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A MODEL FOR RURAL PSYCHIATRIC SERVICES—RAIPUR RANI EXPERIENCE*

N. N. WIG[1]
R. SRINIVASA MURTHY[2]
T. W. HARDING[3]

SUMMARY

During the last five years efforts have been directed to understand the needs of the mentally ill persons residing in the rural areas. An outcome of our work involving 60,000 people living in a geographically defined area in Ambala District of Haryana has resulted in a realistic model for wider application in the country. The project work has led to the development of a number of research instruments and data regarding the prevalence of mental illness in the rural areas. A method for identifying mentally ill and to study the community attitudes has also been developed. The preparation of the Manual and simple training programmes has been a significant contribution. Knowledge regarding the practical problems of supervision and support of peripheral health workers in carrying out mental health work has been gained. The formation of the Mental Health Association by the village leaders has enhanced the community awareness and involvement in the ongoing programme of care.

It is hoped that the experiences and the results of the above research work would act as a stimulant for similar experiments and further refining of the needed expertise and data for making mental health care a reality at the primary health care in the near future.

Mental health objectives should be defined in each country taking into account the nature, extent and consequences of mental disorders and the resources available. The objective should be realistic and should be formulated in terms of the health effect or the service delivery to be achieved for a stated proportion of the population in a defined area within a stated time.

—Recommendation No. 4,
"*Organisation of Mental Health Services in Developing Countries.*',
WHO TRS No. 564. (1975).

Traditionally 'mental health' is considered to be of relevance to the affluent societies. It is not surprising to note that there is very little recognition of the mental health needs of the population in the general health programmes of our country. The reasons behind this relative neglect are important to understand for the reorientation of the programmes and policies. The factors contributing to the relative neglect can be summarised as follows :

Firstly, until about a decade there was very little reliable epidemiological data relating to the distribution and prevalance of the mental disorders in India and other developing countries.

Secondly, in the past major efforts in planning the services were directed towards establishing mental hospitals and psychiatric clinics. These mental hospitals were more custodial than therapeutic.

Thirdly, there has been severe shortage of trained professionals and most of those available are working in the urban areas.

Fourthly, the general public often view mental disorders from religious, super-

*The work reported in this paper is a part of WHO international multicentred collaborative study. "Strategies for extending mental health care in the community." Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh-160 012.

[1] Prof. & Head, Deptt. of Psychiatry, AIIMS, New Delhi.
[2] Assistant Prof., Deptt. of Psychiatry, NIHMANS, Bangalore.
[3] Principal investigator of the project at WHO, Geneva.

stitious and magical stand points. This has limited the effective utilisation of the available modern psychiatric facilities.

Fifthly, there were no meaningful models for the provision of services suited to the rural community, utilising alternative approaches other than through trained psychiatrists. The research efforts of professionals have only recently been directed to this area. Lastly, the production and supply of psychotropic drugs have been limited in the developing countries and there are very few welfare agencies to undertake rehabilitative work (Wig & Murthy, 1978, Murthy & Wig, 1978, Murthy, 1977).

The present report describes the experience gained and the results of a project aimed at developing and examining a model to provide basic mental health care through the existing health infrastructure in India in collaboration with the WHO. The basic approach is presented diagrammatically in Figure 1. This is part of a WHO International collaborative study titled 'Strategies for extending mental health care'. This study is being carried out in seven geographically defined areas in Brazil, Columbia, Egypt, India, Philippines, Senegal and Sudan and is designed to develop and evaluate alternative and low cost methods of mental health care (including training methods) in developing countries (Clement *et al.*, 1980).

MENTAL ILLNESS AT THE VILLAGE LEVEL

The currently unmet needs for care of the mentally ill persons in the villages of India was dramatically brought to our attention in the initial contact and 'survey' of two villages, namely Ramgarh and Manka, in the Ambala District of Haryana State. These villages are situated not more than 30 Km. from Chandigarh. Of the two villages Manka was surveyed to understand the existence of mentally ill in the village and their needs. The village has a population of about 1000. A simple house to house survey by the authors to identify severe forms of mental disorders showed that nearly 2% of the population were suffering from treatable neuropsychiatric problems like epilepsy, schizophrenia and depression. Of these half of them had not received any psychiatric treatment. Nearly two-thirds were significantly disabled in their personal and social functioning. The reasons given for not taking treatment referred to fears of going to distant, big treatment centres, the problems of expenditure, loss of earning time and transport. However, subsequently when treatment was provided to the patients close to their homes, the ill persons accepted them with resultant benefits to them and the community. More details have been reported by us elsewhere (Murthy *et al.*, 1978). This initial micro level study of a single village and experience of providing help to those in two villages brought home to us the need for mental health care for those living in the villages, close to their homes. The problem was 'reaching the unreached' through appropriate approaches.

ISSUES

Attempts to plan or think of providing basic mental health care by integration with general health services (Fig. 1) to the rural population raises the following questions :

(1) Can mental health care be integrated into general health services ?

(2) What are the mental health priorities to be included at the primary care level ?

(3) Are there suitable training tools and manuals for the training of the peripheral health personnel ?

(4) Can the interventions and treatment bring about benefits to the individual, family and the larger community ?

(5) How can the community be involved in the important task of caring for the mentally ill in the community ?

