Clinical profile of patients seeking services at urban community psychiatric services in Chandigarh

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ABSTRACT

Context: About two-third of patients with mental, neurological, and substance use disorder in India do not get adequate treatment due to insufficient clinical facilities. In a country with diverse population such as India, no single model can be effective and each region needs to develop local system of service delivery unique to population needs. Community outreach clinics (COCs) being run by the department of psychiatry provide mental health services in the primary health-care setting. The study reports on the pattern of service utilization across different COCs in Chandigarh.

Aims: The aim of this study was to describe the sociodemographic and clinical profile of patients seeking mental health-care services from COCs and to compare this with patients seeking care at tertiary care center.

Settings and Design: This was a cross-sectional case record review.

Subjects and Methods: Community services are provided in the areas adjoining Chandigarh, through four COCs: Civil Dispensary, Dhanas; Khuda Ali Sher; Rural Health Training Center, Palsaura; and Police Dispensary Sector 26 by Department of Psychiatry, Government Medical College and Hospital, Chandigarh. The current study reports on sociodemographic and clinical profile of 728 patients seen in these clinics from July 2010 to June 2011.

Statistical Analysis Used: Descriptive statistics were performed using SPSS version 16.0. Chi-square test was used to compare two groups, ANOVA for comparing more than two groups.

Results: Out of the 728 patients, majority were males in productive age group with diagnosis of substance use disorder. Majority were reaching the clinics on their own and only a few were referred by various community referral agencies. Only twelve patients needed referral to the Department of Psychiatry in the above mentioned period.

Conclusions: Patients of substance use disorder prefer to be seen in the outreach clinics and it is possible to manage them in these clinics with very little need to refer them to tertiary care hospitals.

Key words: Community psychiatry, primary care, urban model

INTRODUCTION

Mental, neurological, and substance use (MNS) disorders constitute 13% of global burden of disease.[1] The burden caused by MNS disorders has increased by 41% from 1990 to 2010 due to population rise.[2] Three quarters of this burden lie in low- and middle-income countries out of which, a similar proportion do not have access to services owing to poor resources.[3] Globally, there has been a call for increasing access to mental health services.[4] The focus is on developing models...
of services that are effective, efficient, sustainable, replicable in a similar set-up and are grounded on firm research base.\textsuperscript{[5]}

Community-based models are found to be effective and efficient in providing mental health care to the masses.\textsuperscript{[6]} Experts suggest a two-pronged approach in meeting the unmet needs of the community-strengthening of psychiatry units at district hospitals to work as focal centers for mental health services delivered through outpatient clinics and training of mental health personnel working at primary health care.\textsuperscript{[7]} Internationally, there are efforts at integrating mental health care into community-based primary level health services.\textsuperscript{[8]}

Mental health service providers are continuously striving to devise innovative ways to bridge the unmet needs.\textsuperscript{[9]} In the resource-crunched low- and middle-income countries, many local models of care delivery have proven their efficacy and feasibility.\textsuperscript{[10]}

The District Mental Health Program, currently running in 123 of the 652 districts of India, is a component of the National Mental Health Program aimed at integrating mental health services into general health care. Shortage of qualified mental health professionals and low involvement of primary health-care professionals in mental health services delivery are adversely impacting service delivery.\textsuperscript{[11]}

The large disease burden and huge treatment gap in India need a network of decentralized system of mental health services and development of effective, efficient services at local level which is culturally and socially acceptable.\textsuperscript{[12-14]}

The authors discuss here a model of urban community psychiatry services by the Department of Psychiatry, Government Medical College and Hospital (GMCH), Chandigarh. The study describes the clinical profile of patients seeking care from the community outreach clinics (COCs) and supports the need to scale up existing services.

The study was carried out with the aims:
\begin{itemize}
  \item To describe sociodemographic profile of patients seeking treatment from COCs
  \item To compare the clinical profile of patients seeking treatment from COCs
  \item To compare the sociodemographic and clinical profile of patients of COCs with tertiary care centre (Psychiatry Outpatient Department [OPD] of GMCH, Chandigarh)
  \item To study the sources of referral to COCs
  \item To study profile of patients requiring referral to tertiary care facilities.
\end{itemize}

**SUBJECTS AND METHODS**

**Study setting**
Chandigarh is the joint capital of Punjab and Haryana and has an area of 114 km\textsuperscript{2}. The city provides health services through one district headquarter hospital, two community health centers, 30 civil dispensaries, and 17 subcenters. The four COCs provide mental health care integrated into existing health-care facilities in areas adjoining Chandigarh. The community clinics started functioning at Palsaura in 1996, Maloya in 1999, Daddu Majra in 2000, Khuda Ali Sher in 2004, Bapu Dham Colony in 2006, and Dhanas in the year 2008. The most recent outpatient facility was initiated at Sector 26 Police Hospital in 2009.

