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Commentary

Role of primary care in the management of schizophrenia

Schizophrenia is a severe mental disorder with devastating consequences for a patient. Approximately 26 million people are affected with schizophrenia worldwide, and it ranks fifth among men and sixth among women as a leading cause of years lived with disability[1]. Schizophrenia accounts for nearly 1.3 per cent of disability-adjusted life years globally and 1.2, 1.6 and 0.8 per cent in the upper middle-income, lower middle-income and low-income countries, respectively[2].

The disability in schizophrenia can be attributed to several reasons such as early onset, chronic course, limited mental health resources and social stigma, leading to long duration of untreated psychosis[3]. These factors are further exaggerated in low- and middle-income countries like India due to lack of resources and workforce. According to a survey[1], the treatment gap was nearly 69 per cent for schizophrenia in low- and middle-income countries. Treatment gap was identified as the absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder. The figures in lower income countries are even more alarming at 89 per cent[1].

India's National Commission on Macro economics and Health (NCMH) Report of 2005 estimated the prevalence of severe mental disorders, including schizophrenia at a staggering 71 million[4]. One of the main reasons behind this alarming situation is the lack of mental health facilities and infrastructure. According to the WHO Global Health Observatory, India has 0.3 psychiatrists per 100,000 general population, 0.07 psychologists per 100,000 general population, 0.82 and 2.05 psychiatric beds in general and psychiatric hospitals respectively, per 1,00,000 general population, and 0.12 and 0.07 psychiatric nurses and social workers per 100,000 general population, respectively[5]. These figures suggest that India is grossly underprepared to address the needs of schizophrenia patients.

Untreated psychoses for long durations lead to poorer outcome in schizophrenia[6]. This results in greater disability, social isolation, violation of human rights and increased mortality[7]. The caregiver burden and the cost of treatment are increased manifold in such patients[8]. Evidence supports the role of antipsychotic treatment with community-based family-focussed psychosocial interventions as a cost-effective therapy for schizophrenia patients in low- and middle-income countries[9]. In India, the strong family structure can be positively utilized by involving the patients' family in schizophrenia care. Community-based interventions involving the family can increase awareness, reduce stigma about severe mental disorders and improve compliance to medications. The key to effective management lies in community-based programmes which are inexpensive, feasible and evidence-based. However, in the backdrop of limited mental health resources, this approach poses a big challenge.

The solution lies in the integration of mental health services with general health services provided at the primary healthcare level. This has been envisaged by the WHO as the most viable method of reducing the mental health gap particularly in low- and middle-income countries like India[3]. The objectives of the National Mental Health Programme (NMHP) in India include the application of mental health knowledge in general healthcare facilities as well as the development of community participation in mental health services[10]. To strengthen community resource building, the District Mental Health Programme was launched under NMHP in 1996[10],with the primary objective of integration of mental health with general health services through de-centralization of treatment from specialized mental hospital-based care to primary healthcare services. However, lack of defined operational roles of the Central and State authorities has led to a lot of logistic issues in implementation of these programmes. Thus, the effective delivery

of community-based interventions still remains a challenge in India. Also, there has been limited work to evaluate the efficacy of community intervention programme aiming at antipsychotic medication adherence and psychoeducation in improving the outcome in schizophrenia in India.

Naveen Kumar *et al*[11] in this issue have provided evidence in their study that continuous antipsychotic therapy and low-intensity psychoeducation can improve the adherence and outcome and reduce disability in schizophrenia patients. The study was conducted in rural province of Karnataka, India, and the sample of 201 patients was selected from the cohort of schizophrenia patients being treated and followed up as a part of an ongoing Community Intervention in Psychotic Disorders project. Treatment with antipsychotic medications was provided by research or private psychiatrists as preferred by the patients. All patients were regularly followed up at the nearest primary healthcare centres at two months and evaluated for psychopathology, adherence, course, outcome and disability assessments. Low-intensity psychoeducation was imparted at recruitment and continued at the follow ups. Research social worker was appointed to ensure regular follow ups, to arrange continuous supply of medications at the primary healthcare centres and to conduct home visits for the irregular patients. All patients were followed up for nearly four years.

The most important finding from this study was that nearly 70 per cent of the patients had a satisfactory outcome with this community intervention. Approximately three-fourth of the patients were adherent to medication. There was significantly less disability in patients with good adherence to medication. However, such an association could not be established between symptom severity and adherence. Reasons for this might be lower baseline symptom severity scores in adherent patients. Some important limitations of this study were as follows: (*i*) Since this was a naturalistic follow up study and not a randomized control trial, definite evidence for community interventions was lacking. (*ii*) Only rural population was studied; therefore, the findings cannot be extrapolated to urban population. (*iii*) Causes of poor medication adherence were not evaluated. This might have given a better idea of the core areas that need to be focussed upon in patients with poor compliance. (*iv*) Both treated and untreated schizophrenia patients were recruited; the patient population was, therefore, not homogenous. (*v*) Family members and/or primary caregiver should have been involved in psychoeducation since family support plays an integral role in schizophrenia care in India, and, therefore, the assessment of caregiver burden would have provided an insight into treatment adherence.

This study was a commendable effort highlighting the role of community participation in the management of severe mental disorders. So far, majority of the efforts were limited towards providing mental health services for common mental health disorders at the primary health centres. The present study has suggested a viable model of affordable and effective public health strategy for schizophrenia that can be implemented at primary level with good results. There is a need to evolve an evidence-based community model of psychoeducation[12] so that it can be objectively implemented in training of personnel involved in care of patients with schizophrenia.

The most important step towards achieving integration of mental health services in primary care is workforce development. Following are some suggestions in this regard. Specialist psychiatric services are mostly limited to tertiary centres or urban areas with acute shortage of supporting members such as clinical psychologist, psychiatric social workers and psychiatric nurses. Therefore, the need of the hour is training of general health workers by specialists so that they are capable of identifying symptoms of schizophrenia in the community. Their role would be to bring such patients to the primary care centres where general medical practitioners trained in providing basic mental health services will diagnose and start treatment. Referrals to specialist should only be advised if there is atypical symptomatology, poor response to treatment or complications. This will significantly reduce the time and money spent in travelling to tertiary care centres. The role of these trained general health workers would also involve ensuring adherence for irregular patients by home visits and providing medications at doorstep for patients with significant disability. The general health practitioners should also be trained in providing basic psychoeducation sessions for the patient and more importantly the caregivers. These sessions can also be group sessions with emphasis on education about nature of the illness, course, prognosis, outcome, importance of treatment adherence and rehabilitation. Detailed psychological therapies are both time-consuming and expensive and, therefore, are difficult to implement in community setup. Another approach for ensuring adherence and reducing the disease burden is

supervised administration of antipsychotic medications. This can be done by the trained general health workers or the primary caregiver. Most importantly, the general awareness about psychiatric disorders in the community needs to be improved. Most people in a country like India still consider psychiatric disorders as untreatable and seek faith-healing and alternative medications for the same. This leads to under-utilization of mental health services. Non-government organization should also be roped in to create awareness and reduce stigma associated with mental illnesses, particularly schizophrenia.

Schizophrenia, if left untreated, takes an enormous toll on the family, both emotionally and financially. The treatment gap in schizophrenia is an alarming figure suggesting poor mental health service availability and utilization. In low- and middle-income countries, integration of mental health in primary care settings can be a cost-effective strategy of providing quality care and reducing disability associated with schizophrenia. Further research is needed to provide evidence-based and affordable community interventions in schizophrenia that can be implemented in primary health centres with ease.

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