Indian J. Psychiat., (1981), **23**(2), 139—141

A PROFILE OF THE FOLLOW UP OF THE RURAL MENTALLY ILL*

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SUMMARY

108 Psychotic and 268 epileptic patients were followed up for 3½ years as a part of an ongoing rural mental health care programme. Some of the observed situations, possible limitations and reasons for the evolved follow up pattern in this endeavour of non-institutional, family centred and community oriented treatment programme, are reported. The strategies to improve the follow up rate among the rural patients are discussed

As severe mental illness and epilepsy could easily be identified by the community (Isaac & Kapur 1980) and these illnesses require prolonged treatment, the success of any mental health programme should not be measured by the number of new cases detected, but rather by the number of patients, who, duly diagnosed, continue their treatment to its end. A study of follow up pattern reveals facts relating to community or family's perception of mental illness. It also serves as an indirect evaluation of the impact of the initial therapeutic strategies and the multifarious problems faced by the patients and their relatives in maintaining such follow up.

Many studies have focussed on the follow up aspect of the treatment programme for physical illnesses like tuberculosis and hypertension. Factors brought to light in relation to follow up of these illnesses could also be applied to mental illnesses. Banerjee and Anderson (1963) pointed out that due to one or the other reason, the default in any tuberculosis clinic in India may be somewhere to the extent of 70-90% of the total patients diagnosed. Nagpal *et al.* (1970) found that the distance to be covered between the patients house and the treatment centre played a decisive role in the follow up of patients with tuberculosis. In the equally life threatening condition of hypertension, 20% to 50% of patients drop out in the first year of treatment. (Beckland & Lundwall, 1975). Similarly, in general psychiatric clinics ; 20%-57% of the patients failed to return after the first visit and 31-56% attended no more than four times (Dodd, 1971). More than one third of the mentally ill persons do not keep up the psychiatric appointment after brief evaluation and another third drop out after detailed initial evaluation thus leaving only a third of the identified population with problem to utilise the presently limited existing psychiatric facilities (Srinivas Murthy *et al.* 1974 and 1977).

Almost all the follow up studies are based on samples of patients admitted to the hospital while there are very few based on out-patient clinics or schizophrenic patients diagnosed, treated and followed up by general practitioners (WHO, 1977).

METHOD

The method adopted in the present study differed from other studies : patients were identified in the rural community with the help of those residing there and

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*Paper read in XXIII Annual Conference of I.P.S. held at Ahmedabad, 1980.

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treatment was given in their home settings. Hence the method was non institutional, family centred and community oriented while others were predominantly institutional and individual oriented.

Steps involved in follow up work :

The method involved establishment of relationship with the leaders, teachers and other significant members in the community. Communication regarding the services available in the centre, treatment for mental illness and epilepsy and other issues like importance of family cooperation in follow up programmes, after care and rehabilitation activities formed the main tools of initial relationship. This was further strengthened by the active involvement, education at informal and unstructured group level and social net work approach in the follow up programmes.

The patients and their family members were asked to visit the rural clinic situated in Sakalwara. Wherever possible the ANMs and the doctors who worked in the area were involved to give depot anti-psychotic injections or to motivate the family members to maintain regular follow up. Whenever a patient was brought to the clinic for follow up, enquiries were made about other patients in the same village and nearby villages. If the patients failed to keep up the follow up appointments, instructions were sent through those residing in the same village, and who were at the clinic for general physical ailments. When the patients were on maintenance dosage, they were asked to send their prescription slips through one of these individuals to the clinic with all the necessary details of the progress which would get these required drugs. Even if all these procedures failed, the team would then visit the village again for the purposes of follow up.

RESULTS

Tables 1 to 5 below describe the details and pattern of follow up visits.