In addition, to clinical services, these outreach clinics are run with the aim of developing as a model for community-based services. These also work as centers for training health professionals in mental health and carrying out research activities. Currently, the clinics operate on a weekly basis at four centers: Dhanas Civil Dispensary (Clinic-1), Gurudwara of Village Khuda Ali Sher (Clinic-2), Rural Health Training Center, Palsaura (Clinic-3), and Sector 26 Police Hospital (Clinic-4). Only one clinic at Khuda Ali Sher is rural, Dhanas and Palsaura are semiurban centers, whereas the Police Hospital is an urban center.

**Community outreach clinics**

**Community outreach clinic 1**
Civil Dispensary, Dhanas, is a primary health center which provides services to a population of about 22,000. It is located in the periphery of Chandigarh about 10 km away from the city center. The village came into existence before independence much before the city of Chandigarh came into being. In addition to the local residents, there are many migrants from neighboring states of Haryana, Himachal Pradesh, Uttar Pradesh, and Bihar working as daily laborers. The milk colony houses the civil dispensary which is run by a single Medical Officer with the support of nurses and health workers. The COC operates in this dispensary.

**Community outreach clinic 2**
Khuda Ali Sher: The COC functions in a Gurudwara located in the heart of village Khuda Ali Sher. This is a rural village with a population of about 6000. The basic health-care facilities are provided through a subcenter. The majority of the population consists of Sikhs who originally belonged to this place. Only about 20% of the population consists of migrants from Haryana and Himachal Pradesh with main occupation being agriculture.

**Community outreach clinic 3**
Palsaura is a Rural Health Training Center for the medical students from GMCH, Chandigarh. The total population of this area is about 35,000–40,000. Majority of the population are migrants from Uttar Pradesh and Bihar.

**Community outreach clinic 4**
Police Dispensary, Sector 26 is a secondary level hospital for personnel serving in the Chandigarh Police and their dependents. The dispensary provides health services to
about 7000 police personnel and their families. Most of the people are from Punjab, Haryana, Himachal Pradesh, and Uttar Pradesh.

The COC team is composed of a psychiatrist, social worker, and nurse. The team provides pharmacological and psychosocial treatment on a weekly basis. Treatment records of patients are systematically maintained by the team. An effort is made toward maintenance of continuous supply of essential psychotropic drugs including oral substitution therapy such as buprenorphine in the clinics as per specific requirements through hospital supply and donations from different sources such as pharmaceutical companies. Only ambulatory care is provided in the COCs and the department of psychiatry GMCH acts as a referral center.

The team remains in regular contact with the community leaders. Spreading awareness about mental and substance use disorders is a continuous activity of the team. Education about early signs and symptoms of mental disorders and availability of treatment is carried through distribution of health education material and community meetings with community leaders. Public announcements in the village, Panchayat meetings, and religious and social gatherings in the Gurudwara are also used to spread awareness.

Collaboration is maintained with the primary health service provider and the health-care staff is encouraged to manage common mental disorders on their own. Periodically, they are provided with hands-on training for the management of common mental disorders. The medical officer refers more difficult patients to the outreach center on the scheduled day and contacts the COC team in case of any emergency for immediate service delivery.

**Study sample**

In this study, we included all new patients who registered in the COCs from July 2010 to June 2011. The data were retrieved from patients’ records maintained in the clinics. The records are semistructured pro forma which includes sociodemographic details and diagnosis as per the International Classification of Diseases (ICD) 10 diagnostic criteria.[15]

**Statistical analysis**

The data were entered into MS Excel sheet, double checked, and necessary corrections made. Descriptive statistical analysis was carried out using IBM SPSS version 16.0 (Chicago, SPSS Inc.). Summary statistics was presented using mean and standard deviation. Differences between different proportions were calculated using Chi-square tests at a significance level of 0.05 (p value). The distribution (mean and standard deviation) of different variables across four subgroups was compared using ANOVA.

For statistical analysis, the mental disorders were grouped into six major categories: mood disorders, neurotic stress-related and somatoform disorders, substance use disorders, psychotic disorders, other psychiatric diagnosis, and general medical conditions. Personality disorders, cognitive decline, sexual dysfunction, mental retardation, and marital discord were classified under other psychiatric diagnoses category as their number was small. Seizure disorder, migraine, and diagnosis of nil psychiatry were kept under the category of general medical condition.

