

Comparative study of the effectiveness of district mental health programme

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Abstract

Background: Mental, neurological, and substance use (MNS) disorders are major contributors to morbidity and premature mortality. 14% of the global burden of disease can be attributed to MNS disorders. It is estimated that 6-7 % of population suffers from mental disorders. District mental health programs (DMHP) are run in many districts of India and an effective strategy to provide mental health care to rural populations. Hence the aim is to study the effectiveness of District Mental Health Programme and to assess the subject satisfaction. **Methods:** The study was carried out at DMHP clinic and hospital psychiatry department. 200 cases and 200 controls were selected, after meeting the inclusion and exclusion criteria. Diagnosis made as ICD-10 by treating psychiatrists. Patient satisfaction questionnaire (PSQ -18) and global assessment of functioning scale were administered to both groups. **Results:** At hospital 28% were diagnosed with ADS, 29% psychotic disorder, 15% depressive disorder, 14% bipolar disorder and at DMHP clinic 41% had psychotic disorder, 22% depressive disorder, 17% somatoform disorder. The average PSQ-18 satisfaction score, was 3.5 and 4.3 at DMHP clinic and at hospital respectively. **Conclusion:** None of the patients were aware of DMHP programme. DMHP clinic had more psychotic disorder (41.0%) and psychiatric unit of hospital had psychotic disorder of (29.0%) and ADS (28.0%). Patients expressed more overall satisfaction in Victoria hospital (4.3) than in DMHP clinic (3.5). Rural DMHP clinics are friendlier for rural women and people from LSES.

Key Words: Community psychiatry; DMHP; PSQ-18

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INTRODUCTION

Mental, neurological, and substance use (MNS) disorders are prevalent in all regions of the world and are major contributors to morbidity and premature mortality. The resources that have been provided to tackle the huge burden of MNS disorders are insufficient, inequitably distributed, and inefficiently used, which leads to a treatment gap of more than 75% in many countries with low and lower middle incomes. Despite the prevalence and

burden of MNS disorders, a large proportion of people with such problems do not receive treatment and care.^{1,2} It is estimated that 6-7 % of population suffers from mental disorders. One in four families is likely to have at least one member with a behavioural or mental disorder (WHO 2001). These families not only provide physical and emotional support, but also bear the negative impact of stigma and discrimination. Most of them (>90%) remain un-treated. Poor awareness about symptoms of mental illness, myths and stigma related to it, lack of knowledge on the treatment availability and potential benefits of seeking treatment are important causes for the high treatment gap.^{3,4} Due to the under-diagnosis of these patients, unnecessary investigations and treatments are offered which heavily cost to the health providers. The needs of patients and families far outstrip the availability and accessibility of services for those with mental disorders. When the burden became too great for the families to bear, then the mentally ill person would often be abandoned and left in the care of the religious order. In the seventies a number of epidemiological surveys were

carried out in this country to assess the morbidity due to mental disorders.⁵

The findings of these studies have clearly established that prevalence and distribution of various forms of mental disorders are as much as in western countries. To meet the mental health care service requirements in 1982 a programme for India popularly known as National Mental Health Programme (NMHP) was planned with objectives to "decentralise" and "deprofessionalise" mental health services.⁶ The programme commenced with much expectations, remarkable interdisciplinary cooperation, enthusiasm and inputs. However, soon when the output was assessed, it became clear that its success is far from the expectations.⁷ 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.⁸ District mental health programs (DMHP) are operational in many districts of India, and government is planning to extend its coverage, there have been doubts about this are an effective strategy to provide mental health care to rural populations.⁹ Some have pointed out that data based publications are lacking about this national flagship programme. Hence the aim of the present research was to study the effectiveness of district mental health programme.

MATERIALS AND METHODS

The study was carried out at the clinic of the District mental health program in psychiatry department, medical college and research institute. Data were collected from patients attending DMHP clinic and Victoria hospital psychiatry department from psychiatry postgraduate. Postgraduate joined DMHP team and saw patients attending the clinic. Investigator collected data after 14 visits. Tools of Data Collection Semi structured interview schedule, GAF was used to collect information for the study. Comparative study: Cases were selected from DMHP clinic on every 4th Tuesday. Patients attending the DMHP clinic with mental illness were selected after confirming whether patient was newly registered or has come for follow up and after confirming diagnosis. Patients who have come for follow up were selected. Controls were selected from Victoria hospital psychiatry department OPD. Patients attending the OPD with mental illness were selected after confirming their follow up and diagnosis. Information such as monthly income, personal information and demographic information of the families, substance abuse, and the patients' perception of the problem were collected. Emphasis was also given on the

perception of the problem/illness among the patients' family members/caregivers, information about the awareness of DMHP, details of any previous DMHP interventions, and the patients and family member's perception of services and mental health and illnesses. From the review patients attending the clinic every case was chosen for inclusion, excluding epilepsy, mental retardation and newly registered cases. Diagnosis was made by the treating psychiatrist based on ICD – 10. Informed consent was taken from the eligible subjects and care givers for inclusion in this study. After this data was collected, data entered on the specifically prepared data sheet covering basic sociodemographic and diagnosis. Details were collected from the patients and accompanying care givers whenever possible. Global assessment of functioning scale was used to assess the functioning. Study is mainly looking at the 'service provision' component of DMHP at DMHP clinic. Variables were described using mean \pm standard deviation (SD) or percentage where appropriate. All the questions that assess satisfaction level were scored on a five point scale. After scoring, items within the same subscale were averaged together to create subscale scores. Sample included 200 consecutive cases seen in district mental health programme and compared to 200 consecutive cases from general hospital psychiatric unit of medical college. Institutional ethics committee approved the study. CASES: Inclusion criteria: Patients who have visited DMHP clinic more than once. • Patients with mental illness. • Patients who have consented. • Exclusion criteria: Patients who have refused to consent. • Patients with major medical illness, epilepsy, mental retardation and aggression. • Patients who have visited once. • Patients who do not understand Kannada language. • CONTROLS: Inclusion criteria: Patients who have visited DMHP clinic more than once. • Patients with mental illness. • Patients who have consented. • Exclusion criteria: Patients who have refused to consent. • Patients with major medical illness, epilepsy, mental retardation and aggression. All items should be scored so that high scores reflect satisfaction with medical care. After item scoring, items within the same subscale should be averaged together to create the 7 subscale scores. Global assessment of functioning scale (GAF). The Global Assessment of Functioning (GAF) is a quick and simple measure of Overall psychological disturbance. GAF is a reliable measure of disturbance of psychological functioning in long-term mentally ill patients. The GAF can be administered as both an overall scale and as two separate measures assessing symptoms and disability. Can be readily used by multidisciplinary raters, without the need for extensive training.