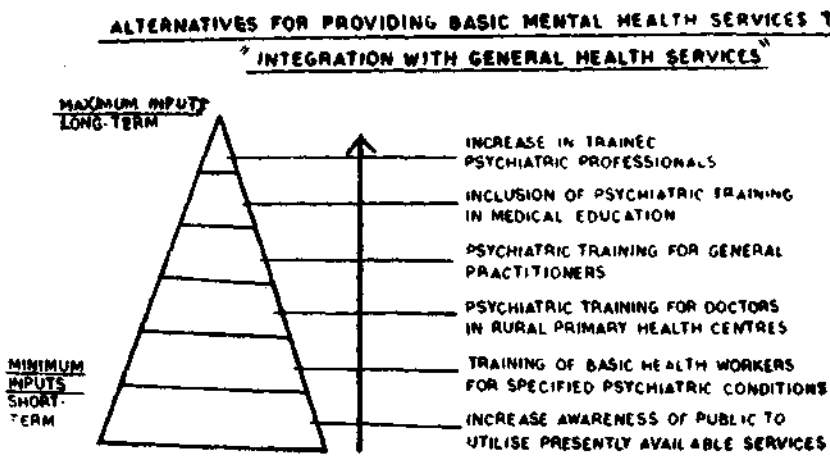

Fig. 1

These broad questions have formed the areas of enquiry and objectives of the project 'Strategies for Extending Mental Health Care'. The experience, since 1975, has provided information regarding the above questions and experience with mental disorders in the community suggest a model for organizing mental health services in the rural communities of developing countries.

THE STUDY AREA

The study was initiated in June, 1975 in the Raipur Rani Block, Ambala District of Haryana State. Two administrative sectors of the Raipur Rani Block with a population of about 60,000 were selected as the catchment area for the project. As in the rest of the rural India, the health organisation consists of a Primary Health Centre (PHC) and the subcentres. Qualified medical doctors are located at the PHC (usually 3) with in-patient (12 beds) and daily outpatient services. The health auxilliaries, namely the Multipurpose worker (MPW) and the health Supervisor (HS) are working at the peripherally based subcentres. The function of the health personnel in the field is to organize preventive and promotive health activities in the community (by home visits etc.) and to provide first level curative service for the day to day problems. In addition to these health staff, since October, 1977, a new category of health worker, community Health Volunteer (CHV) have been included. The CHV are local persons selected by the villagers and trained for three months for basic health promotive and preventive work. The distribution of the health personnel are : one CHV for 1000 population, one MPW for 5000 population and one HS for 20,000 population. Generally the CHV and MPW have their well defined catchment area for health work. From the welfare sector, the Anganwadis of the Integrated Child Development Scheme (ICDS) are located in villages of 1000 population. The basic objective of ICDS scheme is to provide a package of services including non-formal education to the pre-school child, adult literacy and health care. The above organisation forms the full complement of staff from the health and welfare sectors in the catchment area.

The study area consists of 100 villages. Nearly half of them have a population of less than 500. About 50% of the population live on either side of the road, at least one kilometer away, with transport facilities being available only during day time. Water supply schemes provide port-

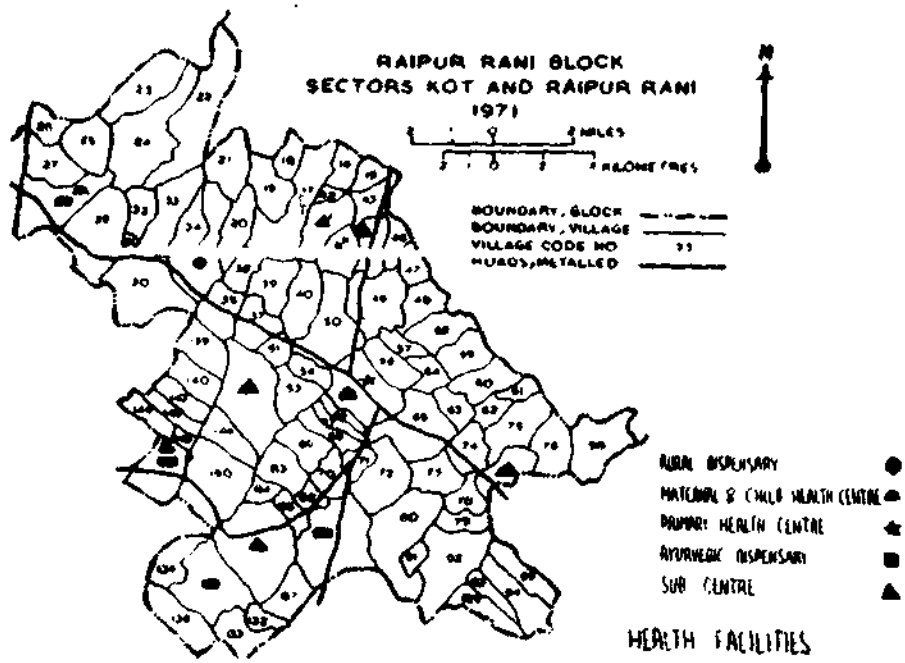

Fig. 2

able water supply to nearly half of the villages. Agriculture is the main occupation of the villagers. There is no significant migration into and outside the area. The distribution of the health facilities, in terms of the PHC, and subcentres is presented in Fig. 2. The Ayurvedic dispensaries refer to the Government supported traditional system of medical care which is organised fairly independently of the modern medical system. They are mainly clinic based and enjoy the acceptance of the general public for health care.

