Mental Health Care in Primary Care for Medical Officers My Work Book

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Department of psychiatry
NIMHANS

Work Book

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Training for medical officers to integrate mental health into primary health care

My Work Book

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CONTENT

FOREWORD

Mental health care is an integral part of total health care. This has been recognized from the time of Alma-ata declaration. Integration of mental health care into general health services is occurring uniformly across both developing and developing countries since the early seventies. Unfortunately, involving primary care physicians working in the public health care services and the general practitioners and other non-mental health specialists has been a challenge in view of limited knowledge and skills with respect to mental health care. Training and capacity building of these professionals has been recognized as important to ensure integration of mental into general health services. This approach increase access to essential mental health care in the community and there by reduce treatment gap.

The Department of psychiatry, NIMHANS has been in the forefront of developing different models to extend mental health care to the community beyond four walls of the institution since 1980. This has resulted in development of training modules and standardization of assessment tools such as pre and post assessments (MCQS and Case Vignettes). It is interesting to note that the efforts of former professors R.Srinivasa Murthy, Mohan. K.Isaac, C.R.Chandrashekhar and the involvement Governments both at the state (Karnataka in particular) and central level is largely responsible for availability of wide range of resource material. These materials are used both within and out side the country particularly the developing nations.

The primary care doctors and the paramedical staff are trained to carry out specific tasks as part of essential mental health care in the community. Since the 11th five-year plan envisages extension of integrated mental health care through District mental health program to all districts in the country, mental health professionals were encouraged to arrive at some consensus regarding the content of the manual so that training can be conducted uniformly across the country and the workbook is an attempt to standardize the module for training doctors all over the country. This consensus was arrived at the national consultative meeting held at NIMHANS, Bangalore in 2007.

I have no doubt in my mind that the present module will be extremely useful and trainers will greatly benefit from it across the country.

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PREFACE

Integrating mental health care into general health services and other medical settings is the key strategy to extend mental health care into the community. The 11th five-year plan envisages extension of district mental health program to all the districts in the country. This is a very positive development in so far as mental health care is concerned. To ensure that minimal mental health care services is available in primary care settings, a manual for mental health care for primary doctors has been developed by NIMHANS nearly three decades ago. This manual has been revised several times since then.

Training primary doctors in mental health knowledge and skills is crucial since they have limited knowledge and skills for recognizing mental health problems. The manual for mental health care in primary care has been a useful and standard self-instructional manual in the country. Though several other manuals are available, the manual developed by NIMHANS has been field tested and used extensively not only in the country but also in several other developing nations. Currently, the same manual is available as a computer based learning modules with videos of actual patients seen in primary care settings in addition to videos on presentation of various disorders and side effects of medication.

The workbook for medical officers training has been a long felt need since many centres have to share the responsibility of training medical officers across the country. Formatting and structuring the training program and availability of relevant l live patient interviews is absolutely essential for conducting the training program. The workbook developed by NIMHANS will serve the purpose of uniformity in conducting the training program to deliver essential mental health care services for priority mental disorders in the community. I am sure the work book will go a long way in helping trainers to train medical officers using a standard format and also make training an enjoyable experience for the trainees.

Dr.B.N.Gangadhar
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Overview of the three days training module

Training for medical officers is considered essential because of lack of knowledge and skills about mental disorders and their management. Building capacity in the primary care physicians, general practitioners, and other specialists performing general duties in various public health facilities are the core resources in the government and private sector to provide basic mental health in the community. **Basic mental health care or essential mental health care** can be provided in the community for majority of person needing mental health care in primary care settings. This care is proved to every effective, economical and reduces treatment gap for persons with mental health problems. Therefore, capacity building in doctors is an urgent need and there is strong justification to do so in view of limited knowledge and skills about mental disorders. The trained doctor is expected to provide mental health care in an integrated manner with in the context of primary care in the community. Those who need higher level of care should be referred to tertiary care institutions.

The training program is so designed that the doctors learn about diagnosis and management, so that essential and basic mental health is provided to those who seek help in primary care settings. It is estimated that one in four patients using primary health care services have one or the other mental health problems and most often these disorders are under diagnosed and those diagnosed are inappropriately treated. This results is chornicity of the mental health condition, dissatisfaction with care and often patients incur huge cost since they seek help to redeem their distress.

The three-day training program is designed to sensitize the doctors about mental health problems and its consequences on the individual, his family and the community, impart basic clinical skills required to diagnose and manage such disorders in their own settings and lastly to provide support and supervision to health workers, ANMs so that cases are identified in the community and follow up care reaches diagnosed patients.

The training uses brain storming sessions, group discussion, didactic lectures and case demonstration using a wide range of videos typical of person with mental health problems in the community.

The program officers will provide the trained primary care doctors support and supervision periodically. They are expected to visit each of the primary health centers in the district to provide on job training every month as part of district mental health program. Further, the trained doctor will be provided refresher-training every 6 months for three days over the period of implementation.

