Indian J. Psychiat. (1982), 24(3), 237—241

EXTENSION OF MENTAL HEALTH SERVICES THROUGH PSYCHIATRIC CAMPS : A NEW APPROACH

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SUMMARY

Psychiatric camps in the manner they are usually conducted serve no useful purpose in the long run, except to identify cases and to increase people's awareness about mental illnesses. The main drawback is poor follow up of the cases detected.

To overcome these drawbacks and to make these camps more useful in delivering mental health services to the community, a new approach is being worked out. Screening and selection of the patients for the camp by the local doctors with the help of symptom check-list, a good propaganda well in advance incorporating the cardinal symptoms through mass media, training of the local doctors to gain basic skills and knowledge to manage cases during follow up, periodic visits by the psychiatrists to help these doctors in this job for some time, mental health exhibition during the camp were some of the strategies adopted in Kollegal Neuropsychiatric camp by community psychiatry unit of NIMHANS.

It was a three days' camp. 312 cases were registered after screening. Only 6.7% cases were non-psychiatric. 30% epileptics, 30% neurotics, 12% Headache, 9% MR, 9% neurological cases, 5% psychoses. 25 doctors participated in training programme and camp patients were allotted to them for follow up. Monthly follow up is in progress. Findings and experiences are discussed.

Psychiatric camps as a means of extension of mental health services to the community is being tried for many years all over the country. Only a few of them are reported in literature (Deb Sikdar, *et al* 1976, Luktuke *et al* 1978, Narayana Reddy *et al* 1980).

Ideally in addition to taking mental health care facilities nearer to people, the psychiatric camps serve the following purposes,

(a) increase people's awareness about mental health.

(b) help to remove misconcepts, stigma and wrong attitudes towards mental illness and mentally ill.

(c) offer a potential to local community resources to rehablitate the patients.

These camps, as they are usually conducted, do have some of the following limitations :

(i) they are usually arranged only once at one place.

(ii) psychiatric patients registered are asked to contact the psychiatric team at the base hospital place irrespective of the distance from the camp. The camp is used only for purposes of identifying patients. Thus the follow up of these patients is totally indadquate since many patients and their

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family members fail to report to a psychiatrist, due mainly to the problems that originally prevented them from consultation.

(iii) The voluntary agencies which organize such camps do take care of free drug distribution during the camp but do not extend the same facility later.

(iv) many times drugs prescribed are not available in the local drug stores.

(v) unless somebody does the screening of the patients who want to consult the psychiatric team, a lot of non-psychiatric patients register their names. Thus valuable time of the team is wasted in attending to these patients and in convincing them that they do not need team's assistance.

Narayana Reddy *et al* (1980) report that 51% of the patients in their monthly neuro-psychiatric camp suffer from non-neuropsychiatric illnesses. In monthly neuro-psychiatric camps started in June 1981 by NIMHANS, more than 60% patients registered are general cases (personal communication). Deb Sikdar *et al* and Luktuke *et al* conveniently overcame this particular problem by sending a symptom check-list to general practitioners who did the screening and thus there were only 4% non-psychiatric cases in their Bagalkot and Ahmed Nagar Camps.

If all the problems listed above are attended to, the psychiatric camps can be very useful in extending mental health care to people.

When Lions club and Indian Medical Association of Kollegal town, in Karnataka state requested the community psychiatry unit of NIMHANS, Bangalore to hold a neuro-psychiatric camp in their town, the unit decided to take all necessary steps to overcome these problems and try a new approach. The following strategies were adopted.

