Mid-term Evaluation of Project sanctioned to Schizophrenia Research Foundation (SCARF), Chennai: "Community Mental Health through Tele-medicine: An innovative strategy in delivery of mental health care"

Report

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Executive summary

The Schizophrenia Research Foundation (SCARF) – a Chennai based non-profit voluntary organization for the care, treatment and rehabilitation of persons suffering from chronic, severe mental disorders such as schizophrenia – is currently implementing a community mental health programme through telemedicine in Pudukottai, a districts with the lowest social development indicators in the state of Tamil Nadu. This programme titled STEP – SCRAF Telepsychiatry Programme, is funded by the Tata Education Trust through a grant of Rs 257.77 lakhs over a period of three years, since 2010.

The main objectives of this programme are to create awareness about mental health problems in the community in Pudukottai district, identify persons with severe mental disorders, provide treatment and rehabilitation for such persons through fixed and mobile telepsychiatry clinics, train local community mental health workers, liaise with existing non-governmental organizations (NGOs) in the district, empower and train patients and their families to reduce disability, establish and strengthen a referral system and ultimately integrate the community mental health services with the local private, NGO and public sectors. The programme aims also to estimate the prevalence of severe mental disorders in the community and study the effectiveness of telepsychiatry – profile of users and non-users, course and outcome of interventions provided largely through telepsychiatry.

A mid-term evaluation of the programme, commissioned by the Tata education Trust, was carried out by two consultants – Mohan Isaac and Manish Bhardwaj – in July 2012. The main purpose of the evaluation was to understand how STEP worked, what were its strengths, weaknesses, its cost-effectiveness, efficiency and replicability and what feedback, suggestions and recommendations regarding its extension, expansion or otherwise could be made towards its future. The evaluation was carried out over a period of nine days. The evaluation included field visits to the SCARF centre in Chennai and the programme sites in different taluks of Pudukottai district during 16-20 July 2012, besides review of programme reports, reference materials and other documents provided by SCARF, interaction with staff of SCARF and STEP and interaction with various stakeholders in the community and partner organizations.

The STEP is well monitored by SCARF and it is currently one of SCARF's "high-profile" programmes. SCARF has been successful in providing mental health care to persons with severe mental disorders in 4 taluks of Pudukottai district of Tamil Nadu by establishing a telepsychiatry service consisting of two fixed line services (in Avadiyarkoil since October 2010 and in Thirumayam since November 2010) and mobile telepsychiatry clinics (the first such service in the country - in Gandharvakotai and Alangudi taluks since May and June 2011 respectively). In about a year and half after starting the fixed line service and a year after starting the mobile telepsychiatry service, the total number of patients receiving treatment on a regular basis at all centres is 753. Majority of patients/family members whom the evaluators saw and assessed during the evaluation period were referred to the service by either present or past patients/family members of STEP who were satisfied with the ongoing service. About 30% of these patients come from outside the catchment area of STEP. Currently, the service focuses predominantly on persons with severe mental disorders. Based on the two stage prevalence survey completed by SCARF as part of STEP, the prevalence rate of psychotic disorders in Pudukottai district is 35.56 per 10,000

population. Accordingly, one would expect to find about 1145 persons with psychotic disorders in the 4 taluks (1188 villages, population, about 3.22 lakhs) where the telepsychiatry programme is currently being implemented,. The number of persons with psychotic disorders in the whole district which has a population of about 14 lakhs would be about 4978.

The assessment, diagnosis and management of most patients in both fixed line and mobile clinics c were quite appropriate and the overall quality of the clinical service was satisfactory. The teleconsultation seem to be quite as effective as face-to-face consultation, in terms of completion of assessment, correctness of diagnosis, management planning and patients' as well as doctors' satisfaction. However, certain types of patients and situations such as immediate management of acutely excited/disturbed, non-co-operative and potentially dangerous (due to risk of violence or harm to others) patients, patients who have co-morbid serious physical illnesses, patients who require immediate hospitalization / physical investigations, patients who stubbornly refuse depot injections, wandering patients who cannot be brought to the clinic, children and the elderly patients and patients who suffer from chronic abuse of alcohol can all pose special problems at the telepsychiatry clinic requiring innovative and creative solutions by the STEP staff.