AIM

- Integrate mental health into primary care by training primary care doctors, general practioners, and specialist doctors performing general duties as part of public health service so that basic mental health care is delivered at the primary health centers.
- Ensure that all person with mental health problems get uninterrupted and continuous care in their own settings.
- Early identification and treatment should result in reduction of disability, family burden, and improvement in quality of life of person with mental disorders.
- To educate the community about the nature and cause of mental disorders and help them access care in primary health centers, Taluk hospitals, other public health care facilities and GP clinics

OBJECTIVES

- To impart diagnostic and management skills to care for persons with mental health problems in non-mental health medical professionals.
- To bring about attitudinal change in non mental health medical professional so that mentally ill are treated in primary care settings
- To sharpen leadership, motivation and supervisory skills in doctors so that care for the needy is available at the primary health center as well as in the community
- The community should recognize mental disorders as bodily afflictions and seek treatment rather than conceptualizing them as due to supernatural, mystical and inherent weakness of people.
- To impart knowledge about referral guidelines, mobilization of community resources and networking with local agencies and people to improve the quality of life and reduce stigma discrimination due to mental disorders

METHODOLOGY

- Didactic lectures
- Role-plays
- Group discussion
- Video demonstration
- Brainstorming
- Case studies
- Games and activities

Background material for the training program

- Mental health care in primary care doctor's manual
- Manual of counseling for medical officers
- Interactive computer based learning modules for primary care doctors.
- Use live case demonstration during the training program as and when possible. This is in addition to the large pool of cases already available as part of interactive CDs.

DETAILS ABOUT SESSIONS AND METHODOLOGY

No	Details of the session	Methodology	Duration
1	Inauguration of the session	Public health importance of mental health	30 minutes
2	Pre-assessment	KAP and Case vignettes	30 minutes
3	Brain and Behavior	Power point slides	45 minutes
4	Presentation of persons with mental health problems in primary care settings	Group work to brain storm and free list the presentation	60 minutes
5.	Signs and symptoms of mental disorders	Power point slides	60 minutes
6	Psychotic disorders – definition, magnitude of the problems, features, diagnosis and management	Power point slides	60 minutes
7	Skills to diagnose psychosis	Video interviews – discussion on rating psychotic symptoms, diagnosis and management	90 minutes
8.	Depressive disorders- definition, magnitude of the problems, features, diagnosis and management	Power point slides	60 minutes
9.	Skills to diagnose depression	Video interviews – discussion on rating psychotic symptoms, diagnosis and management	90 minutes
10.	Neurotic and stress related disorders- definition, magnitude of the problems, features, diagnosis and management	Power point slides	60 minutes
11	Skills to diagnose neurosis	Video interviews – discussion on rating neurosis, diagnosis and management	90 minutes
12.	Recognition and management of mental retardation	Video interviews of person with mental retardation – management in primary care settings	90 minutes
13	Identification and management of person with substance use	Lecture	60 minutes

	disorders		
14.	Identification and management of epilepsy in primary care settings	Lecture	60 minutes
15	Identification of child mental health problems	Lecture	60 minutes
16	Implementation of mental health care in primary care	Lecture	120 minutes
17	Disaster mental Healthcare	Lecture	60 minutes
18	Clarification time	Panel discussion	60 minutes
19	Post assessment		30 minutes
20	Valedictory		30 minutes

How to use this workbook

This workbook has been developed for serving as a guide and standardizes training for doctors across the country. The activity sheets contained in the workbook is based on the training modules and activities conducted during the training program.

The workbook is divided into 20 activity sheets on various topics related to mental health in primary care. Each activity sheet corresponds to the sessions on each of the topic identified for trai9ning doctors over three days.

The trainers and the trainees follow the activity from the beginning to the end of the training program so that training occurs uniformly all over the DMHP sites in India

I. Mental Health Care as part of General Health Care

The world Health organization defines health, as Health state of well being not merely absence of disease or infirmity. Healthy individuals are happy and contented. They have the ability to face difficulties, losses and frustrations. They are capable of living in harmony with others. Not only they are happy but also are able to do their best to keep others happy. They see that others are not put into trouble because of them. They also have certain moral and spiritual values. Such persons who are physically, mentally, socially and spiritually well can be considered healthy.

People become physically ill due to many reasons. Under-nourishment, disease causing organisms invading the body, fluctuations in the environment, wear and tear of bodily organs, injury to the body, defective blood supply to specific organs of the body etc., can lead to illness. When an individual is ill, it is usual to consult the doctor and take treatment.

Like the body, the 'mind' too can become ill. The mentally ill person's sense of well-being and emotional equilibrium are disturbed. The various mental functions like thinking, emotions, memory, intelligence, decision-making etc., can get disturbed. Talk and behaviors can become abnormal. As a result, the ability to work satisfactory can be impaired.

It is easy to imagine and share the experiences with the various difficulties caused by damage or dysfunction to any part of the body. For e.g., all of us know that what it is to have high fever, blindness or broken leg. So, we usually react and sympathies with a person who is physically ill or disabled. However, most of us do not understand what it is to be mentally ill. We often fail to sympathies with a mentally disabled person. We often neglect such individuals. When a person becomes mentally ill, such a person is usually not taken to a hospital immediately for proper treatment. To add to the problem, currently most of the mental health care facilities are available only in cities and towns.

As primary health care doctor, you are already aware of the goal '**Health For All by the year 2000 A.D.'**
Our country has accepted this goal. Provision and Promotion of mental health care is one of the 8 components of Primary health care. Alma Ata Recommendation outlines this as follows:

"Education concerning prevailing problems, and the method 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; control of locally endemic diseases; appropriate treatment of common disease and injuries; promotion of Mental Health (emphasis added) and provision of essential drugs."

Therefore the medical officers, multipurpose workers and other health staff of primary health centres have the primary responsibility of delivering basic mental health care to the community along with general health care. As the most important step for extending mental health care to the individuals in the community.

MENTALLY AND MENTAL HELATH FACILITIES IN OUR COUNTRY

The following table shows the number of cases in the district taking into consideration that an average district population is 1.73 millions. Based on the rate per 1000 population given in the table below, the total number of cases likely to be seen in the district in mentioned below.

Mental disorders rate per 1000 population.