1. A symptom check-list was given to the local doctors—both Government and General practitioners to enable them to start registering suitable patients. Pamphlets, posters, cinema slides were prepared incorporating the cardinal symptoms and displayed for general population well in advance.
2. An orientation training programme was planned for the doctors so that they get sufficient knowledge in managing common neuro-psychiatric problems and thus are able to do the follow up of the camp patients themselves.
3. Simple case record and follow up proforma were designed for quick but efficient record keeping by these doctors. The initial camp case records were to be filled up by the psychiatric team members and follow up findings would be filled up subsequently by the local doctors (see appendix).
4. Monthly visit by one or two psychiatric staff members to Kollegal for a period one year were arranged with an aim of
   i) observing how the cases registered would be managed by the doctors.
   ii) offering consultation services to them for any difficulty during follow up.
   iii) encouraging them to identify and manage new cases which would also indicate the efficacy of the training.
5. After one year but gradually the unit would withdraw with a hope that, these doctors would then be able to offer basic mental health care to the community. If felt necessary, periodic refresher course could be arranged.
6. A mental health exhibition was planned to educate the public. A hand-out was designed in vernacular describing different types of mental illnesses,

mental retardation, epilepsy and treatment modalities for each. These strategies were described to the local doctors and their consent and co-operation was obtained. A list of essential and limited number of drugs were given keeping in mind their cost and availability in the local shops. The duration of the camp was decided to be three days. Every day between 9.00 a. m. and 1.30 p.m. consultation services to people and between 2.30 p.m. and 5.30 p.m. training sessions for the doctors were planned. Audio visual case demonstration and discussion were arranged on the second night between 9.30 p.m. and 11.30 p.m

The camp was thus organized on 26, 27 and 28th June 1981 and the programmes were carried out as scheduled earlier. Four staff psychiatrists, two staff psychiatric social workers, three senior resident post-graduate students formed the team. While staff psychiatrists managed the consultation and teaching, the staff social workers looked after the exhibition, educated the people and counselled the parents of mentally retarded. The post-graduate students helped the team in working up the cases. On an average more than 100 cases were examined each day. The consultation timings had to be extended to the afternoons also on second and the third day. The names of the referring doctor or the doctor to whom patient liked to go for follow up were recorded on the case records so that these case records could be left with the respective doctors for follow up. About 100 patients who came by themselves but screened out as non-neuro—psychiatric perferred to consult the team and forced the organizers to arrange for their consultation. The organizers and the team had to agree and on the third afternoon they were evaluated. As expected there was not even one psychiatric case amongst the whole lot.

In the orientation training programme eight sessions of 45 minutes each were arranged. Each was followed by 15 a minute discussion. The topics covered were—introduction and role of peripheral doctors in mental health care, psychiatric symptoms-history taking, interview techniques, psychoses, neuroses, head injuries and epilepsy. Drugs and their side effects and psychiatric emergencies were also discussed.

A manual* incorporating all this information was given to each doctor. In the audio-visual demonstration, 8 cases were demonstrated—2 schizophrenics, 1 endogenous depressive, 1 neurotic depressive, 1 hysteric, 1 manic, 1 adolescent with behavior problem and 1 patient with extra-pyramidal side-effects. After each case was shown, the doctors were asked to pick up important signs and symptoms, make a diagnosis and talk about management. It was found that this exercise made a tremendous impact on them and they actively participated in the discussion. At the end, though it was already 11.30 p.m., they requested the team to demonstrate some more cases. Thus audio-visual aids can be very effective in such training programmes.

Pre and post training assessment was done by requesting them to answer a set of questions after going through a set of 8 brief case- histories. The results of this evaluatory exercise will be communicated separately.

RESULTS

TABLE 1

Total number of cases registered ..	312	..
Number of neuropsychiatric cases ..	291	..
Number of non-neuropsychiatric cases	21	6.7%
Number of patients from Kollegal town	151	52%
Nearby villages ..	140	48%

*This manual can be obtained from the Unit on request.

TABLE 2

Sex :

	Kollegal	Bagal-kot*	Ahmed Nagar*	Gunjur*
Male % ..	54	64	74	61
Female % ..	46	36	26	39

*Male predominant.

