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INTRODUCTION OF MENTAL HEALTH CARE INTO PRIMARY HEALTH CARE

ITS POSSIBILITIES AND LIMITATIONS

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INTRODUCTION OF MENTAL HEALTH CARE INTO PRIMARY HEALTH CARE : ITS POSSIBILITIES AND LIMITATIONS.

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The internationally accepted definition of health includes positive mental health as one of the three components. However, in reality health programmes in developing countries have largely focussed on the physical aspects of health namely care of the physical illnesses and problems. This relative poor emphasis on mental health as part of general health is due to a variety of factors. It is worth considering them before examining the scope of mental health care at primary health care programmes.

NEGLECT OF MENTAL HEALTH

The main reason has been the greater focus on illnesses of high mortality like infectious diseases in the past. In addition there are other reasons: Firstly, until about two decades there was very little reliable epidemiological data relating to the prevalence and distribution of the mental disorders in the community. Secondly, in the past major efforts in planning services were directed towards establishing mental hospitals and psychiatric clinics. The mental hospitals were largely custodial than therapeutic and the psychiatric clinics were located in big urban centres. Thirdly, there has been severe shortage of trained mental health professionals. For example, the number of psychiatrists in India is about the same as that in Denmark which has less than 1% of the population of India. Further, the limited number of professionals are working in urban areas where less than quarter of the population live. Fourthly, the general public often view mental disorders from religious, superstitious and magical stand-point and thus consider medical help only as a last resort. This has limited the effective utilisation of the available modern psychiatric facilities. Fifthly, till recently there were no meaningful and practical approaches for the provision of Mental health services at PHC level i.e., to meet the needs of the rural communities utilising alternative approaches other than through trained psychiatrists. Another important factor has been the limited organised type of welfare and rehabilitative services in the countries. In view of these factors, 'mental health' till recently, has not been a part of 'primary health care' in practice.

In the context of the current meeting, I would like to examine the issue of introduction of mental health care into primary health care

from three vantage points, namely (i) the historical reasons for consideration of MH as part of PHC.

(ii) the experiences in the last one decade of integrating MH into PHC programmes in the developing countries, and

(iii) the critical issues for wider application of the pilot, small community (micro level) projects into national and international programmes.

ALMA ATA CONFERENCE

One of the significant milestones in the organisation of primary health care (PHC) throughout the world is the ALMA ATA conference organised by World Health Organisation in 1978. This forum provided an opportunity to examine the issues in PHC and develop an international committment to the concept. (Appendix I).

It is salient to note the recommendations of the components of PHC. The conference stressing that PHC should focus on the main health problems in the community but recognising that these problems and ways of solving them will vary from one country to another, recommended that PHC should include at least :

"Education concerning prevailing health problems and the methods of identifying, preventing and controlling them: promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation, maternal and child health care including family planning; immunisation against major infectious diseases; prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries; PROMOTION OF MENTAL HEALTH (emphasis added) and provision of essential drugs".

It is noted that promotion of mental health forms one of the eight components of PHC. It is in this broad context that the possibilities for including mental health (MH) as part of primary health care (PHC) has to be considered. The inclusion of MH as part of PHC becomes especially significant in the developing countries where even specialised mental health programmes are not take root.

EXPERT COMMITTEE ON MENTAL HEALTH (WHO, 1975).

During the decade of 1970's the focus of health programmes in developing countries have shown a move towards 'some care for everyone

rather than everything for a few'. A reflection of this concern in organising MH services in developing countries has been the series of activities that culminated in the WHO Technical report Series (No.564) titled organisation of Mental Health services in Developing countries (WHO, 1975 a). The final document was the outcome of a WHO seminar at Addis Ababa in 1973 (WHO 1975 b). The 1973 conference reviewed the needs and the available approaches for MH care in developing countries

The recommendations of the Sixteenth Expert Committee on Mental Health are most relavent to the deliberations of to-day. I would like to special draw your attention to the following recommendations.

Resolution No 4 : The Committee recommends that mental halth objectives should be defined in every country taking into account the nature, extent and consequences of mental disorders and the resources available. The objectives should be realistic and should be formulated in terms of health effect or service delivery to be achieved for a stated proportion of the population in a defined area within a stated time.

