Initiating a Community Mental Health Programme in Rural Karnataka

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Introduction

Mental disorders are prevalent in people of all regions, countries and societies. They affect men and women at all stages of life. Contrary to popular belief, the poor are more likely to suffer mental and behavioural disorders[1] and are more likely to suffer tragic outcomes as a result of their illness. The National Mental Health Programme was developed in India to address the problem of mental illnesses especially in rural areas. However, it has come under some criticism as it has laid emphasis on identifying and treating severe mental disorders [2] such as psychosis, while not addressing Common Mental Disorders [CMD], which are equally disabling.

CMD, which are neurotic disorders presenting with anxiety and depressive symptoms, are widespread and are known to cause significant disability worldwide. In India, prevalence rates of CMD range from 2% to 57%[3]. Majority of patients with CMD present at primary care centres but end up receiving symptomatic treatments like painkillers and vitamins because they are not recognised by primary care physicians as being mental illnesses. CMD in such patients leads to chronic disability and progress in severity, making ultimate treatment more difficult.

This paper describes the development of a community mental health programme which is integrated with other services rendered at a primary care institution in a rural area and that addresses CMD alongside psychotic disorders and epilepsy. This initiative was a collaborative effort between the Departments of Community Medicine and Psychiatry of St. John's Medical College, Bangalore. The programme was based at the Community Health and Training Centre at a village called Mugalur, which is 30 km from Bangalore city. This centre serves as the hub for all community-based activities of the Department of Community Health. Services include a 24-hour general health clinic, antenatal, intranaal and postnatal care, child care, care of the elderly and specialised services for those with visual and hearing impairments. The other health care facilities available in the area are a government Primary Health Centre and a few private clinics, all of which are located about 10 km away from the centre.

Material and methods

Four motivated women were chosen from the local women's groups called *Mahila Mandals.* All steps were taken to ensure that the four workers were married women with good social standing in the community, who had demonstrated a keen interest in community activities and an ability and eagerness to learn about the proposed project. They also enjoyed family support and encouragement to participate in this programme. The women chosen to be Community Health Workers were then trained in identification and referral of patients with mental illnesses, the common myths and misconceptions prevalent in the area and in conducting community surveys. The training lasted 3 days and included lectures, role plays and observation of patient interviews at the psychiatry out patient department at St. John's Medical College Hospital.

The CHWs then commenced a survey of twenty five villages around Mugalur. The survey included administration of a field tested questionnaire ["Symptoms in Others Questionnaire"[4] to identify patients with epilepsy and severe mental illnesses like psychosis, and an enquiry as to whether any one in the household suffered from long standing headaches and other bodily complaints. The latter enquiry was made to identify persons who could be suffering from CMD since primary care attenders with CMD frequently present with somatic symptoms [5]. CHWs interviewed one adult member of every household in the intervention area. Persons suspected as having an illness described above were requested to visit a weekly clinic at the Mugalur Centre for a "check-up". The CHWs also followed up such persons in their homes to encourage them to visit the clinic. The survey commenced in March 2003 and was completed in July of the same year.

Patients who visited the clinic initially underwent a physical examination conducted by interns posted at the centre, to rule out any obvious physical illness. They were then clinically evaluated on the basis of the ICD 10 criteria, by a psychiatrist from St. John's Medical College Hospital. The CHWs facilitated the initial interviews by being present while the patient was being interviewed. Treatment mainly consisted of pharmacotherapy.

Concurrently, to increase awareness of mental illness in the community, a street play was developed. It included messages on CMD and epilepsy, the need for accessing treatment and continuation of care as well as the need to treat mentally ill patients without stigma. The play also advocated tolerance and compassion for such patients. The play depicted real life situations of patients with CMD and epilepsy and was enacted in different villages. These street plays were preceded by song and dance programmes of the local school children in order to increase viewership. In addition to these plays, the CHWs also disseminated

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information informally in the community through discussions in small groups.

Results

A population of 12886 was surveyed. 574 suspect patients were identified in the survey, of whom 181(31.5%) were males and 393 (68.5%) were females. 242 patients attended the clinic from March to July 2003. 176 (73%) were females and most of them were in the age group 21-40 years. Of the 242 patients who were registered, only 212 (87%) were from the surveyed area. Others had come from surrounding villages after hearing about the service. Attendance at the clinic varied from 20 to 30 patients per clinic day. Patients with CMD formed the majority of those who visited the clinic as compared to those with severe mental disorders (Table I).

Many female patients agreed to come for the check-up after they were followed-up by the CHWs at their homes. Severely ill patients were admitted to the psychiatry ward at St. John's Medical College Hospital for initial treatment and were referred to the rural centre for the followup. Thus many patients well known to the community as being "mad" were able to receive treatment with good results. Improvement in such patients played a major role in bringing more numbers of severely ill patients for treatment.

Table I :Commonest neuropsychiatric conditions encountered at the mental health clinic at Mugalur village, Karnataka

Diagnosis (ICD-10 code)	No. of Patients (%)
Mild depressive episode (F 32)	81 (33.5)
Dysthymia (F 34.1)	54 (22.3)
Epilepsy (G40)	29 (12.0)
General Anxiety Disorder (F 41.1)	20 (8.3)
Persistent somatoform pain disorder (F 45.4)	16 (6.6)
Adjustment Disorders (F43.2)	14 (5.8)
Psychosis NOS (F 29)	13 (5.4)
Mental Retardation (F 71, F 72, F 73)	10 (4.1)
Alcohol Dependence Syndrome (F1x.2)	8 (3.3)
Social Phobias (F 40.1)	6 (2.5)
Panic Disorder (F 41)	4 (1.6)
Bipolar Affective Disorder (F 31)	3 (1.2)
Schizophrenia (F 20)	2 (0.8)

Discussion

This program has succeeded to an extent in attaining the objectives of the National Mental Health Programme. Minimum mental health care is made accessible, available and affordable to the underprivileged sections of the population. It is integrated with general health services and it involves community participation through the community health workers. There is an unmet need for mental health services particularly addressing Common Mental Disorders in rural areas as evidenced by the fact that many more people accessed the service than were originally targeted. Community Health Workers can play an important role in disseminating correct information regarding these disorders to the community and in reducing stigma. Because CMD affect women more commonly and because women were more likely to be homebound, it could explain the greater percentage of their attendance at the clinic. Further, life stressors like marital discord, poverty, and alcoholism, which are known to be risk factors for CMD, begin to affect women after marriage. This could explain the large numbers in the 20 to 40 year age group. There are usually many myths and misconceptions associated with severe mental disorders in rural areas and these are very resistant to change. However, the cure of one such patient in a village is enough to change people's attitudes.

Conclusion

Common Mental Disorders form a large proportion of the total burden of mental illnesses and must be addressed in all mental health programmes. Collaboration between Departments of Psychiatry and Community Medicine is useful in developing such programmes at the primary care level. This collaboration also helps in the training of primary care physicians to better address common mental health problems in rural areas. In our initiative, postgraduate students of both departments got an opportunity to encounter the entire spectrum of mental illnesses and the social, economic and cultural, factors that were intertwined with them. The involvement of Community Health Workers can improve utilization of services. Innovative programmes such as this are definite steps towards achieving Health For All and can be developed by medical colleges across the country with basic resources and community participation.

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