Name of the disorders	Rate per 1000 population
Schizophrenia	3
Mood disorders	16
Common mental disorders	20
Epilepsy	9
Dementia	2
Mental retardation	10
GAD	43
Alcohol users	60
Alcohol dependents	10

Source: Burden of mental and neurological disorders in India , Gururaj et al 2006

Number of cases in the district

Name of the disorder	Number of cases in the district	Minimum # of cases in the district	Maximum # of cases in the district
Schizophrenia	5204	4500	6000
Mood disorders	27753	24000	32000
Common mental disorders	95402	82,500	110,000
Epilepsy	15,611	13,500	18,000
Dementia	2637	2280	3040
Mental retardation	17,345	15,000	20,000
CAD	43018	37,200	49,600
Alcohol users	433,647	3,75,000	5,00,000
Alcohol dependents	136767	1,20,000	1,60,000

Source: Burden of mental and neurological disorders in India , Gururaj et al 2006

While there are millions of people suffering from various types of mental illness, the mental health care facilities available for them is very meager. There are only 37 **mental hospitals** in the country with about **20,000 beds.** More than 50% beds are occupied by chronic patients. In the state of Karnataka, there is one mental hospital with 300 beds and

the other major psychiatric facility NIMHANS is at Bangalore with 800 beds. The number of mental health specialists, also is less. There are about two to three psychiatrists for one million populations in the country at present, whereas in developed countries there are 50-150 psychiatrists for every million of population. Recently, psychiatric units have been established in Medical College hospitals and a few general hospitals. But it is very important to recognize that most of these facilities available in the country are situated in cities, and such facilities are not available in the rural areas.

MENTAL HEALTH FACILITIES ARE AWAY FROM PEOPLE:

Most people do not make use of the available limited facilities. It is estimated that less than ten percent of patients who need help, take modern treatment. Majority of the patients remain without getting, help because of ignorance, fear stigma, misconceptions and wrong attitudes regarding mental illness, their causes and treatment. General public often consider that mental illness are caused by evil spirits, black magic, witchcraft, bad stars and bad deeds in the present or past life. Therefore ill persons seek the help of **faith healers, (mantravadis)** and magicians who perform Puja, counter-magic, exorcism, or offer prayers to Gods and give native / herbal medicines. Most often, they not know that modern doctors can treat mental illness similar to the treatment of physical illness.

People have their **own fears** about mental hospitals. It is often felt that mental hospitals are place where dangerous mental patients are locked up. Families would not like their relative to be kept in such a dangerous set up. An ex-patient of mental hospital and his family members are times socially isolated and stigmatized. Therefore people seek help from mental hospitals as last resort. Delays in treatment decrease the chances of recovery.

Distance: There are only one to two mental hospitals in most states, which often are very far away for majority of the needy persons and their families to take treatment on a regular basis.

Poverty and lack of social welfare support: In our country large numbers are poor and do not have money or other help to take the patient to the hospital or buy medicines for regular and complete treatment.

Long duration of treatment and follow up: Some patients need medications for a long time. This is especially true for those who are ill for long periods and those not receiving care early in the illness. They have to consult the doctor periodically. For example, almost all the epileptic patients need drugs for 3-5 years. Most rural patients find it difficult to come even for the first consultation and treatment. They often become irregular and even stop the follow up visits to the hospital. They seek help again, when there is a replace. They often lose faith in hospital treatment and become victims of quakes who claim instantaneous, quick relief or cure with their treatment. When patients do not improve, the attempts to treat the ill persons are given up with frustration and

helplessness. These failed attempts also contribute to the myth of mental disorders are being untreatable.

BASIC MENTAL HEALTH CARE PROGRAMMES:

The initial experiments in organizing basic mental health care programs were at Chandigarh and Bangalore. Both these centers aimed to integrate mental health care at primary health care level.

The **Chandigarh program** carried out at the Raipur Rani Block of Ambala District of Haryana state (1975-1982) was part of a WHO project titled 'Strategies for Extending Mental Health Care '. Efforts were directed to develop a system of priority selection to train the existing primary health care personnel to carry out basic mental care tasks and to involve the community through public education and formation of Mental Health Association, 60,000 population of PHC block was selected for work. Over the course of 6 years, the levels and limits for mental health care work at primary health care level were outlined. The results demonstrated that there are significant numbers of mentally ill living in the rural areas needing urgent treatment and not receiving any help. Further it was demonstrated that it was possible for the different categories of primary health personnel to carry out a limited range of mental health activities with the support of the medical officers. It was also shown that it was possible to involve the community in a meaningful manner. This experience resulted in a practical Manual of Mental Disorders and mental health education materials. A simultaneous project was carried out at **Bangalore** by the Community Psychiatry unit of Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS) Bangalore from 1975. In a series of planned studies and training programmes it was noted that it was possible to define clear tasks for doctors and health workers working in the PHC system and provide training to them. Separate manuals for the multipurpose workers (MPWs) in Kannada and the medical officers in English were developed based on the experience of the many years of fieldwork. Majority of the above rural mental health programmes were carried out from the Sakalavara Centre in Anekal Taluk. In addition, the Solur PHC set up was also involved in the application of the knowledge gained. The experience in these PHCs have shown the urgent need for taking mental health care to villages and the vital role the multipurpose workers and medical officers can play in providing basic mental health care. Both these projects used relatively inexpensive and a limited range of medicines for treatment. The range of drugs needed was only 4 to 5.

TRAINING FOR DOCTORS AND MPWs IN KARNATAKA STATE

A positive development in the State of Karnataka has been the initiation of regular monthly training courses of medical officers and MPWs at NIMHANS, Bangalore since April 1982. The training program is of one to two week's duration and is a residential one. During the training, with the help of classroom teaching, fieldwork, clinical demonstrations and manuals, the basic mental health knowledge and skills are provided. This one-week program for MPW's and two weeks program for doctors was organized **every month** from April 1982 to December 1990 at NIMHANS.