TABLE 3

Age :

< 15 years	86	30%
15—30 years	109	37%
31—45 years	58	20%
46+	38	13%

Majority were children and adults

TABLE 4

Marital Status

Single	146	50%
Married	135	46%
Widow/separated ..	10	4%

TABLE 5

Religion		Class	
Hindu ..	83%	Poor ..	41%
Muslim ..	9%	Middle ..	56%
Christian ..	8%	Rich ..	3%

TABLE 6.

Education

Education	Kollegal	Bagalkot	Ahmed Nagar
Nil % ..	43	28	23
1—4 years	15	14	11
5—10 years	29	49	47
> 10 years	7	8	19
No information ..	6	..	..

TABLE 7.

Diagnostic Break-up :

Epilepsy ..	87	30%	*Neuroses* :	
Neuroses ..	87	30%	Neurotic/	
Psychoses ..	15	5%	Reactive	
M. R. ..	26	9%	depression ..	48%
Child problems	14	5%	Anxiety Neurosis	20%
Headache ..	36	12%	Hysteria ..	6%
Neurological ..	25	9%	Others ..	26%

TABLE 8.

Diagnostic Groups : Comparison

Diagnostic group	Kollegar	Gunjur	Bagal-kot	Ahmed Nagar
Neuroses % ..	30	39	12.5	26
Psychoses % ..	5	6	54	43
M.R. % ..	9	8	20	20
Child problems %	5	..	..	..
Epilepsy % ..	30	33	13.5	11
Neurological %	9	13	..	..
Headache % ..	12	..	..	..

DISCUSSION

Due to enthusiasm, efforts and good organizing abilities of the local IMA and Lions club members, it was a successful camp. Number of people who sought consultation was large and the number of doctors who turned up for the training sessions was equally impressive. The task of screening people for registration was ably done by the local doctors. Out of 312 cases registered only 21 (6.7%) were found to be non psychiatric. Significance of more female, more illiterates as compared to other camps (Table 2 & 6) attending this camp is difficult to explain.

Epileptics and neurotics (depressives in particular) out-numbered the other categories, constituting 60% (Table 7). Headache formed sizeable number. Neurotic

patients presenting with somatic symptoms like aches and pains, weakness, tiredness reported in large numbers indicating the need to orient the doctors about psychological origin of these symptoms. The number of psychotics was less than we expected and very much less compared to Bagalkot and Ahmed nagar camp (Table 8). This may be due to (a) probably a strong emphasis lieving made in those camps on referring psychotic cases to the camp being (b) our deliberate omission of the word 'madness' in the symptom-checklist which was done because its use could discourage other patients with minor mental problems reporting to the camp. Thus it seems that psychotics were not brought as people did not get the message that 'mad persons' would be treated in the camp. We did want more psychotics to come because comparatively it is easy for the local doctors to manage them rather than neurotics.

Regarding the training sessions the number of doctors who attended, fluctuated (between 20 and 25). The attendance of general practitioners was better than that of doctors working in Government hospital. While conducting the assessment exercise, inspite of assuring them that the exercise was done not to test their knowledge but to measure the efficacy of the training method, there appeared to be some apprehension present on the part of the doctors,

Thus the first phase of the camp was successful and the unit is looking forward for an equally successful second phase where in the follow up of these cases is done by the local doctors. The findings and experiences of this phase will be communicated in due course.

ACKNOWLEDGEMENTS

Our sincere thanks to

Dr. G. N. Narayana Reddy, Director, NIMHANS.

Dr. Gourie Devi, Professor & Head, Neurology Dept., NIMHANS.

Dr. Somnath chatterjee, Dr. Babu Mathew, Dr. Ghorpade — Post-graduate and resident doctors NIMHANS

Mr. G. N. Girirajan, President, Lions club, Kollegal.

Dr. P. G. Sridhar, Treasurer, I.M.A.

Dr. Krishna Swamy, Chairman, Health committee, Lions Club & Secretary, I.M.A.

Dr. G. K. Basavarajan, President, IMA, Kollegal branch.

and other office bearers and members of IMA and Lions club, Kollegal Staff of general hospital, Kollegal.

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