Resolution 5: To achieve these objectives, the Committee recommends decentralisation of mental health services, integration of mental health services with agencies Decentralisation of mental health services implies that mental health care should be made available at the community, district and regional levels through psychiatric inpatient and out patient units linked to the general medical facilities. The creation of large mental hospitals should be discouraged and where they already exist the prime consideration should be to ensure that the staff - patient ratio allows adequate treatment, care and rehabilitation. They should be supported by a network of other services as described in the report. Integration of mental health care into the general health service means that the mental health component should be incorporated into the work of the primary health worker, the community health centre, district and regional health centres and hospitals. Collaboration with nonmedical community agencies means that the contribution of community agents such as religious leaders, teachers, development workers, the police and the various associations should be sought and that mental health professionals should devote part of their time to the mental health education of such workers in the community in order to make such a broad approach possible.

The Committee further spells out the needed changes to implement the above:

Resolution No.8 : The committee recommends that governments make adequate financial provision for the following programme:
(a) recruitment, training, and employment of personnel; (b) adequate provision of drugs; (c) a network of facilities, including transport, and (d) data collection and research. In the developing countries trained mental health professionals are very scare indeed - often

they number less than one per million of the population. Clearly if basic mental health care is to be done by non-specialised health workers at all levels, from the primary health worker to the nurse or doctor working in collaboration with and supported by more specialised personnel. This will require changes in the roles and training of both general health workers and mental health professionals.

The implications for the training and functioning of professionals is outlined as follows:

Resolution No.10 : The Committee recommends that specialised mental health workers should devote only a part of their working hours to the clinical care of the patientsl, the greater part of their time should be spent in training and supervising non-specialised health workers, who will provide basic health care in the community. This will entail significant changes in the role and training of the mental health professionals.

Reslution No. 11 : The committee therefore, recommends that the training of mental health professionals should include instruction and supervised experience in this new task of training and supporting non-specialised health workers. There will also be need to provide training in mental health service administration for personnel down from the various disciplines involved in these services. In the view of the Committee, there is still and will remain for some years, a pressing need for the recruitment and training of additional mental health professionals to carry out these new roles.

Resolution No.13: The Committee recommends that steps should be taken to reduce the cost of drugs, to make them more readily available and to ensure that they are correctly used.

In addition the other recommendations refer to the need to alter legislation, collect relevant data and carry out appropriate research.

The above summarised recommendations are relevant even today. In this document we have a commitment to basic mental health care outlined as well as the necessary steps to be taken. Thus the committee has clearly pointed out the importance of PRIORITIES, the need for DECENTRALISATION of the services and the involvement of all categories of health and welfare personnel (DEPROFESSIONALISATION). Further it has outlined the needed ROLE CHANGE and FUNCTIONING of the specialist mental health professionals. The other requirements like

the drug availability, the legal changes and the research commitments have all been given due recognition. Thus, this forms avevery important document as a guiding instrument for planning mental health services.

EXPERIMENTS IN MENTAL HEALTH CARE

It is indeed a happy and a most fruitful development that the deliberations of the above group was followed by an attempt to apply these ideas into practice. WHO initiated a multicentred international collaborative project 'STRATEGIES FOR EXTENDING MENTAL HEALTH CARE'. The objectives of this project begun in 1975 and completed in 1982 were:

(i) To determine the feasinility of introducing basic mental health care directed towards defined priority conditions into health services in developing countries ;

(ii) To develop methods of priority selection for interventions in the field of mental health care ;

iii) To develop and evaluate methods of task oriented training in mental health for health workers and for those in other systems of care;

(iv) To evaluate the effectiveness of alternative and low cost methods of mental health care introduced into basic health services, and

(v) To develop and evaluate ways of stimulating the community understanding of and response to the problems related to mental disorders.

This project was initially started in 4 countries, namely Colombia, India, Senegal and Sudan and later Brazil, Egypt and Philippines joined the project. The experiences of the project have provided information about (i) the current patterns of care for mental disorders by the PHC personnel (ii) the magnitude of the problem in those attending PHC facilities, (iii) the community attitudes to mental disorders and (iv) the burden of mental illness on the family (Climent et al, 1980; Harding et al, 1980; Wig et al, 1980; Giel et al, 1983).