PROGRESS AND OBSERVATIONS

The organisation of the project and the results can be viewed under the following br oad headings :

A. BASELINE OBSERVATIONS
B. ORGANISATION OF SERVICES
C. TRAINING OF THE HEALTH PERSONNEL
D. COMMUNITY INVOLVEMENT

The baseline observations were aimed to describe the existing system in regard to the health personnel, the attendance of mentally ill in the general health services, the community perception and methods to identify the mentally ill persons in the community. It was envisaged that these initial observations will provide data for future comparison following the intervention phase as well as providing data for the choice of priorities, training methods and public education. The results of the baseline observations, in a number of areas have by themselves become valuable in terms of the research methodology and information regarding mental disorders in rural areas. An account of these are presented below and more detailed reports are given in the published articles (Murthy & Wig, 1978).

The baseline observations included the following : (i) the health staff interview, (ii) screening of the general health clinic population, (iii) the interview of community leaders (the key informant interview).

HEALTH STAFF INTERVIEW

All the different categories of health personnel working in the study area were

interviewed using a specially prepared interview schedule the HEALTH STAFF INTERVIEW (HSI). The objective was to obtain information regarding the level of knowledge regarding mental health, their attitudes to work with the mentally ill, and their suitability and willingness to carry out mental health care. The interviews were carried out in one-to-one situation with sufficient privacy. On an average each interview took about 30-45 minutes. In addition field visits by the research staff were made to observe their routine work and understand the scope for inclusion of mental health care, alongwith their routine health acitivities. These efforts have highlighted the following : Presently the health personnel receive very little training in the recognition and management of mental disorders during the initial training. Their existing responsibilities do not involve caring for the mentally ill persons. Most of the health personnel could not name more than one or two mentally ill persons in their area of work. Their knowledge about the available drugs for the treatment of mental disorders was very limited. Interestingly, they were aware of 'Calmpose' (Diazepam) and not Chlorpromazine or Imipramine which are specific agents of treatment of mental disorders. However, most of them expressed a desire and willingness to take part in the training and provide care to the ill persons. The other observation that surfaced was the already existing load of ongoing health work that allows for only minimal addition to their work. In terms of responsibility for use of drugs, at present, the different categories of health personnel are dispensing limited variety of drugs like vitamins, sulfonamides, antacids, antipyretics, antidiarrhoeals. It was noted that the amount of curative work was limited though occupying high prestige position in their own evaluation. This offers an avenue for possible inclusion of 'curative' components of mental need for developing priorities and training methods suited to the background of the health personnel (Fig. 3) (Murthy & Wig, 1978).

SCREENING OF THE GENERAL HEALTH CLINIC POPULATION (ADULTS)

As part of the planned intervention it was envisaged that the primary health care facilities and personnel will be involved in basic mental health care. In view of this it was essential to know, prior to interventions, the answer to the following : How many and what type of mental disorders are already present among patients coming for primary health care? What proportion is correctly identified by the health workers ? Which presenting complaints are associated with the presence of a psychiatric disturbance ? Answers to these questions were provided by the screening of the general health clinic population using a systematic method. A detailed report of this part of the study is reported elsewhere (Harding *et al.*, 1980).

Three hundred and sixty one adults were screened utilising the above instruments. The male : female ratio was 1 : 2. The estimate of frequency of mental disorders is 17.7%. The great majority of these cases were diagnosed as being neurotic disorders and few cases of functional psychoses or mental retardation were diagnosed. Ratings by the health staff showed that most patients were diagnosed as having physical health problems. In 8.3% the diagnosis was made as physical and mental health problem and as mental health problem only in 4.4%. The combined total of the above two categories was less than the amount identified by the screening. Further analysis indicate that the diagnostic sensitivity is relatively low (Less than 40%), while the diagnostic specificity is high (more than 90%). Another interesting observation was relating to the reasons for attendance. Those patients quoting three or more reasons for attendance have twice the chance of suffering from mental disorders.