TABLE 1—*No. of patients for follow up and the year*

Year	Schiz.	Ac. Psych.	M.D.P.	Epilepsy	Total
1977 ..	14	4	10	85	113
1978 ..	17	12	13	105	147
1979 ..	37	20	21	203	281
1980 ..	51	30	27	268	376

TABLE 2—*Period of Follow up*

Period	Schiz.	Ac. Psy.	N.D.P.	Epilepsy
< 6 months ..	1	..	..	16
6–<12 months	14	10	6	49
1–2 years ..	20	8	8	98
2 years ..	16	12	13	105
	51	30	27	268

TABLE 3—*Follow up Pattern : Schizophrenics*

Pattern	No. of patients	
Regularly coming to clinic ..	8	16%
Mod. coming to clinic ..	9	18%
Patients seen in their villages ..	13	25%
Refusal	7	14%
Patient not traceable ..	8	16%
Family moved out	3	6%
Death	3	6%

TABLE 4—*Follow up details of M.D.P. & Ac. Psychoses*

2 persons with M.D.P. are on maintenance medication & are regular.
The rest are doing well.
Their Health status are enquired at every village visit.

TABLE 5—*Follow up pattern : Epileptics*

Patern	No. of patients		
Regularly keep appointment ..	83	31%	39%
Mod. Reg. keep appointment ..	21	8%	
No follow up inspite of frequent fits	66	25%	
No follow up inspite of frequent fits (<4 attacks/year) ..	21	8%	
Left the village	12	4%	
Stopped coming .. No fits— —1 year	36	13%	
Deaths	16	6%	
No information	13	..	

DISCUSSION

Follow-up of psychotics :

60% of the schizophrenics detected were put on continuous medication. The improvement achieved by the patients not only changed their behaviour and social functioning but also impressed the family members and neighbours, which resulted in more intensive follow up.

Though the services were available freely, about 14% of the schizophrenics did not take medication and were non-cooperative. Deep rooted misconceptions, ignorance and long duration of the illness made the patient and the family members reluctant about follow up.

Poverty adds to the problem. If the patient had to be brought for follow up, the family has to lose a day's income of at least one member of the family. The distance they had to cover for follow up was also a decisive factor. As Nagpal (1970) found that the zone of effective influence does not exceed four road miles around the centre. In those cases, where the improvement that could be achieved was not much, because of various factors including the limitations of the available treatment methods and side effects of the drugs, the family concluded that it was not worth the efforts. Usually, a combination of the above said factors would be seen in families who refuse to continue the treatment.

The requirement that medicines should be taken every day, not missing a single dose at any cost and continued at least for 3 long years is really a rigorous procedure and difficult to follow for many villagers. Inspite of this, 39% of epileptics continued the medication and 13.5% stopped medication (after being regular for some time) as they became fit free for more than one year. 29% of epileptics took drugs irregularly inspite of being aware of the consequences of irregular treatment. In most of the cases, social functioning was not at all disturbed except during or 'post-fit' period. They tend to live with the illness.

These are some of the possible, observed situations, limitations and reasons for the follow up pattern in the village set up. A depth analysis of various factors contributing for poor follow up would be communicated later.

Suggestions for regular follow-up :

Consistent and continuous efforts, involvement of doctor-cum-health worker team of the PHC and other volunteers from the village, beneficial delivery of drugs at the patient's door step and group basis follow up, are helpful.

REFERENCES

BAEKELAND, F., LUNDWALL, L. (1975). Dropping out of treatment : A critical review. Psy. Bull., 82, 5, 758.

BANERJI, D., AND ANDERSON, S. (1963). A sociological study of the awareness of symptoms suggestive of pulmonary tuberculosis. Bull. of WHO, 29, 665.

DODD, J. (1971). A retrospective analysis of variables related to duration of treatment in a university psychiatric clinic. J. Nervous & Mental Dis., 151, 76.

ISAAC, M. K. AND KAPUR, R. L. (1980). A cost Effectiveness analysis of three different methods of psychiatric case finding in the general population. Brit. J. Psychiat., 137, 540.

NAGPAL, D. R., VISHWANATH, M. K., DWARKANATH, G. (1970). A socio epidemiological study of OP attending a city TB clinic in India to judge the place of specialised centres in a TB Control programme. Bull. WHO, 43, 17.

SRINIVASA MURTHY, R., GHOSH, A., & WIG, N. N. (1974). Treatment acceptance patterns in a psychiatric out-patient clinic. Study of demographic and clinical variables. Indian J. Psychiat., 16. 323.

SRINIVASA MURTHY, R., GHOSH, A. & WIG, N. N. (1977). Drop outs from a psychiatric Walk in clinic. Indian J. Psychiat., 19(2), 11.

WHO (1977). Schizophrenia—an International follow up study. John Wiley & Sons Ltd.