In this project Epilepsy and acute and chronic psychisis were considered as priority conditions by all the centre while one or more centres included depression, mental retardation, neurosis and alcohol dependence. As part of the training programmes Manuals were developed in a number of centres. An example of how this work was undertaken in one field area, namely, India is included as one of the background papers (Wig et al, 1981; Wig and Srinivasa Murthy, 1981).

There are a number of new issues that have emerged from the work outlined above which will be considered at a later part of this paper.

During the same period, since 1975, a number of other centres have been working in the same area. Though the focus of work has been the same, the approaches have differed from country to country reflecting on the local and national realities in terms of available PHC personnel, legal constraints about use of drugs and other supportive social welfare agencies.

The experience of the other major centre in India, namely NIMHANS, Bangalore provides an example of how small scale projects can enlarge to large scale programmes. The essential directionso of the Bangalore centre has included the PHC personnel, the GPs, the school teachers and lay volunteers. (Background document, Reddy, 1983). Since 1982, the state Government has been deputing regularly groups of 10-15 PHC personnel for a two week training programme in MH care, raising the hope that at least in one state the benefits will be reaching a larger population. One other notable development in India in the last 12 months is the formulation of a National Mental Health Plan essentially outlining the need for integrating MH in primary health care programmes.

Similarly, in Indonesia, since 1973, a decision has been made to include 'mental health component' activity in health centres or Pushkesmas. To-date more than 150 centres have been covered. In Thailand, in May 1981 the department of medical services appointed a working group to formulate plans and curricula of mental health for training PHC workers. Following this, a systematic effort has been made to develop appropriate levels of tasks for health workers at TAMBON (Subdistrict) mental health practitioners and doctors. Already staff of more than 6 provinces have been covered by 5 day training courses. In Bangladesh, since 1982, a 3 week training in mental health care has been initiated. It is interesting to note that the 'resistance' from professionals has been limited and short lasting. For example, at present the health workers of Thailand use 3 psychotropic drugs for specified neuropsychiatric conditions. The other notable experiments have been those in Zambia to train MH assistants and that of Lesotho to train nurses. I have only touched on someof the approaches and the list is, luckily, is not so limited as the above section would indicate.

CRITICAL ISSUES

The experiences reviewed so far have been of limited coverage and mainly centred around centres with special interest in this area. However, a wider application calls for a greater clarity about some of the issues. There are some answers currently available but much of the solutions can only result from continued systematic attempts.

Two documents illustrate the needs very well. AFRO Technical Report Series No.7 (WHO, AFRO 1979) reviews the developments in Africa region and outlines the future possibilities. Similarly a recent WHO/SEARO Document titled 'Advances in Mental Health' (WHO/SEARO/Ment/1983) presents the picture of SE Asia Region. Both these documents present both the positive developments and the areas for further work.

The common issues in integrating Mental health in PHC are : (i) selection of priorities, (ii) the training programmes and development of manuals, and (iii) provision of drugs.

SELECTION OF PRIORITIES :

The public health approach to selection of priorities has been to base in on (i) prevalence, (ii) mortality and morbidity or the public health importance of the problem. On both these counts mental health care has been a loser. Till recently prevalence figures were limited for most countries and the effect of mental disorders has been more on the quality of life than the mortality. However, with the shifting focus on total health care the situation is changing to consider mental health aspects of all developmental and human activities.

For the purpose of selection of priorities for the current aim of integrating MH in PHC the following criteria need to be considered:

(i) the magnitude of the problem
(ii) the 'health effect' on the individual, family and community.
(iii) availability of reliable and inexpensive treatment modalities of simple technology.
(iv) the acceptability of these interventions to the population and
(v) the suitability of these for inclusion in the training of the PHC personnel.

Experience in different countries have shown that a very limited number of conditions only can be included for PHC personnel. At present there appears unanimous in including Epilepsy, Acute psychoses and Chronic psychoses. There are different view points about including the care of 'neuroses' or otherwise called 'psychosocial problems', 'problems of living' in view of the limited knowledge available about their frequency, ease of identification and proven methods for intervention. It is to be noted that currently some groups of investigators are examining this area in detail (SEARO, 1982). The problem of mental retardation appears suitable as it provides for a totally non-pharmacological intervention to be applied by the PHC personnel. The feasibility of such an approach is yet to be considered systematically.

In addition to these, depending of the countries certain other problems become priorities. A good example is drug dependence which may not be a problem at all in one country but may be the most important MH priority in an another country.