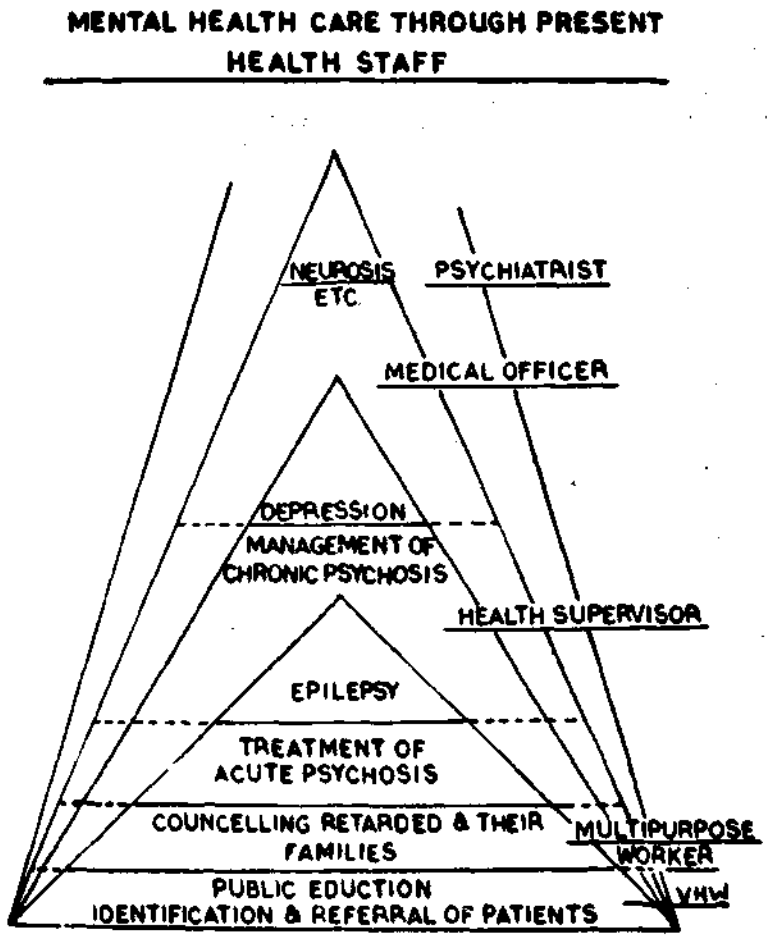

Fig. 3

Two important points emerge from this part of the baseline study. Primary health care personnel see mental disorders as part of their routine work in significant numbers. However, at present significant proportion of the psychotics and epileptics are not reaching the health facilities. Alternative approaches of identifying these groups need to be developed to reach them. A method of reaching this group has been developed and reported at a later section as part of this study.

SCREENING OF THE GENERAL HEALTH CLINIC POPULATION (CHILDREN)

The two stage screening of the children attending the general clinic facilities of the study area was carried out. The procedure was along the lines used for adults and presented in Fig. 4. The instruments employed were the Reporting Questionnaire for Children (RQC). Follow up interview with Children (FIC), and the Research Staff Rating (RSR).

A *total* of 151 children were screened. Of these 96 (60%) were males and 55 (40%) were females. Of these 52 (34%) were thought to have potential psychiatric problems at the first level of screening with RQC. Following detailed psychiatric evaluation 34 (23%) were found to have a clinical psychiatric syndrome and/or mental retardation. Of these, the primary health personnel identified only 4.6% of

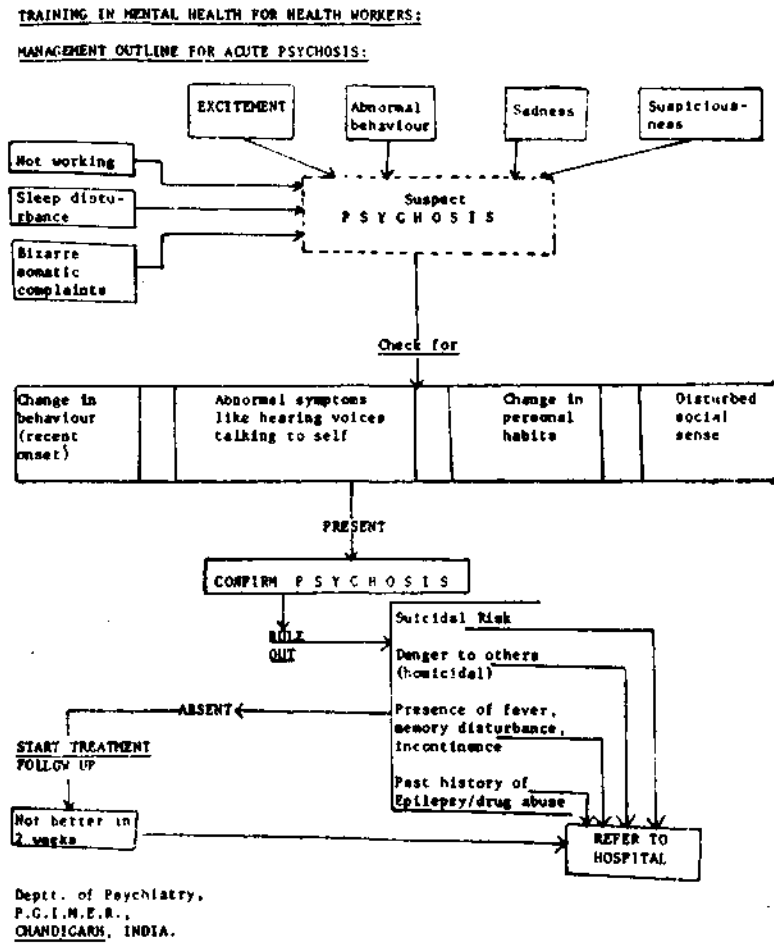

Fig. 4

the cases.

It is important to note that people accompanying children to primary health care facilities do recognise, with the help of trained interviewers, mental health problems while at the same time primary health personnel hardly identify any of these problems at present.

COMMUNITY ATTITUDE TO MENTAL DISORDERS

One of the important criteria for selecting priorities for mental health care is the 'felt need' of the population. An attempt was made to study how the different mental disorders are perceived in the community and what are the usual reactions to them. A survey was carried out by a structured questionnaire utilising a series of vignettes describing people with mental disorders. The questionnaire, Key Information Interview (KII) was administered to key persons in the village like the village leaders, teachers and elders of the community. All of them were occupying positions of trust in the community and living continuously in the study area for the last four years. On an average one key informant for 300 population was chosen. The interviews were carried out by trained research staff in the homes of the key informant in a one to one setting.

An average interview took about 30-40 minutes. The attitudes were rated on the basis of (i) gravity or seriousness of the disorder, (ii) prognosis, (iii) marriage prospects, (iv) living at home and (v) work (Murthy, 1971).

