Asian Journal of Psychiatry 46 (2019) 51–53

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Short communication

Change in attitude of ASHAs towards persons with mental illnesses following participation in community based rehabilitation project

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ARTICLE INFO

Keywords:
ASHAs
Community health workers
Attitudes
Mental illness
Rural community

ABSTRACT

Background: Accredited Social Health Activists (ASHAs) play an important role in health care in rural India.
Aim: To study the change in attitude of ASHAs towards persons with mental illness (PMI) after involvement in a community-based rehabilitation program.
Methods: ASHAs (n = 95) were trained to identify and refer PMI. Community Attitudes to Mental Illness scale was administered at baseline and after 18 months of training.
Results: Domains of benevolence, social restrictiveness, and community mental health ideology showed significant improvement $p < 0.001$. There was no change in authoritarianism domain.
Conclusion: Engaging ASHAs in identification, referral and treatment positively changes their attitudes towards PMI.

1. Introduction

One of the grand challenges in mental health is to "provide effective and affordable community-based care and rehabilitation" and "develop effective treatments for use by non-specialists, including lay health workers with minimal training" (Collins et al., 2011). Consistent with this, in India, recent legislations and programmes have had specific focus on community-based mental health care and rehabilitation (Namboodiri et al., 2019; Sadh et al., 2019; Ul hassan et al., 2019). Negative attitude of health workers is a deterrent for patients to seek health care (Ibrahim et al., 2014). Training and practical exposure to mental health care can positively influence attitudinal barriers (Abera et al., 2014).

In India, Accredited Social Health Activists (ASHAs) are literate female health workers selected from the local community. They are honorary volunteers and are financially compensated (ranging from Indian Rupee 1–5000 (US$0.01–71.98) depending on the task. (National Health Mission, 2019). ASHAs are trusted as source of health information and referral in their communities (Scott et al., 2019). They form the backbone of public health system. ASHAs play an important role in maternal and child health (Saprii et al., 2015).

There is limited literature on their involvement in mental health programmes. To scale up mental health services in resource constrained settings, there is a need to train ASHAs about mental illness (Shah et al., 2019; Sadh et al., 2019). When trained, ASHAs can screen and refer PMI for treatment (Maulik et al., 2017). In this paper, we report change in attitude of ASHAs towards PMI after their involvement in a community-based rehabilitation (CBR) program for persons with severe mental illness (PSMI).

2. Methodology

2.1. Setting

Jagaluru taluk (an administrative block) in Davangere district (Karnataka, India) is drought-prone and economically backward. The taluk is predominantly rural and agrarian. The taluk has 10 Primary Health Centres (PHCs) and 1 Taluk hospital. There are no psychiatrists in the Taluk. Davangere, the district headquarters town, has a government district hospital with psychiatrists working full time, 2 private medical colleges with departments of psychiatry and a few private psychiatrists. Recently, services of the District Mental Health Program have been extended to Davangere.

As part of the CBR program, mental health camps are conducted on

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https://doi.org/10.1016/j.ajp.2019.09.031
Received 17 June 2019; Received in revised form 23 September 2019; Accepted 26 September 2019

the 1st and 3rdTuesday of every month at PHCs & the taluk hospital since August 2015. Free psychotropic medicines are dispensed. Two social workers liaise with stakeholders, coordinate the camps, do periodic home visits to address needs, and offer telephonic reminders before camps. When PMI are unable to come to the PHC, home visits are done by the psychiatrist to assess their health status and initiate treatment.

2.2. Sample

As part of the CBR program, ASHAs were invited to attend a training program on mental illness. Out of 156 ASHAs who were invited, 95 participated. After obtaining written informed consent, Kannada translated version of Community Attitudes towards Mental Illness (CAMI) (Martin and Dear, 1981) was administered.

Permission to translate and use the CAMI scale was obtained from the authors. This scale has been widely used in understanding the attitude of community members towards mental illness, it has good internal consistency $\alpha = .70$. CAMI is a 5-point scale it contains 40 questions with 4 domains: authoritarianism, benevolence, social restrictiveness, and community mental health ideology; higher scores in benevolence and community mental health ideology, and lower scores in authoritarianism and social restrictiveness are considered favourable attitudes towards PMI.

At baseline, all 95 ASHAs were trained for 90 min by a psychiatrist in local language about symptoms, course, outcome and treatment of severe mental illness; to use 'symptoms in others' tool (Kapur, 1975); and followed by an interactive session where queries were clarified. ASHAs were encouraged to refer PSMI to nearby PHC or taluk hospital for consultation.

This was followed by on-the-job training. PSMI were accompanied by ASHAs for evaluation. PSMI were interviewed and treatment initiated in presence of ASHAs who were requested to supervise treatment and ensure follow-up. On-the-job training differed among ASHAs based on number of PSMI referred. ASHAs would accompany social workers for home visit of PMI in their areas. ASHAs would observe social worker educate families of PMI about illness, explain medication side-effects (if any) and need for regular medicines. Social workers from the team were available over the phone to ASHAs for guidance.

After 18 months of involvement in the CBR program, CAMI was again administered to 95 ASHAs.

Institutional ethics committee clearance has been taken for the Jagaluru CBR study.

2.3. Statistics used

R software was used to compute the mean, standard deviation (SD), frequency distribution and paired *t*-test was used to understand the pre and post difference in the mean score of CAMI.

