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Letter to Editor

COMMENT ON: "MENTAL HEALTH CARE: CAN WE CREATE A NEW KERALA MODEL?"

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Dear Sir,

I read the article titled "Mental Health Care in Kerala: Can we Create a new Kerala Model?" in KJP 28 (1) 2015 with interest. The author has to be commended for his effort and interest in improving the mental health of the people of Kerala, especially the poor and vulnerable sections. My comments on this are given below:

PRINCIPLE 1

Kerala has a significant proportion of middle class who are concerned about quality of care and the time taken to access them. They are willing to pay for better services or for services available closer to their homes. The consultation fees charged by most private psychiatrists in Kerala (except those in huge corporate hospitals, which are a few and in bigger cities only) ranges from Rs 150 to Rs 300 per visit. This is affordable to majority of the working class of Kerala who earn around Rs 600 to 800 per day as wages. The actual burden is the cost of medications. Psychotropic medications are not procured adequately by government hospitals, either at state level or locally, for various reasons. Except for DMHP, the availability of drugs is poor in government sector.

Insurance generally pays only for inpatient expenses and not for purchase of drugs by outpatients. The government scheme called Rashtriya Swasthya Bima Yojna (RSBY) does not even reimburse the expenses incurred for psychiatric treatment as inpatient, despite orders from the Honorable High Court of Kerala.

PRINCIPLE 2

There are no standard treatment guidelines or protocols for treating even physical illnesses or emergencies in Kerala. Very few specialized psychiatric services are available at present in the state. What is generally available is service of a general psychiatrist

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without any backing of specialist training, qualifications or supporting staff. There are few special clinics on child mental health, suicide prevention and substance use in government medical colleges. But even these are not offering full range of needed psychosocial services due to lack of manpower and time.

PRINCIPLE 3

The services available in the Government Mental Health Centers (GMHCs) will have to be brought in line with recommendations on human rights. Appointment of additional staff will be the most needed step for this.

PRINCIPLE 4

There is a rapid increase in the number of psychiatrists in Kerala as the number of postgraduate seats has gone up from less than 10 to over 40. But there are no courses to train other professionals like clinical psychologists and psychiatric social workers. Institute of Mental Health and Neurosciences (IMHANS) Kozhikode has started a course in PSW, and will be starting clinical psychology and Diploma in Psychiatric Nursing (DPN) courses next year.

But the government sector or private sector is not prepared to provide job opportunities for these categories. Even those few in government sector at present are unhappy, and are leaving the service due to lack of career path and poor pay. There are few MSc Psychiatric Nursing courses in Kerala. But persons passing out from these centers do not have adequate job opportunities within the state. Their only hope is placement abroad.

Creation of psychiatry units at Taluk level hospitals with presence of a social worker / nurse in addition of psychiatrist would be useful. Provision of free medications is the most essential step.

PRINCIPLE 5

At present, Kerala does not have the system of a designated GP whom the patient has to approach first, who serves as a gatekeeper to the healthcare system. Introduction of this only for mental health may not be feasible. It would be possible only with a state-wide policy decision. But to convince the administration about this, we need evidence from running pilot projects in at least a few panchayats. The qualification of the Mental Health Officer is not specified in the article.

PRINCIPLE 6

This is a welcome suggestion. The GMHCs can be trifurcated in to a) An acute care facility where patients stay with their family members for treatment of acute episodes b) A forensic setting with separate provisions for mentally ill offenders and those admitted as homeless wandering mentally ill captured by the police and c) A long stay residential facility for partly cured mentally ill who have no homes to go. There can be dormitories where they can have personal belongings and freedom to seek employment even outside the hospital.

PRINCIPLE 7

This is another dream that has not materialized even in most developing countries where efforts were made in this direction.

The availability of funds for this initiative is also quite difficult. Considering that the government is trying to reduce expenditure by refusing to sanction new posts and even trim money for buying drugs, they are unlikely to sanction additional amount. If

the local bodies are willing to set aside money, it can be used for purchasing drugs. But, as per the current regulations, they are not generally allowed to sanction posts or appoint staff. Hence it may only be possible to recruit staff for specific projects. The sustainability of this is poor.