As per the available records, 31 patients seen in the community clinics were categorized as nil psychiatry. This group of patients did not meet criteria for any psychiatric disorder because of either inadequate number, severity of symptoms, or duration of presentation. As no psychiatric diagnosis could be made, these patients were categorized as nil psychiatry.

**RESULTS**

A total of 728 new patients were registered in the COCs in 1-year period. Majority of patients attending the clinics were in the productive age group (15–44 years). In the four clinics (Dhanas, Khuda Ali Sher, Palsaura, and Police Dispensary), the mean ages were 39 ± 14.47, 41.69 ± 15.82, 33 ± 14, and 36.34 ± 12.80, respectively. The youngest patient was of 4 years and the oldest patient was 85 years. A total number of new patients seen in the OPD of Department of Psychiatry, GMCH, in the same year were 5131 with a mean age of 36.73 years and range of 7–93. The difference in sociodemographic profile of patients in COCs and those seeking care in OPD of GMCH was statistically significant [Table 1].

The clinical profile of patients seeking care in the COCs was different from those seeking care in the OPDs [Table 2]. Among those coming to the OPD of GMCH, the most common diagnosis was mood disorder (32.85%) as against substance use disorder (51.45%) in the community clinics.

The sociodemographic profile of patients attending the various COCs was different which was statistically significant [Table 3]. Majority of the patients in all the clinics were married (60–80%). More than 50% of patients in COC 1, 2, and 4 had income of less than Rs. 7000/month, whereas more than 50% of patients in COC 3 had income more than Rs. 7000/month. Majority of patients in COC 1 and COC 2 had attained up to middle-level education, whereas in COC3 and 4, it was above matriculation. Majority of patients were females in clinic-2. Majority of patients seeking treatment at the clinics were employed, about 64% of patients at COC2 were homemakers.

**Clinical profile**

Difference in diagnostic groups of the outreach clinics was statistically significant [Table 4]. In COC1, most common
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In COC 2, majority of patients were females and the most common diagnosis was neurotic, stress-related, and somatoform disorders. This was followed by substance use disorders and mood disorders. The most common substance of abuse was alcohol followed by opioids and nicotine.

In COC 3, substance use disorder was most common with opioid dependence as the most common diagnosis. Mood disorders and neurotic, stress-related, and somatoform disorders were the next common diagnoses.

In COC 4, substance use disorder was the most common diagnosis which was followed by mood disorders and neurotic disorders. The most common substance of abuse was alcohol followed by opioid and nicotine.

Source of referral
Majority of patients reported of reaching the outreach clinics on their own, some were brought by their family members, and some by their friends. 76.24% patients in COC1, 50.38% in COC2, 48.83% in COC3, and 67.65% in COC4 were brought by their family members/relatives [Table 6]. Three patients were referred to the centers by community leaders and staff of primary care centers. Nongovernmental organizations working in these areas had also referred four patients. Six patients had reported after reading about the outreach services in newspapers following which, they had come for treatment.
Two patients of substance use disorders were brought by old patients who were under treatment at these centers.

**Need for referral**
In this period of 1 year, only 12 patients needed referral to the tertiary care center. Five patients with mental retardation had to be referred to the Department of Psychiatry, GMCH for formal intelligence assessments and management, three patients with mania and two with psychosis had to be referred for admission in the inpatient unit of the department and two patients with dementia were referred for diagnostic workup.

**DISCUSSION**

The mean age of patients seen in COCs was 37.51 years which is similar to the mean age of patients coming to OPD of GMCH (36.73). Marital status and income were comparable in both groups. However, more patients seeking treatment from GMCH OPD were better educated and had better employment status than those coming to the COCs. Since COCs cater to the rural and colony population where more individuals are daily workers, it might be possible that they find treatment at COC easier to access requiring lesser time.

