



Viewpoint

***Manochaitanya* programme for better utilization of primary health centres**

The prevalence of common mental disorders (CMDs) in primary care settings from India has been reported to be from 17 to 46 per cent¹. There has been limited success in earlier attempts in integration of mental health in primary care, even in National Mental Health Programme (NMHP), despite huge burden and availability of demonstrable cost-effective methods^{1,2}. There is a shortage of mental health professionals in India making specialist psychiatric care out of reach to the public³⁻⁵. In India, primary care clinicians are not trained to diagnose and/or treat these CMDs⁶. Inadequate knowledge about the diagnostic criteria of CMDs, lack of awareness about the appropriate questions to be asked about CMDs and time limitations are inherent in a busy clinic setting⁷. There is a lack of psychiatry training during undergraduate medical education and internship^{8,9} leading to under diagnosis and/or sub-optimal treatment (predominantly symptomatic) by primary care physician for these psychiatric disorders⁶. The NMHP has not covered yet all districts under District Mental Health Programme (DMHP)¹⁰. In the State of Karnataka, DMHP/NMHP has covered only eight districts till date¹¹. Hence, it is essential to attempt new initiatives for the integration of mental health care in public health/ primary care institutions.

***Manochaitanya* programme: A unique initiative**

On October 10, 2014, the Government of Karnataka launched '*Manochaitanya* programme (MCP)'. It is a unique public health programme dedicated exclusively for the integration of mental health care at primary care institutions throughout the State under the term 'Super-Tuesday'. The components of this programme are published elsewhere¹²⁻¹⁴.

Critical analysis of *Manochaitanya* programme

Results of a SWOT analysis of MCP followed by discussion with suggestions to overcome some of the limitations are presented below.

Strengths: This is the first-of-its kind dedicated public mental health programme in India, launched by the State government with exclusive aim to integrate mental health at the level of primary care. It includes the treatment of psychiatric disorders by primary care physicians, and refer only the difficult-to-treat cases to specialized centres. Another highlight is making available psychiatric specialist care at every *taluk* hospital (TH) at least once a month for these referred cases. These benefits are available at about 2310 primary health centres (PHCs) and 180 community health centres (CHCs) and 146 THs covering more than 60 million population of Karnataka¹⁵.

Weaknesses: Focus on psychiatric disorders is not spelt out in the programme. Majority of the CMDs presenting at primary care level end up receiving symptomatic treatments such as painkillers and vitamins leading to chronic disability, making further treatment more difficult¹⁶. There is a high proportion of CMD patients having psychosocial stressors¹⁷. There is no emphasis on psychosocial aspects in the MCP.

A manual of treatment guidelines, which is essential for the success of any public programme would be helpful. There is no additional incentive, either financial or professional, to these doctors for successful implementation. Intrinsic motivation is hard to obtain without any incentive.

Other weaknesses of this programme are absence of separate budget and exclusive district mental health officer (DMHO) who can monitor the implementation of the programme. At present, all District Leprosy Officers have been given additional charge of MCP who are unlikely to be psychiatrists. There is poor monitoring of implementation of this programme. The guidelines suggest that medical officers in-charge of MCC should send monthly report to the Deputy Director, Mental Health (DDMH) and/or Karnataka State Mental Health Authority (KSMHA)¹⁴. Analyzing

and preparing feedback from about 2700 reports every month by these authorities is a daunting task. There is an overlap of roles and responsibilities of DDMH/KSMHA/DMHO which needs more clarity.

Opportunities: In general, this programme provides excellent reciprocal opportunities for primary care physicians as well as psychiatrists to expand the horizon of primary care psychiatry with ultimate benefit to the society. It provides an opportunity for private medical colleges to participate in this public health programme, and also opportunity to expose psychiatry residents (either government or private) to primary care psychiatry during their post-graduate training.

Threats: Major threats are perception of MCP as an additional burden along with existing 22 national health programmes and lack of confidence in their busy practice with less/absent training in managing CMDs by primary care doctors¹⁸. Further, continuous support/supervision of these doctors by specialist psychiatrists is missing. Another major challenge is continuous supply of essential psychiatric medications. There is no widespread publicity of this programme in general public.

Discussion

Epilepsy: A debatable issue: The inclusion of epilepsy in this programme is a debatable issue leading to an ethical dilemma for the current generation of psychiatrists. Epilepsy is included in traditional clinical services, teachings and research of mental health¹⁹⁻²². However, modern medicine excludes epilepsy from mental health and considers it as a neurological condition. A National Epilepsy Control Programme (NECP) with focus of integration of epilepsy care in primary care²³ was proposed and a district model was developed with a focus to train primary care physicians by neurologists to run the programme²⁴.

Training programmes and a manual for primary care doctors: The World Health Organization recommends effective training programmes to develop mental health skills of primary health care staff³. Traditional training programmes for primary care physicians in India are criticized as 'never properly trained'²⁵. Providing continuing education for primary care physicians is more likely to improve the quality of mental health care than the recruitment of more psychiatrists²⁶.

The previous psychiatric training manuals were complex and could not be adapted properly for primary

health care and caused difficulty for primary care physicians who had no or little previous exposure to psychiatry. These manuals were also criticized for focus on diagnoses and health worker behaviour, but had no useful information on how to support the family or patient or the process of referral. These manuals were not prepared after the evaluation of previous training or consultation with the primary-level health workers²⁵. Hence, there is a need for a practical, concise manual which is adapted for primary care psychiatry. It should also have simple algorithm of management of CMDs containing ready reckoner of prescription guidelines and list of side effects and their management. Such a manual should also have discussion about the management of CMDs in the presence of other medical co-morbidities.

There is a need to have separate allocation of budget for this programme which may be managed at two-tier level - one at central and other at adopted medical colleges. The outcome measures at PHCs should also be defined for successful monitoring.

Conclusion

Karnataka is the first State of India to launch this innovative MCP, a public mental health programme with exclusive aim to integrate mental health in primary care. Focus on CMDs, exclusion of epilepsy, innovative training programme for primary care professionals, dedicated budget, adoption model to nearby medical colleges, *etc.*, are essential for its successful implementation. There is a need to define the outcome measures at primary health centres for successful monitoring.

Conflicts of Interest: None.

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Received January 5, 2016

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