Formative scoping in mental health, Rural Satara, Maharashtra

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Suresh, a young boy from a remote village of Mahabaleshwar block, like his friends from his village, went to work in Mumbai. However he could not cope up with the pace of the city, witnessed the suicide of his cousin brother and resigned from his job. He started having panic attacks. His father brought him back and sought advice of the primary health centre (PHC) doctor. Additionally, the family prayed to various deities. Suresh is now seeking professional help for his mental health. Every month, they travel 100 km to meet the private psychiatrist at Satara. They spend 4-5 hours to meet the doctor who spares 10 minutes for them. The father keeps all his emotions to himself. The family has never discussed about Suresh with anyone due to fear of discrimination and its effect on the marriage prospects of Suresh and his younger brother. Presently Suresh is feeling better. He enjoys his job as a data entry operator in the PHC which is close to his house. His family is hopeful about his recovery.

Varsha, a separated young woman lives with her parents and two brothers. The family has a hand-to-mouth existence. Her husband is mentally ill, lives in Pune with his parents. Varsha was fed up of his illness, and physical abuse of her and their small boy (who is now 6-year-old) and left his house about two years ago. Her husband has been taken to several faith healers and hospitals however he does not take his medicines. Varsha has no hopes about his recovery. She wants to live only for her son. She is doing a tailoring and beautician course so as to start a small business in their village, a small remote place in Maan. She is unsure of continued family support and community help, hence does not talk about her situation with anyone.

These and other lived experiences of persons with mental health problems and their families from rural Satara reflect upon… Mental health literacy, availability, accessibility and affordability of mental health services in rural areas, skills of health professionals, importance of dialogue within and outside of family, resilience of family, family and community support, mental wellbeing of families, financial constraints and stigma

Why was the scoping conducted?

It is known that mental health problems affect a significant portion of Indian population with its prevalence being 11.36%. Furthermore nearly 83% persons requiring mental health services do not receive those and this gap is even more in rural areas.

As a prerequisite to designing an intervention research, the Foundation for Medical Research (FMR) conducted a detailed scoping to understand the current situation related to mental health in Satara with support from the District health officials during December 2023-May 2024 (6 months). Satara is one of the first districts of Maharashtra to initiate the District Mental Health Programme (DMHP) about a decade ago. Two rural blocks- Maan and Mahabaleshwar- considered vulnerable due to extreme weather, livelihood challenges, and high scarcity of primary mental health services- were

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suggested for this scoping by the District health officials. Specific objectives of this scoping were to-

- Map existing mental health services
- Understand care-seeking pathways
- Assess current mental health literacy, skills, perspectives and needs of family care providers, community and health providers
- Identify opportunities and potential of key stakeholders for future intervention

How was the scoping conducted?

The scoping involved one-to-one (n=22), and group interactions (n=9); and interactive workshops (n=3) including participatory activities, with- a) Mental health and non-mental health professionals (N-MHPs)- district and periphery; public and private b) Community stakeholders- representatives from community-based organizations (CBOs), teachers, priests, and godmen; and c) Persons with mental health problems and their family care givers (n=10)

Figure 1- Role-play by CBO members depicting informal care seeking experience from a godman

What were the results?

The study area and the communities

Maan block has two rural hospitals (RHs) and five PHCs while Mahabaleshwar has one RH and three PHCs. Maan with approximately 2,20,000 population is a drought prone area whereas Mahabaleshwar with 72,000 population has hilly terrain with excessive rainfall. Limited livelihood options result in social issues such as heavy out-migration of youth leaving behind elderly ones, addictions and strained marital and familial relationships.

The socio-cultural fabric of the communities is woven by the **societal norms** of following traditional practices such as marriage within relations, belief in faith healers for seeking care, spiritual and devotional practices and patriarchy.

Mental health problems in the area

Currently 202 (Maan) and 168 (Mahabaleshwar) patients are under treatment for mental health under the DMHP with alcohol addiction, depression and schizophrenia being the highest in number. Stakeholders reported of depression, stress, addictions, anxiety, obsessive compulsive disorder, psychosis, suicides, insomnia, mood disorders, and disorientation as the common mental health problems.

The reasons include relationship failures, poor communication, mobile addiction (post-COVID among children), and impact of social media creating unrealistic expectations, a disconnect between 'real' and 'reel' life, intergenerational conflicts and financial stress. Issues such as exam phobia, marital maladjustments, mood swings, lack of authority among women, impulsive behaviour, and extreme guilt further contribute to mental health problems. Stakeholders stated that **some mental health problems get unnoticed and undiagnosed** e.g. post-partum depression (PPD).

