicious philosophy of building new mental hospitals is a waste of resources which can be better utilized to create therapeutic rational as well as more cost effective community based mental health care services.

According to the world health report 2001 “The failures of asylums are evidenced by repeated cases of ill treatment to patients, geographical and professional isolation of the institutions and their staff, weak reporting and accounting procedures, bad management, ineffective administration, poorly targeted financial resources, lack of staff training , inadequate inspections and quality assurance procedures . Also the living conditions in psychiatric hospitals through out the world are poor, leading to human rights violations and chronicity. In terms of absolute standards, it

could be argued that conditions in hospitals in developed countries are better than living standards in many developing countries. However in terms of relative standards in a particular country it is fair to say that conditions in all psychiatric hospitals are poor. Some examples have been documented of human rights abuse in psychiatric hospitals.

In contrast, community care is about the employment of people with mental and behavioural disorders. In practice community care implies development of a wide range of services with in local settings. Care in the community as an approach means-services which are close to home, including general hospital care for acute admissions, and long term residential facilities in the community. This includes-

- Interventions related to disabilities as well as symptoms
- Treatment and care specific to the diagnosis and needs of each individual
- A wide range of services which address the needs of people with mental and Behavioural disorders.
- Services, which are, coordinated between mental health professionals and community agencies.
- Ambulatory rather than static services, including those which can offer home treatment.
- Partnership with care and meeting their needs.
- Legislation to support the above aspects of care.
- Establishment and maintenance of community support system for non-institutionalized patients.

Reflecting the paradigm shift from hospital to community, far reaching policy changes have been introduced in a number of countries. "For example law 180, enacted in Italy in 1978, mental health act in India 1987, etc.

**National Human Rights Commission Report 1999 (S.M. Chennaabosanna)**

The committee visited 32 hospitals in India, 19 had been constructed in 1800. Out of these, 14 (43%) still retain a prison like structure and ambience and 21 (65%) had high walls. Terms such as 'endosures', 'warders' and 'overseers' are still common parlance, and prison practices like roll call and lining up for handover still exist. Exclusively closed wards existed in 19 hospitals (59%). Building maintenance was extremely unsatisfactory in 26 (81%) and leaking roofs, eroded floors, overflowing toilets and broken doors were a common sight. The huge campus were neglected in more than half of the hospitals visited, with poor lighting, and frequent reports of robbery and assault. Problems of water supply (70%) and electricity (73%) were common. Over crowding was noticed in many of the large strength (more than 500), medium strength (250-500) hospitals to the tune of 200% overcrowding in a hospital in Kerala. The committee recommends that it is time for the Government mental health professionals and the voluntary sector to proactively take up the issues relating to the care and rights of mentally ill. It is crucial they all work together for quality assurance in mental health care.

No politicians ever won votes by operating a residence for the ,mentally ill, no matter how useful or beautiful it was. Yet, by focusing on the appropriate care of your mentally ill population you enhance the standard of living of your country. You may not win votes now by telling the true story may be able to win them in future. The provisions of good medical care for those with mental illness, in general hospitals and clinics is as important as providing such care for patients

with heart disease, cancer, or any other major illness.

By ignoring mental intuitions you are ignoring mental illness itself. With everyday that goes by, more people develop brain disorders like schizophrenia and many of them will have difficult symptoms. They will not able to function well in society unless they have appropriate treatment and a high level support not only from their families but from Government, non Governmental organizations and professional bodies like us.

The private psychiatry is emerging as an important sector in mental health care .Only 15% of them are located in four metros, 67% are working in cities and towns which are not even state capitals (A.K. Kala) In Kerala most of the taluk has got qualified psychiatrists.

**Stigma**

Stigma is a complex phenomenon. It is expressed both subtly and overtly, the bearer of stigma experience it in a multiple way depending up on the nature of the stigmatizing condition and the social reality of the individual.

Stigmatized people have low social status, experience shrinkage in their social supports system; find reduction in their chances and opportunities in life. Experience low self perception that leads to self-depreciation experience, isolation deprived of marriage and parenthood. Stigma act like a "branding and once it is done person becomes labeled, it becomes a part of his identity, there by past of self that generates behavior. (Scoffs 1966)

**An Action Plan for Next One Year**

Database: Identify the areas of concern and prepare detail study reports.