Whatever priorities we choose, it is clear that they have to be limited in number and should be such that the PHC personnel can effectively carry out the tasks involved in their care as part of their routine work. This would not only include the simplicity of tasks but also the frequency with which they will meet in their community. A detailed consideration of this topic has been considered by Giel and Harding (1975)

TRAINING PROGRAMMES AND DEVELOPMENT OF MANUALS :

The relatively recent emphasis to include MH in PHC is reflected in the absence of MH care components in the Manuals of pPHC. A recent review brought out the complexity of the approaches employed and the limited scope as it exists today (Srinivasa Murthy 1983 - Background document). The differences among existing manuals relate not only the amount included, the illness outlined but also regarding drug and other interventions.

On the other hand special manuals prepared by the MH programmes of the last decade are also not uniform in the above aspects. The manual of Swift (1977) titled Mental Health includes all aspects of a traditional textbook of psychiatry. The manual of Essex (1981) employes management flow chart. Other manuals are selective about priority conditions (Wig & Srinivasa Murthy, 1981).

Currently there is no uniformity about the amount, the conditions to be included and the types of interventions to be undertaken by PHC personnel. This is an area calling for greater effort.

THE FUTURE :

There are four aspects that need to be given importance :

(i) The political committment
(ii) The professional committment
(iii) The crystalisation of knowledge in mental health care
(iv) Public education and involvement.

No major programme in the country can take strong roots without adequate committment at the political level and the public acceptance and support. There have been too many failures because of the limitations in these two areas. I will focus my attention to the role of the professionals in the future development of mental health care in the community, outlining the limitations and possibilities for future work.

PROFESSIONAL COMMITTMENT :

The community psychiatry approach calls for a number of actions from the professional personnel. There is a necessity for the role of the professional to be different in the process of decentralisation and deprofessionalisation. To be more specific, the role is different from the hospital-oriented one. The psychiatrist, for example, (this is true for other professionals like psychologists, social workers and nurses) will have to devote significant portion of the time for supervision rather than direct patient care. Furthermore, because their work is carried out in a field setting rather than in the protected environment of a hospital or its clinic, they have to often accept different standards of care more appropriate to the field situations in which they are working. This calls for involvement in signification of the mental health work. Finally, they also need to acquire new skills, including managerial abilities and a community orientation and capacity to coordinate, which are not normally seen as being within the purview of a psychiatrist's abilities in the more traditional settings. At an individual level, it is not infrequent for the supervising psychiatrist to feel overwhelmed and inadequate for the multipurpose role in the community. It is needless to add that perseverance, a sense of openness and willingness to learn from

the people is very satisfying and comparable to the satisfaction from the clinical responsibility in a hospital (Srinivasa Murthy and Wig, 1983).

To support the planned mental health programmes in the community at PHC level, training of psychiatrists should include supervised experience in the above area. This has been one of the important recommendations of the WHO Expert committee on Mental Health (WHO, 1975). At a practicall level there is an urgent need to have field practice areas attached to psychiatric training centres.

There are other sensitive issues that need to be taken cognisance of. The new approach will not give results if the different professionals (i) set up 'artificial' rigid boundaries between the different mental health personnel, (ii) do not devote enough time in terms of research etc., to enhance the know-how in this area of work, (iii) lastly, one will also come up face to face with issues like allowing for limited use of drugs by paraprofessionals and non-professionals as it has happened in the areas of maternal and child welfare, tuberculosis family welfare, leprosy and malaria.

To summarise the issues in this area, it can be said that the need is to accept this approach as the REAL ALTERNATIVE rather than second rate method. This can result by anew generation growing up with these ideas, wide discussion, sharing of ideas and critical appraisal of the pilot schemes and inclusion of skills in this area during the training period.

ADVANCES IN MENTAL HEALTH KNOW-HOW:

Next I would like to focus the attention on an area of importance to the professionals and the programme. This refers to the needed simplification of knowledge on sound scientific basis. It is to be recalled that the domiciliary care of tuberculosis was demonstrated scientifically before care of tuberculosis moved out of the confines of the sanatorium. Similar examples are there in the area of public health. It is self-evident that decentralisation and deprofessionalisation can occur only when such knowledge is available and confidence levels in the day to day clinical work is high. The research efforts need to be in the areas of recognition of mental disorders, their referral, the initiation of treatment and their effectiveness.

