

PSYCHIATRIC SERVICES THROUGH PERIPHERAL HEALTH CENTRES

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In the last two decades, there has been a major shift in the organisation of health services all over the world. There have been efforts to 'deprofessionalise' many health activities, to 'decentralise' services and place increasing emphasis on providing services for 'priority problems' for everyone. This shift can be viewed as a 'public health' or 'community' approach as compared with the earlier emphasis on excellence in individual health care.

During the last decade, a number of major epidemiological studies have been carried out in different parts of the country (Dube, 1970 ; Sethi *et al.*, 1972 ; Verghese *et al.*, 1973 ; Kapur, 1973 ; Nandi *et al.*, 1975). The findings of these studies have clearly established that the prevalence and distribution of the various forms of mental disorders are as much as in the Western countries. Though the different epidemiological studies have shown the magnitude of the problem and clarified the situation, unfortunately, to-date no clear-cut plans have emerged for the organisation of services to meet the needs of the majority of the ill persons, especially those in the rural areas.

Past attempts have been largely directed towards increasing the number of trained mental health professionals, increasing such facilities as hospitals and clinics and improving the training in psychiatry for medical graduates. However, any hope of having enough trained professionals and facilities is unlikely to be

realized in the near future (IPS, 1964). For example, the number of psychiatrists in India is about the same as that in Denmark with the population of Denmark being less than 1 per cent of India (Nielsen and Haul., 1978). On the other hand, there is not likely to be a mass movement of doctors to rural areas. There is also a danger of social isolation in moving patients to hospitals away from their communities. Recent evidence shows that rural life may be beneficial in preventing chronic mental illness. The other deterrent for abandoning the emphasis on imported professional models is the lack of funds available for fresh programmes which require massive inputs in training, building and rehabilitative measures. These aspects have received wide attention in various forums during the past few years (Bagadia, 1971 ; SEARO, 1971, 1974 ; Jayaram, 1972 ; Deb Sikdar, 1974 ; WHO, 1975).

The alternative for the present appears to lie in decentralisation, increasing community participation and deploying available health workers and staff in the peripheral health centres. Such an approach has been recommended by the Sixteenth Report of the WHO Expert Committee on Mental Health (1975). An applicable model to suit the Indian conditions has been suggested elsewhere (Srinivasa Murthy and Wig, 1977, 1978 ; Wig and Srinivasa-Murthy, 1979).

There are a number of questions that arise as part of an approach to 'decentralise'

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and 'deprofessionalise' psychiatric services. Some of them are: (i) are there enough number of mentally ill attending the peripheral health centres to justify organising services? (ii) can psychiatric care be provided in the peripherally placed health centres? (iii) will the rural community accept modern services, when there is such wide spread prevalence of superstition and ignorance about mental disorders? and (iv) can the paraprofessionals provide psychiatric help in the peripheral health centres?

The present experience relates to the organisation of psychiatric services in the peripherally placed health centres over the course of two years, with special emphasis on the second year's experience.

METHODOLOGY

The study was conducted at the Raipur Rani Block, Ambala district, Haryana State. The Primary Health Centre (PHC) at Raipur Rani was the chosen place of work. Starting from June 1976, a weekly clinic was begun at the PHC. Once a week, a team consisting of one psychiatrist, and two social workers visited the clinic and provided psychiatric help to those attending the PHC and referred by the different health workers. Patients were initially seen (first six months) by the psychiatrist and later followed up independently by the social workers, under the supervision and support of the psychiatrist. As the clinic function stabilised and the social workers got experienced they took part in the initial work up and subsequent follow up. In the clinic only three drugs were available, namely a phenothiazine, an antidepressant and an anticonvulsant (phenobarbitone sodium). Regular records were maintained of the initial intake and follow up visits. As the service was utilized by those outside the study area (block), the present data is considered for the study area and non-study area. The first year's experience has been reported elsewhere and the present data refers to the second 12 months, as well

as to the total experience in regard to providing insights into organisation of psychiatric services at the level of the FHC.

RESULTS

Total of 340 patients were seen from June 1977 to May 1978. Of these 206 were from the study area and 134 from outside the study area. The sex distribution is presented in Table 1.

TABLE 1

	Study area (N=206)	Non-study area N=(134)	Total (N=340)
Males	98(47.6)	83(61.9)	181(53.2)
Females	108(52.4)	51(38.1)	159(46.8)

Diagnostic Breakdown

The diagnosis of the patients seen are given in Table 2. Nearly one third of the patients were suffering from psychotic disorders. 45% of the patients were diagnosed to have neuroses. Those referred by the health staff but found to have no psychiatric disorder formed less than 2%. These 5 cases are excluded in further analysis of data.

