MANAGEMENT OF PRIORITY MENTAL DISORDERS IN THE COMMUNITY

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SUMMARY

As a part of designing a suitable model for mental health care delivery in rural India, a study of detection and management of priority mental disorders was carried out in 120 villages around rural mental health centre, Sakalwara in Bangalore District. During three and a half year period, the team attempted to manage 51 schizophrenics, 30 acute psychotics, 27 M. D. P. and 268 epileptics in the community with minimum number of drugs. The experiences and outcome of this attempt is presented and discussed here.

Severe mental illnesses and epilepsy constitute a serious health problem in any population. The rural population of India is remote from any modern psychiatric facility. Majority of them seek the help of traditional healers (Carstairs, 1973; Neki, 1973; Wig and Murthy, 1977) and are being inadequately managed. Strategies are being experimented to organise and deliver mental health care to the rural, both in India and abroad. And since there are great restraints on funds and trained personnel it is recommended that certain diseases like psychoses and epilepsy should be selected and treated on priority basis (Goel and Harding, 1976). WHO Expert Committee (Rep. Ser. No. 564, 1975) has recommended that detection and management of these diseases should form an integral part of general health care programmes. The community psychiatry unit of NIMHANS Bangalore has for some time been attempting to develop and evaluate feasible and inexpensive methods of mental health care. The present study is a part of this ongoing work and communicates our experiences of managing these patients during last 3½ years.

The present study was conducted in 120 villages around rural mental health centre, Sakalwara, situated 16 kms. away from NIMHANS. This centre is being developed as a model PHC where training in rural community psychiatry can be given. A team of the unit consisting of a psychiatrist, a psychiatric social worker and a psychiatric nurse is running outpatient clinic thrice a week. Both general patients with physical ailments and psychiatric patients are treated at this clinic. On other 3 days of the week village visits are made. The team is responsible for both detection and management of psychotics and epileptics in the catchment area. A simple method for detection is described elsewhere (Isaac and Kapur, 1980). This paper deals with the management of these detected cases.

The strategies adopted in management was as follows:

(1) Immediate prescription of free drugs for 2-4 weeks and counselling.

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(2) Further call to Sakalwara centre for follow up.
(3) Medicines and/or messages sent through other patients.
(4) Medicines given at 'dropping points'
(5) Medicines given through A. N. M/ M. P. W.
(6) If all this failed, home visits made.
(7) Encouraging early rehabilitation.
(8) Rarely patients admitted for a brief period.

Main drugs used were depot phenothiazine or tablet chlorpromazine or trifluoperazine for psychotics, imipramine and/or diazepam for depressives, phenobarbitone and hydantoin for epileptics; and trihexyphenidyl hydrochloride for management of extra pyramidal side effects.

**Table 1—Total No. of Villages Covered—120. Population : 75,649 (in 1980)**

| Year          | No. of Population village | Pts. Detected of managed | Total |
|---------------|---------------------------|--------------------------|-------|
|               |                           | Schiz. | Ac.Psy. | M.D.P. | Epilepsy |       |
| 1977          | 50                        | 14     | 4       | 10     | 85       | 113   |
| 1978          | 58                        | 2      | 8       | 3      | 20       | 34    |
| 1979          | 100                       | 20     | 8       | 8      | 98       | 134   |
| 1980 (9 m. only) | 120                      | 15     | 10      | 6      | 65       | 95    |

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**Table 2—Duration of Illness (Schizophrenia) before Detection**

| Duration of illness | Male | Female | Total | % |
|---------------------|------|--------|-------|---|
| 1—<2 years          | 0    | 2      | 2     | 4%|
| 2—5 years           | 7    | 7      | 14    |   |
| 6—10 years          | 9    | 8      | 17    |   |
| 11—15 years         | 2    | 5      | 7     | 70%|
| 20 years and above  | 6    | 5      | 11    |   |