It is seen that acute psychosis was seen as the condition with the most seriousness, but mania and process schizophrenia were almost as serious, with a somewhat more hopeful attitude towards individuals being able to live at home. The prognosis of both depressive neurosis and depressive psychosis were seen as bad but the social consequences were less serious. Mental retardation was seen as the least serious condition.

The findings of this part of the baseline study have been valuable in the selection of priorities for intervention. The other area that calls for action is the need for organised health education and community involvement to bring about greater awareness and acceptance of the mentally ill living in the community. As part of the KII an effort was made to identify the mentally ill in the community. This is described below.

Following the attitude questions, the informants were asked to suggest the names of the possible persons in their village with such a disorder. Names of those mentioned were noted down and followed up by personal visits by the research staff. Those found to be mentally ill were provided the necessary treatment. A total of 114 KIIs were completed for this part of the study (earlier findings about perception related to the date from 50 KIIs). These Key Informants reported and gave information about 227 persons. On follow up and evaluation 169 were found to be having psychiatric disorders. More than 40% were having functional psychosis (42. 7%), 19.5% had mental retardation, 16.6% epilepsy and the rest (23.1%) had mainly neurotic disorders.

The above mentioned KII offers a simple and easy method to study community attitude and to identify the severally mentally ill in the rural communities.

PRIORITY SELECTION

Based on the findings of the baseline studies and the scope for planning interventions, the following were selected as priorites in the study are : ACUTE PSYCHOSIS, EPILEPSY, CHRONIC PSYCHOSIS, DEPRESSION (PSYCHOTIC) and MENTAL RETARDATION (Fig. III). The choice of the above priorities were made on the basis of the following factor :

* Prevalence of the disorder
* Disability caused by the disorder (health effect)
* Amenability to intervention
* Community concern (felt need)
* Acceptability of interventions by the community
* Suitability for care by the health personnel.

The choice of drugs for the treatment of the above disorders were limited to phenobarbitone, chlorpromazine and imipramine. The attempt was not to exclude the use of other drugs but to treat as many of the above problems as possible with the LIMITED RANGE OF DRUGS. It was anticipated that this approach would provide greater applicable model for wider application. This is especially true in India where the per capita expenditure on drugs is very insignificant. Additional drugs like diphenyl hydantoin, injectable phenothiazines, antiparkinsonian agents were used when other drugs were not effective or suitable. However, the effort was in all the cases to use the first line of drugs initially and change to other drugs only when essential.

RURAL PSYCHIATRIC CLINICS (Wig. *et al.*, 1980; Murthy *et al.*, 1979).

The organisation of the services in the 'periphery' raised four important questions,

namely :

(i) are there enough numbers willing to come to the health facilities with severe mental disorders, if suitable treatment is provided ?

(ii) Can psychiatric care be provided in peripherally placed health facilities like the PHC and subcentres ?

(iii) Will the rural population accept modern medical treatment, in terms of drugs, counselling and other therapies ? and

(iv) Can the para professionals provide psychiatric care ?

In order to understand the problems of caring for the mentally ill in a decentralised manner, a weekly psychiatric clinic was organised at the PHC situated at Raipur Rani. This was initiated earlier to training the existing health staff. The clinic was under the overall responsibility of a psychiatrist and social scientists (research staff, non medical) were actively involved in the clinic work. Patients reaching the clinic through referrals from health perosnnel and coming on their own were examined and provided the needed help. The social scientists initially were observers and gradually took part in the initial assessment and follow up care. By the end of the year, the non-medical staff were primarily providing the care in terms of initial evaluation and follow up care.

The utilisation of the services in the clinic, situated at the PHC, alongwith other general health activities gradually displaced the fears that 'there were no mentally ill persons in the area' as well as to 'the non-acceptance of modern methods of treatment' by the rural population. From an initial handful of cases by the end of the third year about 100 patients were taking help every week. The diagnostic break down of the patients is presented in Table I (Wig *et al.*, 1980).

Analysis of the data relating to the utilization of help after initial contact showed that 26% of the patients attended only once, 34% took help regularly by taking treatment on more than 5 separate visits. More details of the I and II year data are presented in greater length elsewhere (Wig *et al.*, 1980 ; Murthy, 1979), Further analysis showed that those close to the PHC took help much more regularly than those coming from long distances. Similarly those with severe disturbances were also more regular with their treatment. Both these findings at the rural clinic are in line with the findings from the urban clinic at Chandigarh by us.

TABLE I—*Diagnostic distribution at Raipur Rani Psychiatric Clinic*

Diagnosis	Ist year	IInd year
Schizophrenia ..	21	39
MD Psychosis	13	62
Organic Psychosis ..	4	5
Epilepsy	22	47
M. Retardation	9	20
Anxiety Neurosis	45	75
Depressive neurosis ..	36	31
Other neurosis	12	26
Miscellaneous	4	11
Total ..	166	335

The experience of three years of work at the peripheral psychiatric clinic can be summarised as follows : There are sufficient number of mentally ill needing urgent psychiatric services. These persons were largely without any meaningful treatment prior to starting of the clinic. Patients are willing to take treatment once the help is available regularly. The regular utilisation is a function of the closeness of the service to the residence of the ill persons. The acceptance of para professionals is satisfactory as long as they are seen as part of the total organisation. Paramedical personnel can acquire skills and confidence to care for the mentally ill persons. Limited range of drugs can take care of majority of the neuropsychiatric problems and in

less than 10% of the patients alternative and more expansive drugs are required. Briefly, by providing services close to their homes, within a reasonable cost and demonstrating their effectiveness modern psychiatric help can reach the remotely placed villagers through paraprofessionals health staff.