In July 1985, an initiative to cover a whole district (Bellary) of Karnataka was taken up by the joint collaboration of Department of Health and Family Welfare, Karnataka, NIMHANS and the district authorities of Bellary. The essentials of the District Mental Health Program (DMHP) were (i) identification of properties for mental health care, (ii) training to all health personnel, (iii) provision of essential drugs and records, (iv) public education, (v) involvement of community and (v) regular monitoring of the program. The results of the five years have been positive. This has resulted in Karnataka State extending a similar program to 6 other districts.

Besides Chandigarh and Bangalore, other psychiatric centres taking up similar rural mental health programmes are Baroda, Calcutta, Delhi, Hyderabad, Jaipur, Lucknow, Patiala and Vellore. Some of the states like Haryana, Himachal Pradesh, Punjab, Pondicherry, Uttar Pradesh, Maharashtra, Gujarat, Kerala, Rajasthan, Andhra Pradesh, Assam, and West Bengal initiated pilot programmes from October 1985.

NATIONAL MENTAL HEALTH PROGRAM FOR INDIA (1982)

Following the experiences of different centres in providing community care for the mentally ill, the professionals and planners formulated a program for mental health care at the National Level in 1982.

The objectives of the program are:

(i) To ensure availability and accessibility of minimum health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged.

(ii) To encourage application of mental health knowledge in general health care and in social development.

(iii) To provide community participation in the mental health service development and to stimulate efforts towards self - help in the community.

The **Central Council Health and Family Welfare** in its meeting held on 18 - 20, August 1982 recommended that : (1) Mental health must from an integral part of the total health program and as such should be included in all National policies and programmes in the field of health education and social welfare ; (ii) realizing the importance of mental health in the course curricula for various levels of health professionals, suitable actions should be taken in consultation with the appropriate authorities to strength the mental health education components. **The planned approach is to integrate mental health services with existing general health services.**

In this introduction, we have considered the current state of mental health services in the country, as well as the current approaches to the provision of basic mental health care. At present we have a practical and an appropriate approach to provide the needed services. What is needed is its applications through professional commitment to strengthen this area of work and the political and administrative support along with public involvement to make it a reality. Such a joint effort can result in meaningful

basic mental care most of the population, with minimum of inputs and within a reasonable period of time.

Inauguration and background to the training

It is desirable to request the District Health Officer / Chief Medical officer to inaugurate the program. The inauguration by the district head gives a sense of importance to this program and helps him to remember the importance of DMHP. He will review the program regularly in his monthly meeting. This is critical for effective implementation of the program.

The DHO will highlight the

- Magnitude of mental disorders in the community
- Universal nature of mental disorders
- Consequences of non treatment of mental disorders
- Availability of very effective and safe treatment for persons with mental disorders
- Need to integrate mental health care into general health care in view of paucity of mental health care resources in the community and appropriateness of such a care to reduce treatment gap, reduce stigma and discrimination, reduction of disability and improvement of quality of life.
- Monitoring, supervision, regular reporting

Session: 1

Brain and Behavior

Brain is an integral part of the human system and it plays a central role in all the functions of the body. Though brain occupies such an important role in regulation of various functions, most non-mental health professionals give least importance to it. They are uncomfortable dealing with disorders of the brain in comparison to myriad physical health problems. Simple lack of familiarity with abnormality of brain dysfunction, understanding and evaluation of brain function is a major barrier.

This session deals with understanding brain, its functions and relationship to behavior.

Behavior of an individual is the net result of his body constitution (genetic, growth and development of the brain) his psychological make up (experiences, knowledge, attitude etc.) and environmental factors (family, social and cultural norms). All behaviors can be understood against the background of these factors. For Example: (i) Hyperactivity or under activity of mentally retarded child is related to the poor development of the brain, (ii) temper tantrums of a child can be due to improper attention given by the parents, (iii) irritability or aggression can be the result of unresolved conflicts and frustrations, (iv) expression of socially inappropriate ideas, behavior and beliefs by individuals can be he result of changes in the frontal lobe or other parts of the brain, (v) antisocial behavior of an individual can be the result of brain damage or reactions to problems in personal life or a reaction to social stresses, (vi) severe emotional reaction in an individual can be the result of past experiences or poor social supports in a crisis. Similarly, bizarre behavior such as laughing to self of talking to self could be in response to auditory hallucination, restlessness and disorganized behavior could be in response to visual hallucination, excessive happiness could lead to overactivity and excessive speech, excessive sadness results in underactivity and slow speech

Thus, when individuals present with physical complaints or abnormal behavior, one should take into consideration the biological factors, early life experiences, current life situation, social and cultural factors to understand his mental health problems.

Highlights

- Brain weighs about 1250 mgs and its consist of three main structures called Cerebrum, Cerebellum and the Brain stem.
- Brain cells are called neurons and there are billions of them. Neuron is connected to each other at the synapse.
- Information is passed as signals from place to the other with the help of neuro-chemical substances called neurotransmitters.
- Mental health problems are related to specific changes in the availability of neurotransmitters in certain areas of the brain.
- Neurons do not under go cell division or repair and therefore damage to neurons results in irreversible changes after trauma, hemorrhage, intoxication or hypoxia.
- Brain has a number of cavities called ventricles and there is filled with cerebrospinal fluid. It acts as a cushion for the brain to prevent it from trauma.

Session: 2

Presentation of person with mental health problems in primary care

Let us know look at how people with mental health problems present in primary care settings.