### Table 3: Comparison of sociodemographic profile of patients presenting to the different community outreach clinics

| Variable          | COC 1 Dhanas, n=101 | COC 2 Khuda Ali Sher, n=133 | COC 3 Palsaura, n=256 | COC 4 Police hospital, n=238 | p       |
|-------------------|----------------------|------------------------------|-----------------------|-------------------------------|---------|
| Gender            |                      |                              |                       |                               |         |
| Male              | 79 (78.22)           | 42 (31.58)                   | 195 (76.17)           | 160 (67.23)                   | 0.001*  |
| Female            | 22 (21.78)           | 91 (68.42)                   | 61 (23.83)            | 78 (32.77)                    |         |
| Age (years)       |                      |                              |                       |                               |         |
| <15               | 1 (0.99)             | 3 (2.26)                     | 15 (5.86)             | 6 (2.52)                      | 0.001*  |
| 16-44             | 69 (68.32)           | 77 (57.89)                   | 191 (74.61)           | 169 (71.0)                    |         |
| 45-59             | 19 (18.81)           | 25 (18.80)                   | 36 (14.06)            | 52 (21.84)                    |         |
| >60               | 12 (11.88)           | 28 (21.05)                   | 28 (21.05)            | 28 (21.05)                    |         |
| Marital status    |                      |                              |                       |                               |         |
| Single            | 21 (20.79)           | 15 (11.28)                   | 85 (33.20)            | 58 (24.37)                    | 0.001*  |
| Married           | 77 (76.24)           | 114 (85.71)                  | 165 (64.45)           | 177 (74.37)                   |         |
| Divorced/widowed  | 3 (2.97)             | 5 (3.76)                     | 6 (2.24)              | 3 (1.26)                      |         |
| Employment        |                      |                              |                       |                               |         |
| Employed (include retired) | 69 (68.31) | 34 (25.56)                   | 170 (66.41)           | 151 (63.45)                   | <0.01*  |
| Not employed (include students) | 10 (9.9)       | 13 (9.77)                    | 40 (15.63)            | 22 (9.66)                     |         |
| Homemaker         | 22 (21.78)           | 86 (64.66)                   | 46 (17.97)            | 65 (27.31)                    |         |
| Income            |                      |                              |                       |                               |         |
| <3500             | 34 (33.66)           | 87 (65.41)                   | 94 (36.72)            | 51 (21.43)                    | <0.01   |
| 3500-7000         | 27 (26.7)            | 29 (21.80)                   | 93 (36.33)            | 57 (23.95)                    |         |
| >7000             | 40 (39.60)           | 17 (12.78)                   | 69 (26.95)            | 130 (54.62)                   |         |
| Religion          |                      |                              |                       |                               |         |
| Hindu             | 39 (38.61)           | 48 (36.09)                   | 139 (54.30)           | 185 (77.73)                   | <0.01   |
| Minorities (Muslim + Christians) | 12 (11.88) | 18 (13.53)                   | 7 (2.73)              | 10 (4.20)                     |         |
| Sikh              | 50 (49.50)           | 67 (50.38)                   | 110 (42.97)           | 43 (18.07)                    |         |
| Education         |                      |                              |                       |                               |         |
| Illiterate        | 27 (26.73)           | 51 (38.35)                   | 56 (21.87)            | 42 (17.65)                    | <0.01*  |
| Primary and middle| 56 (55.45)           | 58 (43.61)                   | 105 (41.0)            | 59 (24.79)                    |         |
| Matric and above  | 19 (18.81)           | 25 (18.80)                   | 103 (40.2)            | 137 (57.56)                   |         |

**COC** – Community outreach clinic; *Indicates statistically significant

### Table 4: Comparison of clinical profile of patients attending the community outreach clinics

| Diagnosis                   | COC 1 Dhanas (n=101) | COC 2 KAS (n=133) | COC 3 Palsaura (n=256) | COC 4 Police dispensary (n=238) | Statistical significance (p) |
|-----------------------------|----------------------|-------------------|------------------------|---------------------------------|-----------------------------|
| Mood                        | 14 (12.06)           | 43 (32.09)        | 47 (15.31)             | 43 (15.99)                      | 0.0012*                     |
| Neurotic                    | 16 (13.79)           | 46 (34.33)        | 27 (8.79)              | 58 (21.56)                      | 0.0001*                     |
| Substance use disorder      | 74 (63.79)           | 26 (19.40)        | 195 (63.52)            | 130 (48.33)                     | 0.0001*                     |
| Other psychiatric disorder  | 5 (4.3)              | 3 (2.24)          | 30 (9.77)              | 12 (4.46)                       | 0.0013*                     |
| General medical condition   | 7 (6.03)             | 16 (11.94)        | 8 (2.60)               | 26 (9.67)                       | 0.0025                      |