The predominant mode of intervention is pharmacotherapy. Use of psychopharmacological agents is appropriate, evidence based and rational. There was no unnecessary poly pharmacy. There is a procedure for continued supervision of registered patients to ensure treatment adherence, through home visits by community level workers (CLWs). Managing non-adherence to treatment is a challenging issue to the well trained CLWs who made frequent home visits to patients who missed follow-up appointments. There is need to enhance the non-pharmacological aspects of intervention such as more formalized patient and family psycho education, formation of support groups and self help groups, involvement of community agencies for employment and rehabilitation of recovering patients (in addition to the NREGA programme).

The STEP staff is well trained and there is an ongoing "on-the-job" training for all levels of staff which is quite impressive. There is also regular feedback to the staff about their performance. The staff appeared to be highly motivated and enthusiastic about different components and activities of STEP.

The local NGO partners of STEP are: 1) Pudukottai Multipurpose Social Service Society (PMSSS www.pmsss.com) in Pudukottai and 2) Rural development Society (RDS) in Gandharvakottai. While the partner NGOs demonstrated tremendous good will for STEP, they did not seem to have any capacity to actively partner in the mental health programme in the district and claim any or part ownership of the programme. There were no ongoing programmes aimed at empowering these NGOs or building capacity of their staff. There were no inter-linkages between these two partner NGOs. Partnership or involvement of any other local organizations, governmental or non-governmental such as youth clubs, youth organizations, student bodies, social workers, police personnel, general practitioners, government run dispensaries, district hospital or any other component of the public health system appeared to be either very minimal or non-existent. There was no evidence of any efforts to integrate STEP services with the existing public health system or local general practitioners.

STEP is quite successful in carrying out numerous modalities of awareness creation programmes in the community. While public mental health education has been an integral component of STEP, the effectiveness of these programmes in case identification and referral, attitudinal and behavioural change and stigma reduction is yet to be established.

There was no evidence of any well structured and planned family psycho education or empowerment programme for groups of families. Specific advice on rehabilitation, employment or likely income generating activity for the patient was not a major component of the education provided to most of the patients/families that the evaluators reviewed. There is scope for more advocacy activities involving recovering persons with mental illnesses.

Efforts are needed to actively establish meaningful contact with and work with the district health administration as well as the state level mental health programme co-ordinator so that integration of STEP with the district level psychiatrist and the District Mental health Programme (DMHP) of the Government of India (as and when the DMHP is established) in the district, can be attempted.

For the month of July 2012, STEP calculated the rough average cost per consultation based only on the recurrent expenditure, to be Rupees 526/. This cost per consultation is indeed not too high.

The survey of severe mental disorders conducted in the district adopted best psychiatric epidemiological survey practices. The two-stage survey was completed in 385 villages (260 from Thirumayam taluk where fixed line clinics are in operation and 125 villages from Gandarvakottai taluk where mobile clinics are in operation) and 1785 families were surveyed. A total of 423 persons with severe mental disorders (psychosis) were identified during the survey. The prevalence rate of severe mental disorders was estimated (data corrected for 30% under estimation) to be 35.56 per 10,000 population. Of these 423 persons, 81% were ill at the time of survey, 26% had never been treated and 31% had discontinued treatment. Of those who were ill at the time of survey, 63% were not receiving any treatment. This information about the status of severe mental disorders in a rural community can be invaluable for planning mental health services in India.

The overarching recommendation emerging from this evaluation is that SCARF emphasize the community aspects of mental health, including greater involvement of stakeholders, and interventions beyond pharmacology including patient rehabilitation, education, and empowerment.

On a similar note, it is recommended that SCARF prepare a plan for gradually reducing its footprint in the target communities, while ensuring the same access and service. This would require transferring ownership to local stakeholders, and transitioning to a training and advisory role.

On the technology front, it is recommend that SCARF consider investigating the use of low-cost, low quality video solutions.