Sl no	Question	Activity	Facilitation
1	How do persons with psychosis present in primary care clinics	Ask the participants to discuss amongst themselves – Free list all modes of presentation	Based on the presentation the trainer will clarify modes of presentation
2.	How do people present with depression in primary care clinic	Ask the participants to discuss amongst themselves – Free list all modes of presentation	Based on the presentation the trainer will clarify modes of presentation
3.	How do people present with minor mental disorders/ neurosis	Ask the participants to discuss amongst themselves – Free list all modes of presentation	Based on the presentation the trainer will clarify modes of presentation
4.	What are the difficulties encountered by the doctor in diagnosing mental health problems in primary care settings	Ask the participants to discuss amongst themselves – Free list all modes of presentation	Based on the presentation the trainer will clarify modes of presentation
5.	What are the barriers for mental health care in our settings	Ask the participants to discuss amongst themselves – Free list all modes of presentation	Based on the presentation the trainer will clarify modes of presentation

Methods: The trainees are divided into five groups by calling out 1-5. All members who called out 1 will be in-group Similarly, four other groups are formed and each of the group is allotted a topic given above. Each group is allotted 15 minutes for the activity and one of the members of the group is expected to make a presentation.

Activity material: The trainers should provide KG cardboard sheets and sketch pens

Facilitation: The trainer will facilitate discussion on each of the presentation and highlight how persons with mental health problems present in primary care

SL no	Presentations	Possible diagnosis
1	• Excitement • Withdrawal • Unusually suspicious • Hearing voices • Odd beliefs • Strange behavior • Unusual bodily complaints • Biological function disturbances • Irregular to work or absent from work • Inability to take responsibility • Poor self care	
2.	• Repeated visits to the clinic • Persistent vague bodily complaints • Biological function disturbances • Lack of confidence • Attempted suicide • Wanting to go away or give up every thing • Being dull and withdrawn • Crying spells/ easily moved to tears	
3.	• Repeated upper GI disturbances • Absent from work or poor work record • Accident proneness • Inability to recall episodes of aggression or things that he did • Breath smelling of alcohol • Demanding or disinhibited behavior • Strained relationship with family members	
4	• Diffuse multiple bodily complaints • Distressed and anxious • Demands tonics/ injections • Needing repeated reassurance • Preoccupied with bodily dysfunction • Repeated investigation which are normal • Dramatic onset of physical symptoms • Life difficulties	
5.	• Scholastic difficulties • Multiple bodily complaints • Dull and withdrawn • Hyperactive • Delayed mile stones • Stealing / lying / absent from school	

	• Bedwetting • Unexplained fears/ school refusal	
6.	• Altered sensorium/ episodes of unconsciousness • Repeated fall and injuries • Poor in studies • Quick tempered • Quarrelsome • Repeated headaches/ vomiting	

Reflect on skills required to identify and diagnose above problems

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Session: 3

Signs and symptoms of mental disorders

1. Hallucinations
2. Delusions
3. Disorganized speech
4. Lack of insight
5. Sadness
6. Multiple bodily complaints
7. Biological function disturbances
8. Excitement
9. Withdrawal
10. Excessive speech
11. Over-activity
12. Motor retardation
13. Repetitive thoughts
14. Alcohol / substance use
15. Craving
16. Tolerance
17. Self neglect
18. Dis-inhibited behavior
19. Suspicious
20. Quarrelsome
21. Confusion
22. Disorientation
23. Memory loss

Categorization of signs and symptoms based on the diagnostic group.

SL no	Diagnosis	Symptoms	Signs
1	Psychosis		
2	Depression		
3	Neurosis		

Differences between psychosis and neurosis

Psychosis	Neurosis

Differences between Mania and Depression

Mania	Depression

What are your doubts?

_____
_____
_____
_____

Session: 4

Psychotic disorders

- Definition,
- Magnitude of the problems in the community
- Features,
- Diagnosis
- Management
- Educating families about the nature of the illness and side effects of medication
- Role of the family in the care of person with psychosis
- Role of health workers in identification, education of families, follow up care in the community
- Referral guidelines

USE POWER POINT SLIDES ON-

- **ACUTE PYSHOSIS**
- **CHRONIC PYSCHOSIS**

Session:5

Skills to diagnose psychosis

Use videos on psychosis to demonstrate the following

- **Presentation in primary care**
- **Features of psychosis**
- **Interview techniques**

Videos –

1. Video Clipping 1 and 4 in Disc 1 of the interactive CDs
2. Videos 2_ psych, 4_psych and 5_ psych
3. Videos on mania in Disc 4
4. Videos on acute psychosis
5. Videos on drug related side effects

Rating the videos for diagnosis

As the videos are shown, the trainees are requested to use the case proforma in medical officers manual page- 129 to rate the symptoms. The trainees are requested to use pencil to tick mark the symptom and later to erase it using a rubber. This will avoid the duplication of case records.

Now discuss differences between organic psychosis and functional psychosis

Functional psychosis	**Organic psychosis**

Differences between acute psychosis and chronic psychosis

Acute psychosis	Chronic psychosis

What are your doubts about psychosis?

_____

_____

_____

Ref to the FAQs in Disc 3 and 4 of the interactive CDs this includes drug interactions with anti-psychotic medication.

Session: 6

Depressive disorders

- Definition,
- Magnitude of the problems in the community
- Features,
- Diagnosis
- Management
- Educating families about the nature of the illness and side effects of medication
- Role of the family in the care of person with depression
- Role of health workers in identification, education of families, follow up care in the community
- Referral guidelines

USE POWER POINT SLIDES ON-

- **Depression**

Session: 7

Skills to diagnose depression

Use videos on depression to demonstrate the following

- **Presentation in primary care**
- **Features of psychosis**
- **Interview techniques**

Videos –

1. Video Clipping 6 in Disc 1
2. Videos 1_ Depression, 3_Depression in Disc 2
3. Videos on depression 1- 4 in Disc 4

Rating the videos for diagnosis

As the videos are shown, the trainees are requested to use the case proforma in medical officers manual page- 129 to rate the symptoms. The trainees are requested to use pencil to tick mark the symptom and later to erase it using a rubber. This will avoid the duplication of case records.