TRAINING OF THE HEALTH PERSONNEL

The experiences and results of the baseline studies paved the way to the next step of involvement of health care personnel. The advantages of involving the primary health care peronnel are :—

* Availability
* Accessibility
* Continuity of service
* Comprehensiveness of care
* Community acceptance
* Individualisation of service
* Treatment in the home environment.

However, the next step to decentralise and deprofessionalise raises the following questions : What tasks they can perform ? What is the best method of training them ? Can they provide effective care ? How can they be supported and supervised ?

The following is brief outline of the approach adopted in training and supervision : It has been already pointed out, in earlier sections, that the scope for inclusion of mental health care in the general health care of the primary health care personnel is present but limited. In view of the approach adopted was to utilise a task oriented approach focussing on specific tasks the health personnel can perform and integrate in their routine work. Based on this general approach, the priority conditions were spread out under the different categories of health staff in the area (Fig. III) (Murthy & Wig, 1978). It is seen that the simpler tasks are delegated to the less trained of the workers and the more complex tasks to the more qualified. The attempt was also made to build in an in-built system of referral and supervision/ support.

TRAINING MANUAL (Wig. *et al.*, 1980)

The approach adopted in the public health programmes have been to deal with health problems at the community level at three levels, namely when to SUSPECT, how to CONFIRM and what TO DO or how to manage. Good examples of this approach is the method of handling of malaria and tuberculosis. Similar approach was felt to be appropriate for mental disorders. The essential task was to simplify the complex process of recognition and management of mental disorders.

The management outlines relating to Acute psychosis, depression and Epilepsy illustrate this approach (FIGURE IV, V and VI). The MANUAL ON MENTAL DISORDERS FOR PERIPHERAL HEALTH PERSONNEL contains the above outlines and the textual material to enable the health workers to master the skills required for the care of the priority conditions. They give information about the methods for integrating with their routine work in the community, clinic and health education activity (Wig, Murthy & Mani, 1980).

TRAINING PROGRAMMES (Wig. *et al.*, 1980, Wig. & Murthy, 1980)

The training of the health staff was carried out in July-August 1979. The training of doctors was followed by that of the health supervisors and the multipurpose workers. In each training session the natural local links of referral and support were strengthened by involving them in the training. For example, for the training of the MPW on epilepsy one of the health supervisors who was actually carrying out the care already was used as the chief resource person, alongwith the medical officers and the research team members. This helped in making the health staff to perceive it as a part of their total programmes and not a special activity.

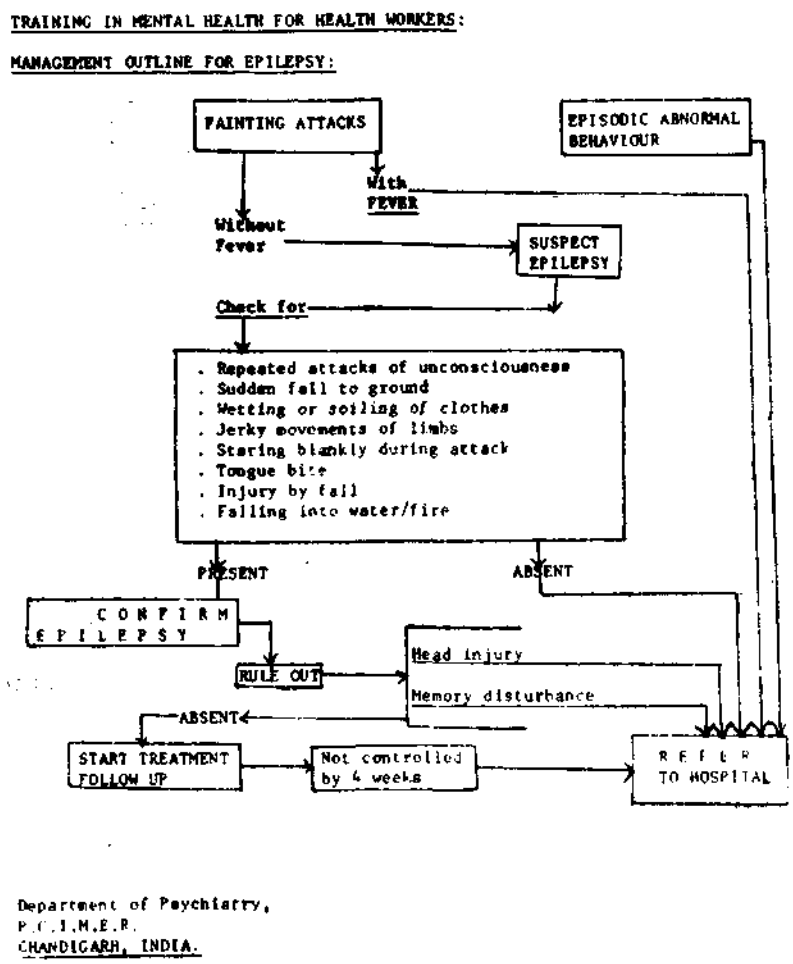

Fig. 5

SUPERVISION AND SUPPORT OF THE HEALTH PERSONNEL

The need for systematic supervision and support became clear to following the initial training. It was noted that though the classroom training provided them new knowledge, the skills required to practise on their own were not adequate, in spite of including practical demonstration in the training sessions. Another important hindrance was the need to change the attitude and role perception.