**COC** – Community outreach clinic; *Indicates statistically significant

### Table 5: Profile of substance use disorders in different community outreach clinics

| Substance use disorders   | COC 1, n (%) | COC 2, n (%) | COC 3, n (%) | COC 4, n (%) |
|---------------------------|--------------|--------------|--------------|--------------|
| Total                     | 73 (73)      | 18 (25.35)   | 125 (71.84)  | 109 (55.61)  |
| F10 (alcohol)             | 21 (28.77)   | 10 (55.55)   | 38 (30.4)    | 39 (35.78)   |
| F11 (opioids)             | 31 (42.47)   | 6 (33.33)    | 77 (61.6)    | 27 (24.77)   |
| F12 (cannabis)            | 0            | 1 (5.56)     | 1 (0.8)      | 5 (4.59)     |
| F17 (tobacco)             | 21 (28.77)   | 1 (5.56)     | 2 (0.88)     | 33 (30.28)   |
| F18 (inhalant)            | 0            | 0            | 0            | 1            |
| F19 (polysubstance)       | 0            | 0            | 7            | 4            |

**COC** – Community outreach clinic

Two patients of substance use disorders were brought by old patients who were under treatment at these centers.

**Need for referral**
In this period of 1 year, only 12 patients needed referral to the tertiary care center. Five patients with mental retardation had to be referred to the Department of Psychiatry, GMCH for formal intelligence assessments and management, three patients with mania and two with psychosis had to be referred for admission in the inpatient unit of the department and two patients with dementia were referred for diagnostic workup.

The mean age of patients seen in COCs was 37.51 years which is similar to the mean age of patients coming to OPD of GMCH (36.73). Marital status and income were comparable in both groups. However, more patients seeking treatment from GMCH OPD were better educated and had better employment status than those coming to the COCs. Since COCs cater to the rural and colony population where more individuals are daily workers, it might be possible that they find treatment at COC easier to access requiring lesser time.
Majority of treatment seekers in COCs are young males having substance use disorders which shows the high prevalence of substance use disorders in these patients. Majority are employed and are married which is similar to findings from a community-based substance use treatment center. Patients with substance use disorders prefer community-based treatment programs. Majority of treatment facilities for substance abuse are located within the psychiatry departments, the stigma associated with psychiatry and mental disorders might discourage many of these patients from seeking treatment.

The comparison of data of COC and outpatients of GMCH shows that patients having severe mental disorders (mood disorders and schizophrenia) preferred to seek treatment from tertiary care facilities, whereas more than 50% patients seeking treatment from COCs have substance abuse problems. The findings strongly suggest that common provision of treatment for substance users along with treatment of mental disorders in tertiary care centers discourages many patients with substance use disorders from seeking treatment.

The authors observed that pattern of substance abuse across the four COCs was different even if these clinics are in proximity of 5–8 km. Alcohol was the most common substance of abuse in two clinics catering to village population and police personnel whereas opiate abuse was common among patients seeking treatment from other two clinics (COC 1 and COC 3). COC 1 and COC 3 have urban setup and have a large migrant population from the neighboring states. The findings indirectly point out that migration and urbanization bring additional hazards. The findings from the present study are similar to the findings of earlier epidemiological study carried out in the rural and urban slums of Chandigarh. Alcohol was the most common drug used in the community in and around Chandigarh and the use of opioids was lower in rural areas.

The high rates of patients with substance use disorder seeking care in the COCs might be due to better acceptability of these services among this population. These centers are run within the community where the amount of perceived stigma might be lower as compared to hospital setup. The patients also do not encounter problems of transport, finances, or wastage of time.

Among patients seeking treatment at COC 2, 60% of patients had anxiety disorders and somatoform disorders. This COC caters to very poor population and majority were female patients. This might explain the higher prevalence of neurotic, stress-related, and somatoform disorder in this clinic. Community outreach team was able to manage majority of patients in the COC and only very few required referral to tertiary care center. The findings demonstrate that common mental disorders and substance abuse can be easily treated in the community along with general health care. Such urban community psychiatry facilities can reduce the treatment gap.

This study demonstrates that appropriate utilization of existing resources at a tertiary care hospital can provide an effective, efficient, and acceptable system of service through community outreach program. This model if adopted on a large scale can result in reduction of burden on tertiary care centers and attaining the ultimate goal of decentralization of mental health services.

### CONCLUSIONS

Treatment provided at the COCs is able to reach patients with substance use disorders which are otherwise impenetrable by the conventional health-care systems. COCs are accepted by such patients. There is a need to scale up these services to meet the unmet need.

### Strengths and limitations

This is the first study which reports on data from an urban model of community psychiatry. Structured diagnostic schedule was not used in this study which remains its limitation. The study is based on data extracted from available patient records.

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Nil.

### Conflicts of interest

There are no conflicts of interest.
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