Now discuss differences between Morbid sadness and sadness in reaction to life events

Morbid sadness	**Sadness following life events**

Differences between acute psychosis and chronic psychosis

Major Depression	Neurotic Depression

What are your doubts depressions?

_____

_____

_____

Ref to the FAQs in Disc 3 and 4 of the interactive CDs this includes drug interactions with anti-depressants medication.

Session: 8

Neurotic and stress related disorders

- **Definition,**
- **Magnitude of the problems in the community**
- **Features,**
- **Diagnosis**
- **Management**
- **Educating families about the nature of the illness.**
- **Role of the family in the care of person with neurosis**
- **Role of health workers in identification, education of families, follow up care in the community**
- **Referral guidelines**

USE POWER POINT SLIDES ON-

- **Neurosis**

Session: 9

Skills to diagnose neurosis

Use videos on neurotic disorder to demonstrate the following

- **Presentation in primary care**
- **Features of neurotic and stress related disorders**
- **Interview techniques**

Videos –

1. Videos on neurosis 1, 2, 4 and 5 in Disc 5
2. Videos on acute neurosis in Disc 5

Rating the videos for diagnosis

As the videos are shown, the trainees are requested to use the case proforma in medical officers manual page- 129 to rate the symptoms. The trainees are requested to use pencil to tick mark the symptom and later to erase it using a rubber. This will avoid the duplication of case records.

Now discuss differences between Hysteria and malingering.

Hysteria	**Malingering**

Differences between Clinical depression and grief

Clinical Depression	Grief / bereavement

Steps involved in counseling for person with neurosis

Step: 1 _____

Step: 2 _____

Step: 3 _____

Step: 4 _____

Steps involved in counseling for person with neurosis

Counseling techniques

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do's and Don'ts in counseling

Do's	Don'ts

What are your doubts on Neurosis?

_____
_____
_____
_____

Ref to the FAQs in Disc 5 of the interactive CDs this includes drug interactions with anti-depressants medication.

Session 10

Mental Retardation

- Definition,
- Magnitude of the problems in the community
- Features,
- Diagnosis
- Management
- Educating families about the nature of the condition
- Role of the family in the care of person with mental retardation
- Role of health workers in identification, education of families, follow up care in the community
- Role of the health workers in home care management of person with MR
- Referral guidelines

USE POWER POINT SLIDES ON-

Mental Retardation

Session 11

Skills to diagnose and manage mental retardation

Use videos on mental retardation to demonstrate the following

- **Presentation in primary care**
- **Features of mental retardation**
- **Management of mental retardation in the community**

Videos –

1. Videos on MR in Disc 3
2. Videos on MR in Disc 2

Differences between mental retardation and slow learners

Mental Retardation	**Slow learners**

Management of mental retardation based on the IQ

Sl no	**Degree of retardation**	**Management**
1.	Mild retardation	
2.	Moderate retardation	
3.	Severe and profound retardation	

Identification of mental retardation in the community

SL No	Primary health care personnel	Methods to identify
1.	TBA/ ASHA / link worker	
2.	ANMs	
3.	JHAs/SHAs/BHE	
4	Primary care doctors	
5.	Parents	
6.	School teachers	
7.	Volunteers in the community	

WHO needs home care management

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____

Key resources for the management of MR in the community

SL NO	Resources	Responsibility
1.	**Parents**	
2.	**ANMs/ JHAs/SHAs**	
3.	**Self help groups members**	
4.	**Primary care doctors**	
5	**Mental Health Professional**	

Welfare Measures for persons with MR

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Training for specific goals

SL	Goal	Activity	SL	Goal	Activity
1	Neck control		7	Reading, writing	
2	Sitting		8	Social skills	
3	Standing		9	Communications	
4	Walking		10	Independent skills	
5	Talking		11	Appropriate Beh	
6	Self care		12	Time management	

What are your doubts on MR?

_____
_____
_____
_____

Ref to the FAQs in Disc 3 of the interactive CDs (module 7)

Session 12

Identification and management of substance use disorders

- Definition,
- Magnitude of the problems in the community
- Features,
- Diagnosis
- Management
- Educating families about the nature of the illness
- Role of the family in the care of person with substance use disorder
- Role of health workers in identification, education of families, follow up care in the community
- Outpatient detoxification in primary settings
- Referral guidelines

USE POWER POINT SLIDES ON-

Substance use disorders

Session 13
Skills for diagnosis and management of substance use disorders

Differences between abuse, harmful use and dependence

SLno	Abuse	Harmful use	Dependence

Primary care intervention abuse, harmful use and dependence

SL NO	Abuse	Harmful use	Dependence

Criteria for out patient detoxification in primary care settings

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Psychiatric morbidity associated with substance use disorders

SL no	Co-morbidity	Management
1	Depression	
2.	Anxiety disorders	
3.	Personality disorders	
4	Psychotic disorders	
5	Others /physical	

Strategies to remain abstinent after detoxification

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

What are your doubts on MR?