Generally these information constitute part of the preparatory phase of any scientific studies and data base for policy makers.

**Recovery mode l :**

Treating the patients at their homes, planning a programme to organize regular clinics in rural area with help of local bodies. Patients may be evaluated properly and distribute free drugs for them. Help them to avail the existing local facilities for rehabilitation programmes.

**Micro financing :** Help the recovered mentally ill to avail small loans from banks or societies to start pan shops, lottery tickets selling, manufacturing household items which has local demand. The process may be guided by social leaders of that area. This model is successfully practiced in Pakistan.

**Mental Health Awareness Programmes:**

An easy method to reach the public is to conduct more awareness programmes to reduce stigma on mental illness. Each one of us should take the lead.

**Suicide prevention:**

Farmers suicide is another area of grave concern. Recent studies show that pesticides are the most common method used by our population. Based on this position, paper have been submitted to the Government of Kerala by IPS state branch. We have to take some bold steps in this regard. South Asian forum also offered help in suicide prevention programmes. As an old saying "people sense how you feel about them. If you want to change their attitudes towards you, change any negative attitude you may have toward them". So we can try to change our attitudes.

**Dr. V. K. Radhakrishnan**
Secretary World Association For
Psychosocial Rehabilitation-IC &
Director, C.N.K. Hospital,
Changanassery.

# Mental Health in Primary Care

Observation of World Mental Health Day was started by the World Federation for Mental Health in 1992. The day is observed on 10th October every year**.**

The goals of observation of this day are to create greater public awareness and understanding of mental health and mental illness, to highlight the critical need to bring mental health care to a higher level of importance and to make mental health a global priority. In connection with the observation a theme will be selected every year which will be discussed all over the world and the out come will be implemented.

Theme for the year 2009 is "Mental Health in Primary Care: Enhancing Treatment And Promoting Mental Health" This theme emphasizes the benefits of enhancing overall health and promoting mental health by integrating it with general healthcare services. Primary care is the long-term relationship between a person and their doctor.

This integration is necessary is because of the following reasons**.**

**1. The burden of mental disorders is very high.**

Mental illness is a serious global health issue, affecting people of all ages , all cultures and all socio-economic status. Major depression at present is 4th in terms of disability adjusted life years and will soon be the second leading cause of disability worldwide. Mental illness is a burden for the affected individuals ,their families and cause economic and social hardships to the society

**2. Mental and physical health problems are interwoven.**

Many patients suffer from both physical and mental health problems simultaneously. Mental illness present with physical symptoms and vice versa. These patients have to be treated through a holistic approach, meeting the mental health needs of people with physical disorders, and the physical health needs of people with mental health problems.

**3. The treatment gap for mental disorders is enormous.**

In all countries there is a significant gap between the prevalence of mental disorders and the number of people receiving treatment and care. Many low-income countries have one or two psychiatrists for the entire population. Many developed countries have "carved out" mental health services from primary care health systems – giving mental health less attention, less money, reduced options and services and little or no connection to the individual's total healthcare needs. Primary care for mental health helps to close this gap.

**4. Primary care for mental health enhances access to treatment.**

When mental health is integrated into primary care people can access to mental health services closer to their homes, help to keep their families together and maintaining their daily activities. This will also facilitates community outreach and mental health promotion, long-term monitoring and management of affected individuals.

**5. Primary care for mental health promotes respect of human rights**

Mental health services delivered in primary care minimize stigma and discrimination. They 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.**

Primary care services for mental health are less expensive than psychiatric hospitals

for patients, communities and governments alike. In addition, patients and families avoid indirect costs associated with seeking specialist care in distant locations. Treatment of common mental disorders is cost effective, and investments by governments can bring important benefits.

**7. Generates good health outcomes.**

Mental illness treated in primary care have good outcome, particularly when linked to a network of services at secondary level.

Early and accurate detection Mental illness followed by appropriate treatment and management plan help in good recovery and early return to work .This also help to reduce the global burden on health and social care systems caused by Mental illness.