TABLE II—*Diagnostic Breakdown of Patients*

Diagnosis	Study area (N=206)	Non-study area (N=134)	Total (N=340)
Schizophrenia	20(9.7)	19(14.2)	39(11.5)
MDP	38(18.4)	24(17.9)	62(18.2)
Organic psychosis	3(1.4)	2(1.5)	5(1.5)
Epilepsy	31(15.1)	16(11.9)	47(13.8)
Mental Retardation	17(8.3)	3(2.2)	20(5.9)
Anxiety Neurosis	43(20.9)	32(23.9)	75(22.1)
Depressive Neurosis	18(8.7)	13(9.7)	31(9.1)
Other Neuroses	16(7.8)	10(7.5)	26(7.6)
Miscellaneous	6(2.9)	5(3.7)	11(3.2)
Non-psychiatric	3(1.4)	2(1.5)	5(1.5)

TABLE III—Duration of Illness at First Contact

Diagnosis	Up to 3 months		3 to 6 months		More than 6 months		Total
	Study area	Non-study area	Study area	Non-study area	Study area	Non-study area	
Schizophrenia ..	8 (9.9)	32(20.3)	2(11.1)	2(12.5)	10(9.6)	3(8.8)	39(11.6)
MDP ..	32(39.5)	20(33.9)	4(22.2)	1(6.3)	2(1.9)	3(5.9)	62(18.5)
Organic Psychosis ..	3(3.7)	1(1.7)	—	1(6.3)	—	—	5(1.5)
Epilepsy ..	6(7.4)	3(5.1)	2(11.1)	—	23(24.0)	13(22.8)	47(14.0)
Ment. Retardation ..	1(1.2)	—	—	—	16(15.4)	3(5.3)	20(5.9)
Neurosis ..	31(38.3)	21(35.6)	10(55.6)	12(75.0)	47(45.2)	30(52.6)	151(45.1)
Miscellaneous ..	—	2(3.4)	—	—	6(5.8)	3(5.3)	11(3.3)
Total ..	81	59	18	16	104	57	385

TABLE IV—Duration of Illness of Epilepsy at first Consultation

	Up to 1 year	1—5 years	5—10 years	More than 10 years	Total
Study area ..	12(63.2)	3(60.0)	5(71.4)	11(68.7)	31(65.9)
Non-study area ..	7(36.8)	2(40.0)	2(28.6)	5(31.3)	16(34.1)
Total ..	19	5	7	16	47

Duration of Illness

The duration of illness at first consultation is presented in Tables 3 and 4. As expected, problems of long standing nature with less scope for any short term improvement like mental retardation and epilepsy have been present for longer period. This is in contrast to more acute disturbances like schizophrenia, affective psychoses and organic psychoses. Among the epileptics, detailed analysis show that in nearly half the cases the problem was present for more than five years (Table IV).

Treatment Utilisation

The utilisation of help subsequent to initial contact and evaluation at the end of the study period is given in Table V.

TABLE V—Number of Visits after Initial Consultation

	Study area	Non-study area
One visit	55(27.1)	34(25.1)
Two visits	40(19.7)	25(18.9)
Three visits	24(11.8)	14(15.6)
Four visits	13(6.4)	15(11.4)
Five visits	16(7.9)	12(9.1)
Six visits	12(5.9)	9(6.8)
Seven visits	7(3.5)	4(3.0)
Eight visits	6(2.9)	3(2.3)
Nine visits	5(2.5)	7(5.3)
Ten or more visits	25(12.3)	9(6.9)

26% of the patients attended only once while 34% of the patients took help by visiting the clinic more than five times.

It is noted that those from the study area were more in number among those who were taking regular treatment. The diagnostic breakdown of those attending more than 5 visits is given in Table VI.

TABLE VI—*Diagnostic Grouping and 'Regular' Treatment Acceptors*

Diagnosis	Study-area		Non-study area	
	Total	More than 5 visits	Total	More than 5 visits
Schiz.	20(9.9)	10(14.1)	19(14.4)	12(27.3)
MDP.	38(18.7)	14(19.7)	24(18.2)	8(18.2)
Org. Psycho.	3(1.5)	2(2.8)	2(1.5)	2(2.3)
Epilepsy	31(15.3)	16(22.5)	16(12.1)	7(15.9)
M. Retar.	17(8.4)	6(8.5)	3(2.3)	..
Anx. Neu.	43(21.2)	8(11.3)	32(24.2)	5(11.4)
Dep. Neu.	18(8.9)	7(9.9)	13(9.8)	4(9.1)
Hys. Neu.	11(5.4)	3(4.2)	8(6.1)	1(2.3)
Other Neu.	16(7.9)	5(7.0)	10(7.6)	4(9.1)
Misc.	6(2.9)	..	5(3.8)	2(4.5)
Total	205	71	132	44