The reactions to the prospect of caring for the mentally ill on their own in their sub centres was varied. Resistance manifested itself in a number of ways : 'I do not have enough time', 'people do not accept this treatment', 'I am afraid that the patients may harm me', and 'traditional treatment may be good enough'.

Thus, it was noted that though the health personnel had acquired new knowledge, there was a big gap in its direct application. The method adopted to take them to the next step was not to 'demand work from them by authority', or to 'set targets' but to meet them once a week in their own subcentres and help them through the initial problems and allow them to experience the challenges and sources of gratification. This approach made the work more practical and relevant. By the

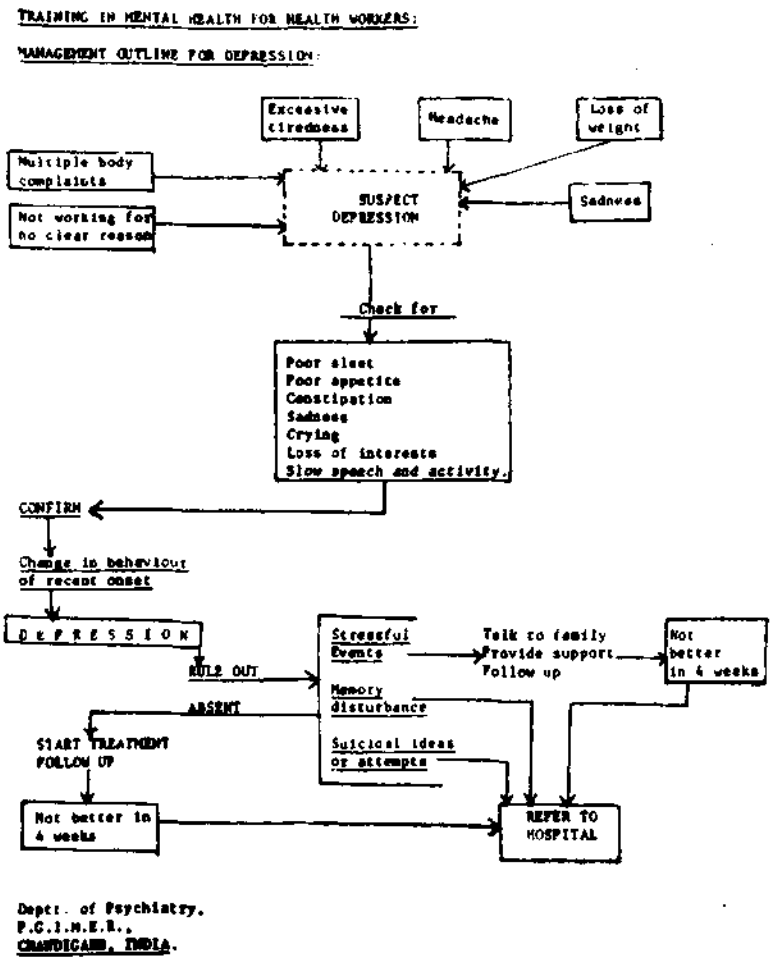

Fig. 6

above process, we were not taking to the health worker of some 'mentally ill' person, but one of their own community, a human being with behavioural problems and symptoms, whose wife was attending the health workers antenatal clinic or the child, immunisation sessions or other health activities. This effort to humanise the problem helped immensely in the decentralisation and deprofessionalisation. Mental illness assumed a reality and became manageable providing emotional satisfaction for the health workers.

DECENTRALISATION OF SERVICES

Following the training and initial follow up visits by the research team, described above, gradually patients known to the team were shifted for follow up care to the subcentres. In each of the subcentres, one day a week for about one hour was designated for the care of the mentally ill. These became the MENTAL HEALTH CLINICS.

The research team members, usually one person visited the centres on the designated day and was available to help in the clinic. This person sorted out problems in treatment and rehabilitation and utilised this opportunity to carry out in-service training utilising the 'Manual'. Gradually the health workers gained confidence in talking to mentally ill giving the drugs,

adjusting the dosage and counselling them. Whenever refined additional help was available at P.H.C., Raipur Rani. Rather infrequently cases requiring investigations or important were passed on to P.G.I., Chandigarh. At present more than 200 cases in this area are receiving continuous regular psychiatric care. Of these 195 were seen only at the subcentres. The Friday weekly clinic at PHC continues as before with a lesser number of patients than before due to the process of decentralisation. TABLE II provides details of the type of patients receiving help at different subcentres of the area :

Distribution of the patients in the villages show that in 90% of the villages, there is at least one ill person who has come under our care during the last four years of care.

Though the total numbers receiving continuous care fall short of the known prevalence figures, what is impressive is the wide coverage and the amount of regular care that can be provided by this approach to real half of the estimated number of seriously mentally ill in a rural community.

OBSERVATIONS DURING SUPERVISION OF HEALTH PERSONNEL

It is difficult to easily describe the sources of strength and weaknesses in the interaction between the project team and the health personnel. However, this area is of importance for others interested in similar work. A small selection of the reactions of the research team and the problems noted are given below : One of the research team members felt "the health workers find it easy to go through the management outlines and ask specific questions, related to the specific problem, in the beginning, they observe me as to how to elicit signs and symptoms. After sufficient practice this work was handled by the health workers themselves and they only needed supervision". Further, in the process of supervision, 'Intervention by supervisor was made when the worker was making a mistake or asking the wrong question'. However, the above method 'did not go in a cut and dry manner. There were good and bad days'. One other point noted by the team was 'we were equally impressed by the real limitations existing in adding mental health care as envisaged at the initial phase of the programme'.