> "*We do not see much of PPD; it may happen because of some family related tensions... maybe it is unnoticed.*"- *Private gynaecologist Maan & medical doctor working with a CBO*

Tobacco and alcohol **addictions** are prevalent but **not considered as a mental health problem.** Care-seeking for de-addiction from formal or informal sector is time and money

intensive without effective results and requires sustained family support which is challenging.

Suicide is a significant concern, particularly among the **young population** with reported reasons being breakup in relationship, lack of parental attention, mobile and social media addiction, and absence of dialogue with family members. Methods of suicide typically include hanging, burning, and poisoning. Currently, there are **no strategies for suicide prevention and no data is available about help sought for suicidal attempts, if any**.

The **uncertainty of climatic condition** has emerged as an indirect cause of stress and tension regarding the farm produce and financial output. **Youth migration** for seeking city-based jobs in turn has several connects with mental health problems such as strained and distant relationships, societal disconnect and loneliness among elderly.

Poor mental health literacy results in poor identification and acceptance of the problem by person, family or society and subsequently delays seeking care/ support with underlying fear of stigma of mental health problems.

Formal mental health services

Mental health services are available only at the Civil Hospital Satara through the DMHP with overcrowded psychiatric out-patient departments (1300-1500 patients per month) and an overburdened team in managing clinical and administrative tasks. The programme faces challenges in terms of **skilled human resource, drug availability and required outreach.** Availability of space and time for provision of counselling and/or psychosocial support to the patient and families can be difficult. Long distances especially from Maan and Mahabaleshwar blocks, infrequent transport availability and remoteness due to hilly terrain further affect access to the Civil Hospital.

Mental health services including drugs have huge gaps at peripheral level highlighting the need for building capacities of the N-MHPs and generating mitigation strategies for regular drug supply. The **N-MHPs** including medical officers (MOs), community health officers (CHOs), nurses from PHC and *Non-Communicable Diseases (NCD) counsellor* are often the **first point of contact for formal help seeking** but they need more skills and competency to handle the mental health related problems.

> *"I need training to counsel alcohol addicts for sleeplessness; and cancer patients about their mental health."- NCD counsellor*

The DMHP involves private psychiatrists in conducting mental health training programmes for peripheral health providers. These are in the form of structured lectures using PowerPoint presentations and can be further improved in terms of frequency and pedagogy.

The DMHP at times organizes mental health screening camps in peripheral areas with support from private psychiatrists however these are implemented as a one-time activity with less support of drugs and follow-ups.

Figure 2- Auxiliary nurse midwives & ASHAs during free-listing activity for mental health problems

Availability of private mental health services is minimal and concentrated in urban areas of selected central blocks of Satara, Miraj or Pune.

Approaching formal mental healthcare (public/private) was generally characterized with

discomfort, fear, inhibition, non-acceptance and embarrassment of consulting a psychiatrist due to stigma.

Informal care for mental health

Approaching informal care providers- godmen, temple priest, faith healer or astrologer was reportedly a common practice for seeking any support, advice or care as an alternative or complementary to formal mental health care seeking. The reasons for informal care-seeking included- lack of (mental health) literacy, poor acceptance of medical explanation of disease/ illness, inaccessible and unaffordable formal mental health services, peer/ other community members' advice/ influence, word of mouth, popularity of the provider, family pressure and previous positive experience-self and others.

Community perception about causes of mental health problems included black magic or sorcery, possession syndrome, bad karma or previous mistakes. Though families at times mentioned about wasting time and resources it was the **"faith" and "feel good"** factor that impacted informal against formal care seeking.

Family care providers

The scoping involved interaction with 10 persons with mental health problems (eight males and two females) and their families. It revealed a key role of parents and grandparents (8/10) as care providers, irrespective of gender and marital status of the persons. All the families accessed private mental health services due to inaccessibility/ unavailability of public services. For four families arranging finances for treatment from private facilities was a major challenge since the illness affected livelihood of the family. All of them were reluctant to disclose their problem to the communities and seek their support due to poor knowledge of mental health and fear of discrimination.

For eight persons, their families sought informal care from godmen/ faith healers of various places by spending money. One of them (female) used to visit a godman from a distant place and was physically abused by him as part of her treatment.

Way forward…

- Create advocacy channels for ensuring uninterrupted drug supply at district and peripheral levels- build capacities of health providers and pharmacists
- Build mental health care capacities of non-mental health professionals through stepped-care and task-sharing approach, expert guidance and mentoring- cadre specific training for diagnosis, management, care and support
- Utilize the community potential through developing a cadre of lay counsellors to navigate mental healthcare and support families- CBO members, ASHAs, family care providers as lay/ peer counsellors
- Improve mental health literacy of families & community stakeholders through co-creation of culturally relevant strategies community suggestions include- creating spaces around big trees for community dialogues, arranging de-stress sessions at stress-intense workplace for men (detox before leaving for home),

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