Is this an important need? I would say yes from two counts. Firstly, professional colleagues have expressed doubts and reservations about the community psychiatry approach on the basis of the complexity of the mental health care. Opinions like treatment of psychiatric problems are based on experience, or the dosage and the type of drug used is too individually dependent, mistakes can be very dangerous etc. etc., are expressed. All these speak for the need for professionals to be the final arbitrers of the diagnosis and treatment. The second area of greater concern has been lack of research into simple but very important issues like the treatment schedules and use of drugs. A recent review of the antidepressant drug studies published in the country in the last two decades showed the lacunae clearly. (Srinivasa Murthy and Raghavan, 1983). The review of more than two dozen reports showed that (i) the diagnostic criteria was very loose, (ii) the duration of use was four weeks in most of the studies, (iii) global evaluation of the improvement was the common approach, (iv) the relevance of age of the patient, sex differences, the duration of illness, the presence of absence of associated physical illnesses etc., have not been the subject of study, and (v) the dosage variations and different treatment regimens has not been studied to offer knowledge about the ideal dosage and duration schedules. Thus, today most of the treatment of depressive disorders is largely experience-based and varies from clinician to clinician. The above point is made as an example of the lacunae and the need for looking into areas traditionally thought to be not relevant when trained professionals are dealing with patients.

The needs in this area are protean and they should receive the most stringent consideration at the earliest time possible. There should not be decisions on an adhoc manner based on isolated pilot schemes but by research work in settings as similar to the field setting as possible. I can outline a few more areas that need immediate answers, namely (i) the relative effectiveness and safety of phenothiazines and ECT for acute psychoses and depression, (ii) the differences in the rates of relapse when the initial treatment for psychoses or depressio is 3 months by as compared to 6 months to one year or more, (iii) the relapse rates for epilepsy when treatment is stopped after one year of fit free interval versus 2,3,4 or 5 years (iv) the methods of public education and (v) the cost effectiveness of rehabilitative measures with chronic patients.

The priority areas for research effort from professionals was also outlined in the last years SEARO-WHO meeting (1982) which is attached as Appendix - II.

TO summarise, during the last one decade we have seen a wide interest to include MH as part of PHC. Initial efforts have dispelled some of the doubts about its relevance. At the same time the bigger and wider issues of priority selections, training programmes and professional committment have come to the forefront. The current situation raises hopes of positive results in the near future, especially in the developing countries with no pre-existing well entrenched MH care system as it is seen in the west.

APPENDIX I

PRIMARY HEALTH CARE

PRIMARY HEALTH CARE is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every state of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Primary health care includes at least: education concerning prevailing health problems and the method of preventing and controlling them; promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

- Declaration of ALMA ATA
W.H.O. (1978).

PRIORITY AREAS OF RESEARCH

The group identified the following areas, where serious gaps in knowledge exist, for the immediate inclusion of research results into the training package for PHC personnel ('the mental health kit').

(1) Improvement/development of modules on the management of :

- acute psychosis, including drug regime in patients with poor nutritional status:
- acute severe depression (the question of sleep deprivation was mentioned but no agreement as to its usefulness in a PHC setting was reached.);
- chronic psychosis; and
- repeated attacks of severe depression/mania including feasibility and safety of lithium prophylaxis in a PHC setting;

(2) clinical equivalents between the locally available neuroleptic drugs;

(3) development of a module on recognition, set of minimum investigations and management of organic psychotic conditions in PHC;

(4) optimal strategies for supervision and referral support for PHC with mental health activities;

(5) simplified classification and recording system for mental disorders in PHC.

(6) impact of day care on the psychosocial development of children from socially disadvantaged families;

(7) evaluation of the impact of a training in child mental health and psychosocial development on overall performance in MCH activities;

(8) community attitudes towards mental illness in relation to the presence or absence of an affected person;

(9) evaluation of the effectiveness of community mental health care through PHC including utilization trends. Ideally, this evaluation would be built into services to be developed;

(10) Systematic study on the outcome of various non-drug interventions for 'neurotic' and psychosocial problems;

(11) technology of developing and maintaining self-help/ mutual-aid groups of parents of disabled children, and

(12) evaluation of interventions in problems related to substance abuse at the PHC level.

- Report of an Inter-country workshop
28 Sept - 2 Oct. 1982.
W . H. O.