Another model tried is the Palliative Care movement that happened in some districts of North Kerala. But this was largely based on charity offerings from public and religious and social organizations. Preliminary attempts by the same group to replicate this is in mental health has not met with similar success.

As a psychiatrist working in Kerala for over two decades, I think most of the patients from middle and upper classes, living in urban or semi-urban areas, would already be receiving psychiatric care, though not of high quality or consistently. The issue is with the poorest sections living in remote rural areas and the tribal community. Providing mental health care for them is the responsibility of the government. Professionals working in the state have to convince the administration about this.

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AUTHOR'S RESPONSE

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I very much appreciate the commentator's understanding of the ground realities and the supporting arguments made for a fairer mental health service. The comments highlight the lack of resources, poor skill mix, absent care pathways and inadequate care provisions.

It is true that the cost of medication is limiting the prospects of recovery for many people. Though psychiatric consultation and provision of medication are essential components of the treatment plan for individuals with severe mental disorders, a modern mental health care system requires much more than that. This is where the population at large, all classes included, is suffering enormously.

In the present system, clinical care is often determined by the purchasing power of the individual. I agree that working class in Kerala enjoy better wages and social conditions than their counterparts in many other Indian states. The idea that daily wages are high enough to afford psychiatric consultation and we should therefore focus more on medication affordability has many limitations.

1. The financial burden of chronic mental illness affecting a family member is far more debilitating than the issue of affording consultation fees.
2. It presupposes that either those with chronic mental illness are earning Rs 600-800 per day, or that patient's family is ultimately responsible for his/her care. Most individuals with severe mental disorders are not in paid employment. If we insist on vicarious responsibility, in essence we are allowing society to abdicate its role.

3. We agree to the morally and ethically objectionable idea that mentally ill patients themselves are responsible for their illness and its treatment.
4. By endorsing the idea that most people are receiving psychiatric care, we fail to bring to forefront the total lack of care provisions for many mental disorders. We would also be inadvertently reducing the notion of psychiatric care to mere prescription of medication. However good the quality of care that individual psychiatrists provide, it forms only a part of the complex care system required for adequate mental health care.

The model proposed in the article is a single mental health service for all, which is free at the point of delivery and driven by the idea of collective social responsibility. It is worth noting that in wealthy countries where market models and ideas of individual responsibility dominate, health services generally fair poorly in population health outcomes, in spite of higher health care expenditure. It is also interesting to note that such countries report lower social trust and cooperation between individuals and lower gross national happiness.

Integration of various care streams into a coherent care pathway is the alternative to the chaos we have today. The case for this is more acute in mental health care, where individuals are often unable to recognize their illness, and where treatment without consent is often necessary.

Integrated primary care is a reality in many developed countries. In such countries, the primary care system controls and coordinates all specialist services for its patients. The bulk of mental health services are provided by primary care. Increasing demands and rising expectations create significant challenges especially when the resources are diminishing. The integration issues faced by these countries are different in nature and dimension. Having a designated general practitioner for individual patients is one step in the direction of integrated services in Kerala. I believe that the case for this is more persuasive in mental disorders.

Mental health Officer would be a local doctor appointed by the local body who coordinates the mental health care for that local community. This would be another step in creating a triangle of care; i.e. between local governments, social services and clinical services. Professional bodies have to define competencies and develop courses to ensure non-psychiatrist doctors, if appointed to the post, are capable of delivering this role. Mental health officers would be crucial in integrating the services across the sectors and pathways.

Immediate and pressing needs should not distract us from the fundamental crisis unfolding in our mental health care system. As the commentator rightly points out, the challenges in creating a radically different mental health service are formidable. I believe that this can be accomplished only if people at large embrace these ideas and fuel a social movement that enforces profound changes in policy. We would need to harness powers beyond lobbying ministers and convincing administrators.