Evaluation Of District Mental Health Programme In The District Of Dharmapuri,Tamil Nadu, India And Evolution Of Mental Health Care Delivery System For Our State

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ABSTRACT
District mental health programme was started in India with the idea of decentralizing mental health care. The plan was to train the general medical officers working in primary health centers so that they can identify and treat psychiatric disorders. After the district mental health programme was started, it is time to review its effects. In Dharmapuri, a district in Tamil Nadu, India, medical officers and paramedical personnel were trained and sensitized to identify psychiatric disorders and a district psychiatrist was posted in the district headquarters hospital, who would conduct psychiatric clinics in headquarters and taluk hospitals. We are evaluating the impact of these in terms of actual benefit to the community. A number of new case registrations, before and after the training of the paramedical personnel, a pattern of referral and the impact of starting the psychiatric clinics in taluk hospitals are all assessed. When the peripheral clinics were started, new case registrations increased by 142% in the taluk hospitals. After the training of the paramedical personnel, there was an increase of new cases in the peripheral clinics from 56 to 70. Based on this experience, a suitable pattern of community mental health care delivery system for our state is evolved, taking into consideration availability of qualified manpower, resources, an expectation of the public and WHO guidelines.

INTRODUCTION
During the past two decades, major advances have taken place in the care of the mentally sick with a shift from hospital to the community (Nagarajaiah et al., 1994). National Mental Health Programme was started in 1982 with the objective of ensuring availability and accessibility of mental health care with active community participation (Wig and Srinivasamurthy, 1979). Three years of research in rural areas as part of a WHO International Multi-Centred Collaborative study, ‘Strategies for Extending Mental Health Care in the Community’ concluded that there were a number of mentally ill persons needing urgent psychiatric intervention and these patients were willing to take treatment once regular help was made available close to their residence (Wig et al., 1981). The next step was decentralisation and de-professionalization of mental health care by integrating with the primary health care (DGHS, 1982). This led to the training of medical officers and paramedical personnel. With these objectives, the District Mental Health Programme was started
and is now implemented in almost all the districts in the state of Tamil Nadu. Dharmapuri is one such district where the District Mental Health Programme was started in 2005.

**Aim Of This Study**

This study attempts to evaluate the effectiveness of the District Mental Health Programme in the district in terms of actual benefits to the community. After the initial training programmes are over, and a regular District Psychiatrist posted, routine District and satellite psychiatric clinics are conducted. We are now curious to know, whether the number of beneficiaries in these peripheral clinics have increased in number and also an attempt is made to find out which aspect of DMHP is really helpful in achieving the final goal of community mental health care, taking into consideration the present day scenario.

**MATERIALS AND METHODS**

Under the District Mental Health Programme, a district psychiatrist occupied the post of district psychiatrist in the district headquarters hospital, Dharmapuri in August 2006. Two training programmes were conducted for the medical officers of the district of Dharmapuri in November 2006. Regular weekly outpatient psychiatric services started functioning in the five taluk hospitals from April 07. Again in Sep 2007, training programmes for all the paramedical personnel, including the village health nurses working in the district were conducted. We are retrospectively analysing the data of these outreach psychiatric clinics to find out the impact of the District Mental Health Programme in the community. Appropriate ethical approvals were obtained, and informed consent was got.

**RESULTS AND DISCUSSION**

On average, there were two clinics in the district headquarters hospital and a clinic in each of three taluk hospitals every week and once in a fortnight in the remaining two taluk hospitals. Total number of clinics in the District Head Quarters and Taluk Hospital are represented in the Graph 1.

The number of new patients recorded in the District Head Quarters and those recorded in Taluk Hospital every month are given in the graph. When the pattern of referral is considered 82 % of patients have reported to either of the clinics on their own, whereas 15 % have been referred by medical officers of the Primary Health Centers and another 3% by the Village Health Nurses. Of these, none of the patients were given any treatment by the medical officers of Primary Health Centres.

When the peripheral clinics were started, a number of new case registrations increased many folds. However, how much of this increase is due to redistribution from District Head Quarters to peripheral clinics is to be assessed. From the Table 1, it is evident that the fall in the District Head Quarters is from 62 to 54 (8 new cases -13 %) between June and August 07. But the increase in taluk hospitals is from 33 to 56 (23 new cases – 143%). Obviously, the increase of new case registrations can not be explained by mere redistribution of cases from district headquarters to the taluk hospitals; but mainly by the starting up of the clinics in taluk hospitals itself.

Next, we look into the impact of the training programmes. After the training of the medical officers, the number of new case registrations has not shown any increase in the district headquarters hospital, as shown in Graphs 2 and 3. The peripheral psychi-
a atric clinics were started little later in April 07. After the training of the paramedical personnel including Village Health Nurses, there was an increase of new cases in the peripheral clinics and a decline in the District Head Quarters clinics as seen in Table 2. But when we look into the total number of new cases, it is almost flat indicating that the increase is mainly due to redistribution from District Head Quarters to peripheral clinics. The information about the availability of peripheral psychiatric clinics could have been passed on by the Village Health Nurses.

In this context, it is worthwhile quoting the study of (Tiwari et al., 1999). In a study conducted by (Tiwari et al., 1999) in a population with 60% illiteracy, it was concluded that majority of the population was aware of the mental symptoms, had seen such patients and believed that drugs were the primary treatment method. The community was largely aware of the various places of treatment (Murthy, 1989). It is relevant here to mention that in our case, about 82% of patients reported to psychiatric clinics on their own without being referred. Only about 15% per cent were referred by the medical officers and another 3% were referred by the Village Health Nurses (vide Table 3).

A basic assumption of the District Mental Health Programme was that simpler tasks can be delegated to less trained workers and more complex tasks to more qualified, while an attempt was made to create an inbuilt system of referral and supervision (Devi, 1993). It is not far from correct to mention that the system of referral has not evolved as per original plans in our state. Not only in DMHP but also in regular OPD, patients getting referred from Primary Health Centers are few compared to patients coming on their own.

(Tiwari et al., 1999) also observed that the majority (52%) preferred treatment in general hospitals over a mental hospital, G.P.s and faith healers. The community was generally dissatisfied with available treatment for mentally sick, which the author attributed to non-availability of services in or near the community, long distance to reach available services, cost of treatment and fear of going to unknown places, etc.

IEC has not yet been started in our district, and so its’ impact could not be assessed.
When the National Mental Health Programme was started in 1982, there were hardly 200 psychiatrists in our state, whereas today it is about 500. Patients’ expectation of specialist care over primary health care that too in the community itself can not be ignored. There is no resource crunch, especially when the District Mental Health Programme is sanctioned for all the districts. It is perhaps time to review the pattern of community mental health care delivery in our state and adapt to the present situation of resources and the expectation of the community. It is appropriate to aim step 2 care with the participation of district psychiatrists and a follow up in Primary care like delivering medicines and ensuring adherence to treatment and identifying adverse effects. Active IEC activities for the public, and training primary care personnel can help in increasing the utilisation of services.

CONCLUSIONS
District Mental Health Programme can be considered to consist of various components like training of medical and paramedical personnel, IEC activities for the public, and regular outreach psychiatric clinics. Mere functioning of the outreach psychiatric clinics seem to attract many people in need of mental health care. IEC activities aimed at educating the public will enhance the community mental health care. It is appropriate to aim step 2 care with the participation of district psychiatrists and a follow up in Primary care like delivering medicines and ensuring adherence to treatment and identifying adverse effects. Active IEC activities for the public, and training primary care personnel can help in increasing the utilisation of services.

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Conflict Of Interest
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