96% were ill for >2 years

**Table 3—Previous consultation in Schizophrenic patients**

| Agency consulted                  | No. of patients |
|-----------------------------------|-----------------|
| Traditional healers only          | 23              |
| Tr. Healers + Doctors             | 3               |
| Tr. Healers + NIMHANS             | 25              |

All had consulted Tr. Healers
All were ill at the time of detection.
TABLE 4—Severity of Disability in Schizophrenic patients at the time of detection

| Disability       | Pts. (schiz.) |
|------------------|--------------|
| Severe           | 24 (86%)     |
| Moderate         | 20 (66%)     |
| Mild             | 7            |
| Little           | 0            |

TABLE 5—Acceptance of Treatment (N=51) (Schizophrenia)

| Outcome                        | No. of pts. |
|--------------------------------|-------------|
| Accepted                       | 31 (61%)    |
| Refusal of treatment           | 7 (13.5%)   |
| Not traceable/wandered         | 8 (16%)     |
| Family moved out               | 3 (6%)      |
| No treatment & death           | 2 (4%)      |

TABLE 6—Response to Treatment (31 Pts.) (Schizophrenia)

| Disability       | Initial | After trt. |
|------------------|---------|------------|
| Severe           | 17 (55%)| 0          |
| Moderate         | 12 (39%)| 2 (6%)     |
| Mild             | 2 (6%)  | 14 (45%)   |
| Little           | 0       | 14 (45%)   |

TABLE 7—Duration of Illness (Ac. Psychoses)

| Duration          | No. of pts. |
|-------------------|-------------|
| Less than 1 week  | 3 (10%)     |
| 1-2 weeks         | 9 (30%)     |
| 2-4 weeks         | 10 (33%)    |
| 4-8 weeks         | 3 (10%)     |
| 9 weeks and above | 5 (17%)     |

TABLE 8—Previous Consultations in Acute Psychoses (N=30)

| Agency                    | No. of pts. |
|---------------------------|-------------|
| Traditional healers only  | 7 (23%)     |
| Doctors                   | 4 (13%)     |
| Tr. Healers + NIMHANS     | 2 (7%)      |
| NIMHANS only              | 8 (27%)     |
| Nil                       | 9 (30%)     |

TABLE 9—Outcome of Acute Psychoses (N=30)

| Outcome                     | No. of pts. |
|-----------------------------|-------------|
| Recovered                   | 21 (70%)    |
| Improved and relapse        | 3 (10%)     |
| Organic brain dis.          | 2 (7%)      |
| Improved, later died        | 3 (10%)     |
| Residual symptoms           | 1 (3%)      |

TABLE 10—Rate of Recovery in Ac. Psychoses (N=30)

| Rate of recovery | % of pts. |
|------------------|-----------|
| Within 2 weeks   | 27        |
| Bet. 3-4 weeks   | 27        |
| Bet. 5-8 weeks   | 40        |
| No recovery/wandered away | 6          |

TABLE 11—Type of Affective Disorder

| Type                | Male | Female | Total |
|---------------------|------|--------|-------|
| M.D.P. Mania        | 10   | 7      | 17    |
| Depression          | 3    | 3      | 6     |
| Circular            | 0    | 4      | 4     |

Taking treatment at Sakalavara, 19
Taking treatment at NIMHANS, 7
Death, 1
2 patients on maintenance drugs, Rest-No drugs.

TABLE 12—No. of Child and Adult Epileptics

| Age               | No. of pts. |
|-------------------|-------------|
| <15 years         | 109 (41%)   |
| 15 years and above| 159         |
| Total             | 268         |
TABLE 13—Duration of Fits

| Duration       | No. of Pts | %   |
|----------------|------------|-----|
| <6 months      | 37         | 14% |
| 6-<12 months   | 17         | 6%  |
| 1-<3 years     | 64         |     |
| 3-5 years      | 55         |     |
| 6-10 years     | 52         | 80% |
| 11-20 years    | 27         | 56% |
| 20 years and above | 16 |     |