_____
_____
_____
_____

Ref to the FAQs in Disc 6 of the interactive CDs (module 8)

Session 14

Identification and management of epilepsy in primary care

- Definition,
- Magnitude of the problems in the community
- Features,
- Diagnosis
- Management
- Educating families about the nature of the illness
- Role of the family in the care of person with seizure disorders
- Role of health workers in identification, education of families, follow up care in the community
- Seizures and associated psychiatric disorders
- Referral guidelines

USE POWER POINT SLIDES ON-

Epilepsy

Session 15

Skills to diagnose epilepsy

Use videos on epilepsy to demonstrate the following

- **Presentation in primary care**
- **Features of epilepsy**

Videos –

1. Video Clipping on epilepsy in Disc 1

Rating the videos for diagnosis

As the videos are shown, the trainees are requested to use the case proforma in medical officers manual page- 129 to rate the symptoms. The trainees are requested to use pencil to tick mark the symptom and later to erase it using a rubber. This will avoid the duplication of case records.

Differences between epilepsy and hysteria

Epilepsy	**Pseudo seizures (Hysterical seizures)**

Differences between epilepsy and syncope

Epilepsy	Syncope

Psychiatric morbidity associated with epilepsy

SL no	Co-morbidity	Management
1	Depression	
2.	Hysteria	
3.	Personality disorders	
4	Psychotic disorders	
5	Anxiety disorders	

Do's and Don'ts in epilepsy

Do's	Don'ts

When to refer person with epilepsy for further care

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

What are your doubts on Epilepsy?

_____
_____
_____
_____

Ref to the FAQs in Disc 1 of the interactive CDs (module 9)

Session 16

Identification of child mental health problems

- Definition,
- Magnitude of the problems in the community
- Features,
- Diagnosis
- Management
- Educating families about the nature of the problem
- Role of the family in the care of children with mental health problems
- Role of Teachers, Anganawadi workers, Health workers in identification, education of families, and follow up care in the community
- Referral guidelines

Use power point slides on child mental health problems – ref appendix

Use videos to demonstrate the following in Disc 3 (module 7)

1. **Attention deficit hyperactivity disorder in children**
2. **Attention deficit hyperactivity disorders in mentally retarded children**
3. **Hysteria in children**

Features of underactive, hyperactivity and SLD

Sl NO	**Underactive Children**	**Hyperactive Children**	**Specific learning disability**

Primary care intervention underactive, hyperactivity and SLD

Sl NO	Underactive Children	Hyperactive Children	Specific learning disability

What are your doubts on child mental health problems?

_____

_____

_____

_____

Ref to the FAQs in Disc 3 of the interactive CDs (module 7)

Session 17

Disaster mental health care

Definition of Disaster

Impact of Disaster

Psychosocial care for Disaster Survivors

Disaster Mental Health care

Session 18

Implementation of mental health program

1. **Sensitize health workers about mental health problems in primary care settings**

EARLY RECOGNITION OF SEVERE MENTAL ILLNESS

Symptom: ----------

Illness: ----------

Management: ----------

Role of MPW:----------

Symptom: ----------

Illness: ----------

Management: ----------

Role of MPW: ----------
-

Symptom: ----------

Illness: ----------

Management: ----------

Role of MPW: ----------

Symptom: ----------

Illness : ----------

Management: ----------

Role of MPW: ----------
-

Symptom: ----------

Illness : ----------

Management: ----------

Role of MPW: ----------

Symptom: ----------

Illness: ----------

Management: ----------

Role of MPW: ----------

Symptom: ----------

Illness : ----------

Management: ----------

Role of MPW: ----------

Symptom: ----------

Illness: ----------

Management: ----------

Role of MPW: ----------

2. Role of health workers in implementation of mental health care in primary care

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

3. IEC activities in the PHC/PHU catchment area

SL no	Location	Activity
1	**PHC/PHU**	
2.	**Sub-centre**	
3.	**School**	
4	**Gram panchayat**	
5	**Self help groups**	

4. Identification of mental health problems in the OPD

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

5. **Registration of person with mental health problems in the PHC/PHU**
    - **OPD registration- daily**
    - **Field registration and transfer of files to the OPD**
    - **Registration of referred cases from other agencies**

Review of registered cases in the PHU/PHC monthly meetings sub-center wise

Diagnosis	Total Number of old cases registered till last month	Total number of new cases registered this month	Total number of cases	Number of patients Regular treatment	First contact dropout	Irregular patients	Number who have recovered	Dead	Migrated
Psychosis									
Neurosis									
Depression									
Epilepsy									
Mental Retardation									
Substance abuse									
Child Mental Health problems									
Total									

1. **Total number of old cases till the last day of the month.**
2. **Total number of new cases registered in the current month**
3. **Number of patients who are regular on treatment ie patients attending the clinic regularly every month (> 75% of follow up visits)**
4. **First contacts drop out. Patients who have dropped after one contact**
5. **Irregular patients: Patients who are not attending the follow up regularly every month. (< 50 % of follow up visits)**
6. **Recovered patients: Number of patents whose symptoms have remitted**
7. **Number of patients who have expired**
8. **Number of cases who have migrated from the area**

Table: 6 Support and supervision to para-medical workers to increase case detection and mental health care coverage

SL no	Activity	Frequency
1	Monthly meetings PHC/PHU	
2.	Sub-centre visits	
3.	Field visits	
4	Emergency care	
5	Case discussion	

7. Reporting

Diagnosis	Total Number of old cases registered till last month	Total number of new cases registered this month	Total cases	Number of patients Regular treatment	First contact dropout	Irregular patients	Number who have recovered	Dead	Migrated
Psychosis									
Neurosis									
Depression									
Epilepsy									
Mental Retardation									
Substance abuse									
Child Mental Health problems									
Total									

Table: 8 Duration of Illness of Registered cases in the PHC/PHU/GAD

Diagnosis	Less than one month	One to three months	Four to six months	Seven to twelve months	One to three years	Four to six years	Seven to ten years	More than eleven years
Psychosis								
Neurosis								
Depression								
Epilepsy								
Mental Retardation								
Substance abuse								
Child Mental Health problems								
Total								