Monthly Distribution of Attendance in the Clinic

Monthly distribution of new patients and patients coming for 'repeat visits' are given in Table VII. The 'repeat visits'

TABLE VII—*Monthly Distribution of Attendance of Patients*

Month	New cases		Repeat visits
	Study area	Non-study area	
June	14	13	39
July	21	9	41
August	26	13	48
September	12	8	70
October	3	9	59
November	4	2	43
December	15	13	59
January	18	14	73
February	24	10	78
March	22	19	97
April	21	6	80
May	26	18	91

refers to the number of patients, as the number of visits in a month by the same patients was from one to four depending on the type of treatment advised.

DISCUSSION

The experience reported here provide interesting insights into the needs and scope for organising psychiatric services for the rural areas. It was 15 years back that an Indian Psychiatric Society expert committee felt "Even if almost all the five year plan effort in the fields of Health were only geared to increasing the number of psychiatric doctors, it . . . would be impossible to provide an adequate number of hospital beds and mental specialists even in the next 50-100 years . . . even if all the training facilities in the country are doubled and trebled, which is not easy, it could still require nearly 100 years to provide an adequate number of psychiatrists for working in the curative field" (IPS, 1964). It was not much later that Dube (1966) opined that: "I believe, for a long time to come, mental hospitals will remain the nucleus of mental health services". Last decade has seen a major shift in focussing attention into the community, away from the traditional institutional approaches (Bagadia, 1971; Jayaram, 1972; Deb Sikdar, 1974; WHO, 1975). However, the subject of providing care to every mentally ill has occupied the minds of professionals, as yet no clear model is available. We have suggested elsewhere that the scope for organising services like "Integration of mental health services with general health services" (Wig and Srinivasa Murthy, 1979; Srinivasa Murthy and Wig, 1978). The following discussion is focussed to provide answers to the FOUR questions raised in the initial part of the paper.

Firstly, are there enough number of mentally ill attending the peripheral health centres? It is clear that from the total number of cases seen during the 12 month period, significant amount of mental dis-

orders reach the health centres. In another study Harding *et al.* (1980) found a much higher number of neurotic problems among those attending the PHC. Prior to organising the present service there was no meaningful help available to the ill persons. Thus the official records of the PHC recorded the magnitude of the mental disorders seen in a one year period as only 2 to 5% of the total seen, after the service was started. The number seen in this study was sufficient to keep the team busy for a full day. In addition, it has been noted that the doctors are taking more and more responsibility to treat these patients. For example almost every week a psychiatric patient occupies one bed in the PHC and treated along with the general medical patients.

Secondly, the present experience has shown that it is possible to provide psychiatric care with limited facilities and a limited range of drugs. Such an approach to management of neuropsychiatric problems have been one of the recommendations of a WHO report (WHO 1976). However, it is to be noted that the management of neurosis poses problems—their treatment utilisation is poor as compared to more serious psychiatric disorders. Similar differences have been noted in the urban psychiatric centres also (Srinivasa Murthy *et al.*, 1974, 1977; Deepa *et al.*, 1980).

Thirdly, the doubts of the non-acceptance of modern treatment by the rural population appear misplaced. From our experience it is evident that the reasons for the villagers to turn to 'traditional healers' has been the lack of proper medical services close to their community. Ill persons and their families accepted help from the PHC once they were assured of the availability of help and its effectiveness. Similar observations have been made by Kapur (1975). Thus one of the most effective ways of educating the villagers could be by making available suitable services. However, the significant drop-outs even among the psychotic and epileptics calls for further

study of the problem.

Fourthly, the role of the 'paraprofessionals'. The present experience is limited to the deployment of social workers. It is gratifying to note that the training was feasible and the acceptance by the public and their satisfaction was good. This could be said to be due to the availability of the psychiatrist to provide support and supervision. It remains to be shown that non-medical non-specialist personnel can independently provide satisfactory care in the rural areas. The present experience needs to be enlarged to evolve such a model.

The present report forms part of a WHO international study 'Strategies for extending mental health care' and progress in four different countries of the world. The attempt is to evolve a model to integrate mental health with general health services. The next step in providing care is to train the existing health workers in mental health work. This remains an area for future work. Further details of this project can be obtained from the authors.

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