TABLE 14—Previous Consultation in Epileptics

| Agency                        | No. of patients |
|-------------------------------|-----------------|
| 1. Tr. Healers only           | 102 38%         |
| 2. Doctor/Doctor+Tr. Hi.      | 94  35%         |
| 7. NIMHANS/N+1+2              | 49  13.3%       |
| 4. Nil                        | 29  8.7%        |

TABLE 15—Outcome of Attempts to manage Epileptics

| Outcome                        | No. of patients |
|--------------------------------|-----------------|
| Acceptance of treatment        | 122 46%         |
| Fits controlled in             | 88  72%         |
| Fits coming occasionally (once in 3 months/less) | 28  23% |
| Death                          | 6   5%          |
| On drugs even now              | 87  75%         |
| Stopped medication by them     | 29  25%         |
| Since No fits for >1 year      |                |

DISCUSSION

Reports on community management of mentally ill patients especially of schizophrenic patients are plenty in the psychiatric literature. But these were the discharged patients from the hospitals who were later managed in the community. As far as epilepsy is concerned, literature on community management is hardly available. What we are communicating here is a unique attempt of detection and management of psychotics and epileptics in their own community. Both of these illnesses run a chronic course and many produce social stigma and stretch the limited resources of the family. Either people are not aware of the modern treatment facilities or for other considerations, they seek help from traditional healers. It may be seen that 37% of the acute psychotics and 64% of the epileptics consulted traditional healers (Table 3, 8, 14) even though NIMHANS was situated within 20 kms reach!

Almost all of the schizophrenic and epileptic patients and their family members, after initial unsuccessful attempts of getting help either from traditional healers, NIMHANS or other agencies had given up the effort and the illness became chronic. All schizophrenics except two were ill for more than 2 years; 1/3 of them being ill for more than 10 years (Table 2). Majority of the epileptics (56%) were ill for more than 3 years (Table 13). Disability in schizophrenics was so severe that 86% of them were a burden to their families (Table 4). But once they were started on medication, all of them showed recognizable improvement and the disability was considerably reduced (Table 6), in a short period.

Similar results were obtained with epileptics too. Patients who were totally disabled because of frequent attacks, after medication, were able to take up useful jobs. Early intervention in patients of acute psychoses helped these patients to recover quickly. 24 out of 30 recovered and only 3 had a relapse (Table 10). Similarly the timely intervention in affective disorders helped to minimise the period of illness, whenever patient had an episode. At present only two are on maintenance medication. Family members know when to consult the team (Table 11). 46% of the epileptics detected accepted the treatment offered and in majority of them attacks were controlled (Table 15).
These improved patients become live examples to motivate other patients in their neighbourhood to take medication regularly. They become a source of referral for our team and also serve to change the attitude of the community towards these illnesses.

Throughout 3 1/2 years, the need to admit a patient bothered us occasionally. Out of 376 patients, 6 schizophrenics, 4 acute psychotics, 5 MDPs, 3 epileptics were admitted for a short period. On the average only Rs. 50 to 60 per year is spent on each schizophrenic patient as majority of them are on depot phenothiazine. Rs. 60 to 70 for M.D.Ps and Rs. 5 to 20 per year for epileptics. We found most of the families cooperative and there was thus a tremendous success achieved. Because of their deep rooted misconcepts, ignorance, poverty and other cultural beliefs, even the initial reservations turned out in the long run, to be a rewarding experience.

CONCLUSION

(1) Majority of psychotics (83%) can be managed at home.
(2) Severe and chronic psychotics show good response to treatment.
(3) Acceptance of treatment is better if duration of illness is shorter.
(4) Cost of treatment can be curtailed by using minimum drugs.
(5) Persuasive efforts are necessary to make them accept long term regular medication.

Thus this study has shown that detection and management of priority mental diseases can be effectively done in the community. If this task is taken up by doctor-cum-health worker team of PHCs after obtaining required training, the dream of extending mental health care to our rural parts becomes a reality in near future.

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