Table 9. Drug stock balance

Name of the drug	Opening Balance	Drugs received in the last month	Total	Expiry date	Total number of patients	Number of tablets dispensed	Balance at the end of the month
Tab Chlorpromazine 100mgs							
Tab Resperidone 2 mgs							
Tab Imipramine 75 mgs							
Tab Phenobarbitone 30 mgs							
Tab Phenobarbitone 60 mgs							
Tab Diphenyl-hydantion							
TabTrihexyphenydyl							
Tab Diazepam							
Inj- Fluphenazine							
Inj-Chlorpromazine 50 mgs							
Inj Promethazine 50 mgs							
Other drugs							

Table 10

Details of drug expenditure record

Date	Record # or case #	PB 30	PB 60	RSPN 2mg	CPZ 100mg	DZM 5mgs	FFZ 25 mgs	THP 2mg	DHP 100mg	IMN 75mgs	FLX 20mgs
Total											

Session 19
Clarification time

Psychotic disorders
Depressive disorders
Neurotic disorders
Epilepsy
Mental Retardation
Substance Use disorders
Disaster mental health care
Implementation of mental health care program

Appendix: 1

KAP questionnaire for medical officers

Dear doctor kindly read the following statements and mark (1) for correct and (2) wrong statements.

SL NO	Items	
1.	Anyone who experiences severe stress can become mentally ill.	
2.	Mental illnesses are caused by black magic or evil spirits.	
3.	Masturbation, semen loss or excessive sex can result in development of mental illness.	
4.	Mentally patients are always dangerous	
5.	Mental illness is treatable. Very effective, economical and safe medical remedies are available.	
6.	Marriage can cure mental illness.	
7.	Mentally ill individuals can be treated very safely in your local hospital.	
8.	A treated mentally person can work with responsibility	
9.	Mentally ill persons need love and encouragement in addition to medication prescribed by the doctor.	
10	Once drugs are prescribed after evaluation, patients need not consult the doctor again	
11	Some illnesses in pregnant mother during the first trimester can cause mental retardation in the child.	
12	Poor development of the brain is the cause of mental retardation	
13.	To improve the intelligence in a mentally challenged child, there is need for tonics/ powerful tablets/vitamin injections.	
14.	Early intervention for children who mentally challenged can help them develop adaptive abilities.	
15.	Black magic/evil spirits cause fits.	
16.	Head injuries can cause fits	
17.	Increased electrical activity in the brain is the cause for fits	
18.	Abuse of cannabis (Ganja) can precipitate psychosis in vulnerable individuals.	
19.	Persons who are addicted to drugs cannot be helped by the primary care doctor or the GP.	
20.	Sexual dysfunction is due excessive indulgence in sexual activities.	
21.	Religious and faith healers are the most appropriate persons to treat severely mentally ill in the community	
22.	An individual with psychotic illness can improve without any treatment	
23.	Recovered mentally ill persons are not suitable for any job	
24.	A third of the homeless persons are mentally ill.	
25.	Severe mental illness affects both men and women equally	
26.	Poverty and mental illness is closely related	
27.	Depression is not common in women	
28.	One out of every four persons using primary health care facility has	

	one or more diagnosable mental disorder	
29.	Persons suffering from mental illness can commit suicide	
30.	Adequate and appropriate treatment for the mentally ill can prevent disability	
31.	Lack of social supports and many exit life events can cause depression.	
32.	Depression is often under diagnosed because patients presents with multiple bodily complaints	
33.	Diagnosis of clinical depression is confirmed if the patient cries in the clinic.	
34.	Counseling is the most appropriate treatment for person suffering from emotional problems.	
35.	Follow up visits by health workers is very critical to improve drug compliance and better outcome.	

PRE TRAINING ASSESSMENT

Case History No:

A: What is the diagnosis?
Normal/Physical problem/Neuro-psychiatric problem.

Specify the diagnosis_____

B What is the drug of choice and the useful daily dosage?

Drug	Dosage

C What are the common side effects of the above drug, and how would you manage them?

Side Effect	Management of side effects

D Do you know of any other drug for the management of this condition?

Drug	Dosage	Side effect	Management of side effects

E Is there any non-pharmacological methods of management. Specify.

_____

F What is the duration of treatment of this case?

_____

G What specific advice you would give patient and family regarding:
Illness_____

Treatment_____

Work_____

H What is the prognosis of this case at the end of 6 months?

a) Asymptomatic
b) Marked Improvement
c) Moderate improvement
d) Mild improvement
e) No change / worse

I Under what specific clinical circumstance would you refer this patient to specialist?

_____
_____
_____
_____
_____

POST TRAINING ASSESSMENT

Case History No:

A: What is the diagnosis?
Normal/Physical problem/Neuro-psychiatric problem.

Specify the diagnosis_____

B What is the drug of choice and the useful daily dosage?

Drug	Dosage

C What are the common side effects of the above drug, and how would you manage them?

Side Effect	Management of side effects

D Do you know of any other drug for the management of this condition?

Drug	Dosage	Side effect	Management of side effects

E Is there any non-pharmacological methods of management. Specify.

_____

F What is the duration of treatment of this case?

_____

G What specific advice you would give patient and family regarding:
Illness_____

Treatment_____

Work_____

H What is the prognosis of this case at the end of 6 months?

f) Asymptomatic
g) Marked Improvement
h) Moderate improvement
i) Mild improvement
j) No change / worse

I Under what specific clinical circumstance would you refer this patient to specialist?

_____
_____
_____
_____
_____