**Levels of Collaboration**.

Integrated Behavioral Health Care is based on level of collaboration between general health care and behavioral healthcare professionals. The following is an excellent description of collaboration levels, put forth by William J. Doherty,Ph.D. Susan H. McDaniel, Ph.D. and Macaran A. Baird,M.D., and summarized in Behavioral Healthcare Tomorrow, October, 1996, 25-28:

According to them the following are the levels of collaboration

**Level One : Minimal Collaboration**

Here mental health and other health care providers work in separate facilities, have separate systems, and rarely communicate about cases.

**Level Two: Basic Collaboration at a Distance**

Here the providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters**.**

**Level Three: Basic Collaboration on-site**

Health providers have separate systems but share the same facility. They engage in regular communication about shared patients, mostly through phone or letters, but occasionally meet face to face.

**Level Four: Close Collaboration in a partly integrated system**

Here health providers share the same sites and have some systems in common, such as scheduling or charting. There is regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases, basic understanding and appreciation for each other's roles and cultures.

**Level Five: Close Collaboration in a fully integrated system.**

Here health providers share the same sites, the same vision, and the same systems in a seamless web of bio psycho social services. Both the providers and the patients have the same expectation of a team offering prevention and treatment. All professionals are committed to a bio psychosocial/systems paradigm and have to develop an in-depth understanding of each other's roles and cultures.

**Improving behavioral health treatment in primary care settings** can be done by

- screening those patients attending primary care settings with symptoms of physical illness for psychiatric disorders and giving them appropriate care.
- providing additional supports and training to physicians in diagnosis and management of common mental health problems. .
- referring deserving patients to mental health providers and giving additional supports.

- placing behavioral health specialist in primary care practice to provide coordinated and evidence-based approaches and by providing collaborative care. However it may also be noted that the primary care behavioral health model have not yet been systematically evaluated.

**Improving physical health care in behavioral health settings.**

This can be effected by

- Screening mentally ill persons for physical health problems and providing quality health care.
- Implementing health promotion programs to reduce chronic physical illness in people with severe mental illness.
- training psychiatrists in primary care and
- enhancing referrals with additional supports

**Barriers for integration**

Few barriers are there for this integration**.** This include barriers at clinical, organizational, policy and financial level.

Clinical barriers are due to the differences in primary care and behavioral health cultures, lack of training and interest for health providers and stigma.

Organizational barriers are due to lack of communication and consultation across physical and behavioral health providers, physical separation of different provider types, and orientation of the primary care physician in the treatment of acute problems.

Policy barriers are mainly legal obstacles for sharing information across provider systems and regulations that limit the services which organizations can provide.

Financial barriers are complex and include issues related to the alignment of incentives in.

**Integration model in India**

Mental health services are integrated with general health care mainly in primary care centres, community health centres and Taluk hospitals which provide outpatient care..

People with mental disorders are identified and directed to these facilities by:

- *Anganwady* workers;
- primary care centre staff – junior public health nurses and accredited social health assistants;
- mental hospitals and private clinics;
- nongovernmental organizations and rehabilitation centres;
- community-based social workers and volunteers;
- Panchayath members;
- district mental health programme team members and
- schoolteachers.

In these primary or community health centre new referrals are seen by the medical officer/physician. If the medical officer have been trained in Psychiatry as part of the District Mental Health Programme, they make a diagnosis and prescribe the next course of action, e.g. medication or referral. If the medical officer have not been trained, or if the problem is beyond their level of expertise, they instruct the patient to attend the district mental health clinic.

People with mental disorders undergo the same procedures and wait in the same queues as other patients who are attending

the centre for other reasons .The medications are usually brought to the facility by the team, and left behind for use between their mental health clinics. Normally, only trained medical officers prescribe psychotropic medicines and actively follow-up patients between mental health clinics.

Untrained medical officers limit themselves to prescribing medications that have already been selected by the team psychiatrist. All new patients receive psycho education at their first visit, including information about their mental disorder, its origin, prevention, treatment, monitoring and management. This involves them in the process and motivates them to continue treatment. The social worker meets those in need of counselling and follow-up services. The social worker conducts periodic group therapy sessions and arranges admission into rehabilitation centres and contacts with other government services. In certain cases, the social worker makes home visits to assess the family situation and assist with ensuring continuous treatment. If required, individual counselling is conducted by the clinical psychologist and psychiatrist. Thus the services offered during mental health clinics are:

- diagnosis and treatment planning for newly-identified patients;
- review and follow-up for established patients;
- counseling by clinical psychologist or psychiatrist;
- Psycho-education.
- Referrals if needed

Dr.D.Raju MD(Gen. Med); MD(Psych.)
Secretary, State Mental Health Authority
State Nodal Officer, National Mental Health Programme

# Report on the observation of the World Mental Health Day 2009.

The day was observed by Kerala State Mental Health Authority on 10th October. A one day CME programme was organized for the Medical Officers working in the Government sector and the private sector at IMA Hall Thiruvananthapuram district from 9am to 4pm. The programme was inaugurated by Sri. M.Vijayakumar, Hon. Minister for Law and Parliamentary Affairs in the meeting presided over by Sri. V.Sivankutty, MLA. Dr.D.Raju, Secretary, delivered the welcome speech. Dr.V.Geetha, Director of Medical Education, Dr.S.Jayaram, Former President India Psychiatric Society (South Zone) and Dr. G.Vijayakumar, Chairman IMA- AMS Kerala felicitated the programme and Dr.Abdulbary, Superintendent Mental Health Centre Thiruvananthapuram expressed vote of thanks. The topics discussed in the CME Programme were Common mental health problems in general practice, Common mental health problems among children and Adolescents, Psychiatric emergencies and District Mental Health Programmes. Dr. D. Raju introduced the theme. Different topics were presented by Dr. Priya Alanchery, (Psychiatrist Mental Health Centre Thiruvananthapuram), Dr. K.P Jayaprakashan (Assistant Professor of Psychiatry, Medical College Thiruvananthapuram), Dr. T.V. Anilkumar ( Assistant Professor of Psychiatry, Medical College Alapuzha) and Dr. Abdulbary (Superintendent Mental Health Centre Thiruvananthapuram). The sessions were chaired by Dr. B. Jayakumar (Professor & Head of Internal Medicine Medical College, Tvpm),

Dr. K. A. Kumar (Former Director of Medical Education, Kerala), Dr. N.Subha (Professor & Head of Psychiatry Medical College , Tvpm), Dr. S. Jayaram (Former Superintendent, Mental Health Centre, Tvpm), Dr. M.K.C. Nair (Director, CDC ,Tvpm), Dr. Ashraf Ali (Former Associate Professor of Psychiatry Medical College, Tvpm), Dr. N. Krishnankutty (Former Professor & Head of Psychiatry Medical College , Tvpm) and Dr. Anil. P ( Professor of Psychiatry Medical College, Tvpm). Two hours of credit time was granted by Travancore Cochin Medical Council for the participants of the CME programme.

The day was observed in other regions of the State by the Mental Health Professionals and NGOs. Institute of Mental Health & Neuro Sciences, Kozhikkode along with Department of Psychiatry Medical College Kozhikkode and Indian Psychiatry Society organized a week long awareness campaign in Kozhikkode, Malappuram, Kannur, Wayanad and Kasaragod districts from 5.10.09 to 12.10.09. Seminars on mental health for NSS volunteers from various colleges at Kozhikkode, Seminar on mental health at Balussery Community health centre, awareness programme on common mental health disorders for junior doctors at Medical College Kozhikkode, workshop for ASHA workers at Sports council hall Kozhikkode, awareness programme and rally by college students at Kalpatta, street play and public meeting at Kalpatta, rally by MSW students at Sulthanbathery, street play and rally at Mananthavady, awareness programme for health workers at Malappuram, workshop for ASHA workers and palliative care volunteers on mental health at Manjery urban bank auditorium, workshop for journalist at press club Kasaragod and street play in tribal colonies were some of the programmes organized by them. A Rehabilitation centre for mentally ill patients was inaugurated at Ullyeri in Kozhikkode district.

*Sri. M. Vijayakumar, Hon. Minister for Law and Parliamentary Affairs, inaugurating the World Mental Health Day observation at IMA Hall, Thiruvananthapuram District*

## IMPORTANT NEWS

National Rural Health Mission sponsored Community Mental Health Programmes

National Rural Health Mission have sanctioned two Community Mental Health Program for Women, Children and Elderly in Palakkad and Kollam districts. The projects will start functioning at the earliest. ❑



*Edited, Printed and Published by Dr. D. Raju, Secretary, on behalf of the Kerala State Mental Health Authority*