The problems noted during supervision could be categorised as follows :

A—*Administrative*

(1) Working situation—lack of privacy, storing (medicines) space like lack of cabinet to lock drugs.

(2) Male workers not working in the

Distribution of patients at subcentres, May, 1980

Subcentre	Clinic day	Registered Patients				
		Psychosis	Epilepsy	Depression	Others	Total
Lamgarh ..	Monday ..	11	18	7	5	41
Kot	Wednesday ..	2	33	1	2	38
Rattewali ..	Wednesday ..	6	9	4	..	19
Parwala ..	Monday ..	5	12	7	2	26
Thuli ..	Monday ..	12	14	6	3	35
Dhrewala ..	Friday ..	12	14	7	1	34
Jhatoli* ..	Saturday ..	1	1	1	1	4
	Total ..	197				

Raipur Rani : Friday clinic : Weekly 50-60 old patients.
10 New cases.

*Initiated in April, 1980.

clinic, so they are not actively involved, as envisaged at the beginning of the project.

(3) Poverty and difficulties of patients to reach even the nearby health centres.

(4) Problems of 'additional' load of work and need to reorient their routine to be available at weekly clinics regularly.

B—*Clinical*

(1) Expectation of too early improvement by health workers.

(2) Difficulties to differentiate depression from physical problems.

(3) Difficulties to differentiate the episodic abnormal behaviour of TLE and psychosis.

(4) Difficulties in differentiating between the different drugs and tendency to refer to as 'calmpose' as the common name for all psychotropic drugs.

(5) Issues about how to handle repeat fits, when to stop drugs for depression/psychoses.

(6) Unwillingness to care for Mentally Retarded as they cannot be cured, 'why touch that problem' ?

C—*Others (Miscellaneous)*

(1) Supervision can occur only with one worker at a time.

(2) Patients waiting for the research team rather to take pretreatment from health workers, as the former may be better. This was noted only in the initial phases.

(3) Problem of needing to accommodate the new work in slots available in the ongoing work.

(4) Difficulty of the public, to understand the motives behind our work to provide free medical help to mentally ill. "Why are we so much interested?", "what do the team gain?".

COMMUNITY INVOLVEMENT AND HEALTH EDUCATION ACTIVITY

An important component in the organisation of services is the altering of the community attitudes so that they can provide support to the ill persons. A significant response to the ongoing work in the study area from the community has been the formation of Mental Health Association at Raipur Rani in January, 1978.

The aims of this Association are to support the service activity, educate the public to accept the modern treatment, rehabilitation of those recovering from illness and impress on the State machinery for the needed services. This association has been functioning in a limited way during the last 2-3 years. The village leaders have been meeting periodically and sharing the experience as well as supporting some other activities of our work. For example, they collect token contribution of 25 Paise from each patient to meet partially the drug cost. Similarly, it was chiefly their repeated requests to the visiting dignataries and health authorities that resulted in the allotment of Rs. 5,000 worth of psycho-tropic drugs to the primary health centre. The work of rehabilitating ill persons has not been so gratifying though isolated instances of their integration and community acceptance have occurred.

Another significant activity that occurred during the last six months was the organisation of a mental health exhibition at the village fare at Raipur Rani. This exhibition was very helpful in sensitizing the local population as to the recognition and management of mental disorders.

Initial efforts to develop health education material relating to psychoses, depression, epilepsy and mental retardation have been made. These are at present available both in English and Hindi (Menon *et al.*, 1980). These health education material are distributed through the different health centres and used for educating the general

population. Further work to include visual material needs to be carried out.

To summarise : during the last 5 years efforts have been directed to understand the needs of the mentally ill persons in the rural areas. The outcome of the work has been development of a number of research instruments and data regarding prevalence of mental illness in the rural areas. A method for identifying the mentally ill and to study the community attitudes has also been developed. The preparation of simple training programme including a manual has been a significant contribution. Knowledge regarding the practical problems of supervision and support of peripheral health workers in carrying out mental health work has been gained. The formation of a Mental Health Association by the village leaders has enhanced the community awareness and involvement in the ongoing work. It is hoped that the experiences and the results of the work would act as a stimulant for similar experiments and further refining of the needed data for making mental health care a reality at the primary health level.

IMPLICATIONS

The Raipur Rani experience and work is an expression of the commitment to examine avenues for providing mental health care as a part of primary health care. The implications of the past five years' work can be summarised as follows :

(1) The study has examined the feasibility of including mental health care in general health services existing in the country.

(2) The project area has become the focus of training of mental health personnel in this area of work. Already more than 50 personnel from different parts of the world have visited for training from this centre.

(3) The project has provided standardised tools for application and evaluation of activities at PHC in local language (Hindi).

(4) The training material—manuals, the programme of training, educational materials—can be adopted and used in different settings.

(5) The new questions raised by the the study can be taken for future collaborative work.

(6) Thus the project should be viewed as an important initial thrust to find answers to the scope for mental health activity at the Primary Health Care.

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Note—Health Education Material in English and Hindi mentioned in this paper is available from the authors.