RESULTS

Total of 400 patients were included in the study. There were 194 males and 206 females. Fifty percent of the population were from urban location and fifty percent were from rural area. Out of 400 patients from both the institutions all patients had previous psychiatric consultation. Overall out of 400 patients from both the institutions (n=194) were males and (n=206) were females.

DMHP awareness: Out of 400 patients none of the patients from both the institution were aware of district mental health programme. Out of 400 patients 140 cases were diagnosed with psychotic disorder, 74 cases had depressive disorder, 62 patients had the diagnosis of alcohol dependence syndrome, 42 patients had bipolar disorder, 44 patients had anxiety disorder, 38 patients had somatoform disorder.

Table 1: Comparative result of diagnoses at Victoria hospital and DMHP clinic

Diagnosis of Psychological disorder	Victoria Hospital	DMHP clinic
Psychotic disorder	58	82
Depressive disorder	30	44
Alcohol dependence	56	6
Bipolar disorder	28	14
Anxiety disorder	24	20
Somatoform disorder	4	34

Table 2: Verbal opinion about mental care

Verbal opinion	Victoria Hospital	DMHP Clinic
Very good	60	12
Good	72	62
Ohk	68	126
Total	200	200

Global assessment of functioning: Out of 400 patients (n=118) had the score of 81-90%, (n=114) had 71-80% score, (n=76) had 61-70% score, (n=46) had 51-60% score, (n=32) had 41-50% score, (n=4) had 31-40% score, (n=10) had 91-100% score.

Verbal opinion about mental care: (n=60) patients at Victoria hospital verbally opined about mental care given as 'very good', (n=72) as 'good', (n=68) patients opined as they are 'okay' with the care. (n=12) at district mental health programme clinic verbally opined about mental care given as 'very good', (n=62) patients opined as 'good' and (n=126) opined as 'okay' with the mental care they received.

DISCUSSION

At hospital no difference found among the different subscales of patient satisfaction. While at district mental health programme clinic patient satisfaction varied in different dimensions with interpersonal manner and communication showing strongest association and accessibility and convenience showing weak association. Client satisfaction might be influenced by social situation and is related with patient expectancy of services. The study showed that majority of patients attending the DMHP clinics suffered from major psychiatric disorders. Based on the above findings, we can confidently say that the DMHP has been a successful strategy for providing mental health care to the rural population. The program

aims to provide continuity of care for those discharged from mental hospitals or medical colleges which provide acute care and in patient. But after being discharged, non-availability of adequate number of psychiatrists (and majority of the few available offering services in urban areas only) makes follow up care extremely difficult. A report on DMHP in Chandigarh also showed majority of male patients (63.0%). Our study showed negligible number of substance use disorders at DMHP clinic (3.0%), a finding similar to a study by Harish M Tharayil¹⁰ and contrasting to the findings of Wariach *et al.*, 2003 where majority of male patients had substance use disorders. Majority from both genders were suffering from only major psychiatric disorders. Satisfaction with service offered in the DMHP clinics was in acceptable range with majority (63.0%) of the patients reporting scores in 'okay' and 'good'(31%) ranges. This shows that the program has a high degree of acceptance among the intended target group of patients. Compared to district mental health programme clinic, Victoria hospital psychiatric OPD saw more number of alcohol dependence syndrome (28.0%) and psychotic disorders (29.0%). where as district mental health programme saw more of psychotic disorders (41.0%) and depressive disorders (22.0%). Majority of patients at DMHP clinic were from lower class (13.0%) and upper lower class (67.0%) compared to Victoria hospital psychiatry OPD where (4.0%) were from lower class and (51.0%) were from upper lower class indicating

more lower class group accessing DMHP clinic. Overall Patient satisfaction questionnaire-18 scores were more (4.3) implying patients were satisfied at hospital psychiatric OPD compared to district mental health programme (3.5) implying 'partially satisfied'. This may be due to the fact that more general perception that being a tertiary care centre hospital has all kinds of medical facilities and manpower and round the clock availability of services where in district mental health programme clinic psychiatric services were available on selected days. None of the patients from both the institution were aware about District Mental Health Programme may be due to poor IEC activities. Functioning, as measured from global assessment of functioning scale, majority of the patients at both the institutions had good functioning getting higher scores on the scale ($p=0.881$) which is not statistically significant. From the above findings, in an answer to our research question we have found District Mental Health Programme is useful for people with mental illness in the community.

CONCLUSION

Rural DMHP clinics are friendlier for rural women and people from low socio economic status. Patients expressed more overall satisfaction from medical college hospital. None of the patients from both the institution were aware of District Mental Health Programme. Because of small sample size and study being conducted at one DMHP clinic and since satisfaction of patients will vary depending on the number factors which affect the satisfaction. So results of our study cannot be generalized.

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