3. Results

Mean age (SD) of participants was 34.76 (4.39) years and average years of education was 10.39 ± 1.40 (Table 1). Among 95 ASHAs, 65 had personally brought a PMI for treatment to one of the PHC. The scores of benevolence and community mental health ideology had increased and social restrictiveness had decreased from baseline to follow up which was statistically significant at $p < 0.05$ (Table 2). Reduction in scores of authoritarianism at follow up was not statistically significant.

Table 1
Demographic details and number of persons personally brought for treatment to PHC by ASHAs.

Demographic variables	Mean (SD)/ frequency (%) (n = 95)
Age in years	34.76 ± 4.39
Education in years	10.39 ± 1.40
Number of persons brought for treatment by ASHAs	
0	30 (31.5%)
1	30 (31.5%)
2	25 (26.3%)
3 or more	10 (10.7%)

4. Discussion

ASHAs' attitude towards mental illness showed significant positive change after involvement in the CBR program. This adds to encouraging literature on the value of lay community workers for mental health programs (Balaji et al., 2012; Chinnayya et al., 1990; Shah et al., 2019).

A study from South Africa reported significant improvement in CAMI scores among health workers who underwent 3 -h daily dialectic mental health training for 7 days (Sibeko et al., 2018). When compared to this study, ASHAs had a more negative attitude towards mental illness at baseline and similar improvement in CAMI scores was observed at 18 months follow-up.

In traditional cultures and rural areas, authoritarian attitude may not be bad as they follow a guru-chela (master-disciple) relationship. The authoritarian attitude of healthcare providers helps in engaging and empowering patients to access health care resources (Fagerli et al., 2005).

More than 30% of ASHAs did not bring any PMI for treatment. This could be because (a) there were no PMI in their catchment area (b) PMI were under treatment elsewhere and preferred to continue treatment there (c) persons suspected to have mental illness were uncooperative and lacked family support for initiating treatment (d) there was a lack of compensation to ASHAs for bringing PMI for treatment. Unlike other programs, ASHAs are currently not compensated for involvement in mental healthcare. Financial compensation of ASHAs for treatment of PMI may enhance referral rates and bring untreated PMI under treatment umbrella in rural communities.

Attitudinal change among ASHAs towards PMI could possibly be attributed to following factors:

(a) CBR program facilitated free treatment to PMI at nearest PHC which reduced 'out-of-pocket' expenditure for families of PSMI (Sivakumar et al., 2019). CBR has also been shown to improve quality of life of PMI (Puspitosari et al., 2019). This helped ASHAs to identify and refer PMI for treatment and ensure medication adherence.
(b) With regular treatment, symptoms and disability due to mental illness reduced (Thirthalli et al., 2010). 'Personal contact' could have reduced stigma and facilitated positive attitude towards PMI (Evans-Lacko et al., 2012; Penn and Couture, 2002; Pinfold et al., 2003).
(c) ASHAs were seen as 'agents of change' who linked the community with the CBR program. Most PMI and family members were grateful to ASHAs for facilitating treatment which led to improvement. This could have possibly motivated ASHAs despite the lack of financial incentives.

5. Limitations

The study did not have an a priori hypothesis about change in attitudes of ASHAs.

Among 156 ASHAs, only 95 participated in initial training. Some ASHAs who were not part of initial training also referred PMI to treatment camps. Their change in attitude could not be assessed as they were not part of the initial training and assessment.

Table 2
Comparison of Community Attitude towards Mental Illness scores from baseline to follow up.

Variable	Mean (SD) Baseline	Mean (SD) Follow up	t	df	p-value (two tailed)
Authoritarianism	31.47 (3.41)	31.09 (3.34)	.782	94	.433
Benevolence	32.86 (3.08)	35.78 (3.90)	−5.99	94	< 0.001
Social restrictiveness	26.56 (3.77)	24.65 (4.31)	3.68	94	< 0.001
Community MH ideology	34.20 (3.79)	36.24 (4.26)	−3.63	94	< 0.001

6. Future directions

Future research needs to focus on factors that lead to positive change in attitude towards PMI when ASHAs are involved in the identification of PMI, referral for treatment and follow-up. The impact of positive change in attitude towards PMI on health, disability, and social outcomes needs to be studied. Impact of incentives to ASHAs for involvement in treatment of PMI needs evaluation.

7. Conclusion

ASHAs can identify and deliver mental health services at the doorstep of PMI. Involvement of ASHAs in the identification of PSMI, referral for treatment, medicine supervision and follow-up lead to positive change in their attitude towards mental illness.

Financial disclosures

Mr James J W was funded by University Grants Commission Junior Research Fellowship. The CBR project was supported by research grants to Dr Thanapal Sivakumar from NIMHANS intramural research grant, The Live Love laugh Foundation and Indian Council of Medical Research (ICMR).

Declaration of Competing Interest

None.

Acknowledgements

The authors would like to place on record their appreciation of the support provided by Department of Psychiatry, NIMHANS, Bengaluru, District Health Officer (Davangere), District Mental health program (Davangere), Taluk health Officer (Jagaluru) and all the heath staff in Jagaluru taluk.

The work would not have been possible without support of Association of People with disability: [Mr Janardhana AL (Assistant Director: Inclusive education & Community mental health program), Mr Santosha S (Executive, Community mental health program, Davangere) and Ms Manjula S (staff, Community mental health program, Davangere)], Mr Dundappa Doddur (project staff), Mrs. Gowramma (Block Health Officer, Jagalur) and officials/ key community members at Jagaluru.

The authors thank Dr Deepak Jayarajan (Assistant Professor of Psychiatry, NIMHANS) for his inputs in revising the manuscript.

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