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NATURE AND COURSE OF DISABILITY IN SCHIZOPHRENIA

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SUMMARY

Sixty eight Feighner positive schizophrenic patients were followed up prospectively for a period of six years using standardized instruments. Disability was assessed in this sample using the Schedule for the Assessment of Psychiatric Disability at the end of 4, 5 and 6 years of follow up. It was found that the three year course of disability tended to be stable and fluctuations were minimal. Disability did not seem to be related to relapses. The implications of these findings in planning intervention programs for chronic schizophrenic patients are discussed.

INTRODUCTION

Traditionally, disabilities have been associated with conditions, physical and mental, where a handicap or impairment has been tangible and obvious such as physical and sensory handicap or mental retardation. In the recent past, however, certain chronic illnesses are being increasingly recognized as a source of great disability in the community. Cardiac diseases, arthritis and chronic mental illnesses are among the most prominent of these (Thara & Menon, 1991).

Disabilities are defined as an inability or limitation to perform tasks expected of an individual within a social environment. The disabilities of persons with schizophrenia can be very severe, encompassing the entire gamut of an individual's personal, social and occupational functioning. The need to measure, quantify and understand disability gave rise to a major WHO initiative of a multi-site study (Jablensky et al, 1981). One significant contribution of the study has been the development of the Disability Assessment Schedule (DAS) which has been modified as the Schedule for the Assessment of Psychiatric Disability (SAPD, Thara et al, 1988).

As an offshoot of the ICMR sponsored multi-site study of the course and outcome of schizophrenia, disability was measured at the end of the fourth and fifth years of follow-up at Madras and Vellore. The SAPD was developed during the course of this exercise (ICMR, 1988). In Madras, disability assessments were repeated at the end of 6 years as well, giving rise to three successive yearly measurements of disability. This, therefore provided an opportunity to study the nature of disability longitudinally and its course over time.

AIMS AND OBJECTIVES

1. To study the nature and severity of disability in schizophrenia.
2. To assess the course of disability in chronic schizophrenia.

METHOD

The ICMR sponsored study on "Factors affecting the course and outcome of schizophrenia" was a major multi-site study conducted at Madras, Vellore and Lucknow between 1981 and 1988.

At Madras, 96 patients were included for the five year follow-up. The following instruments were administered during follow-up. They were:

1. The Present State Examination (PSE, 9th edn; Wing et al, 1974). This measured symptoms at inclusion and at every year of follow-up.
2. The Personal and Psychiatric History Schedule (PPHS): This recorded sociodemographic details at inclusion and the follow up version was used at the end of every year to assess changes.
3. The Interim Follow-up schedule was given every three months to record main psychotic symptoms and treatment details.
4. The Schedule for the Assessment of Psychiatric Disability (SAPD) (Thara et al, 1988) was administered at the end of the fourth, fifth and sixth years of follow-up at Madras. The follow up at six years was done at the initiative of the research team at Madras center after the main study was completed. This instrument, which is a modified version of the DAS II, measures disability in the areas of personal, social and occupational functioning as well as Global Disability. Interviews with the patient and a key informant were used to complete the SAPD.

All these instruments were administered to 68 patients who were available for follow-up after attrition of the sample over the 6 year period (Thara et al, 1991). For the purpose of this paper, data from the SAPD alone is considered.

SAMPLE CHARACTERISTICS: Of the 68, 36 were males and 32 were females. All of them hailed from the city of Madras and the peri-urban areas, and were between the ages of 15 and 45 at inclusion, fulfilling modified Feighner's criteria for schizophrenia. They were all from middle and lower socioeconomic groups. More details of the cohort can be had from the report of the ICMR study.

RESULTS

A. Severity of disability: The mean scores of disability in all the three years of assessments were not high, ranging from a low of 0.67 in the area of social contact friction to a high of 1.63 in occupational functioning. This implies a mild to moderate degree of disability (0=absent, 1=mild, 2=moderate, 3=severe).

B. Personal Disability: The items of self-care, spare time activity, speed of performance, interest and informa-

Table -1
Mean Disability Scores

	4th yr	5th yr	6th yr
PERSONAL DISABILITY	1.18	1.07	1.03
SOCIAL DISABILITY	0.91	1.11	0.79
OCCUPATION DISABILITY	1.39	1.63	1.35
GLOBAL DISABILITY	1.39	1.63	1.35

tion and dealing with an emergency situation constitute personal disability. The scores for the 4th, 5th and 6th years of follow-up were 1.18, 1.07 and 1.06 respectively. The maximum disability perceived was in the area of functioning in emergency situations.

C. Social Disability: This includes household activities, communication, friction in social contact, marital and parental role functioning. The scores for the three years were 0.91, 1.11, and 0.79.

D. Occupational Disability: Occupational performance, interest in getting back to work and number of days of work make up this item. Of all the three areas of disability, maximal scores were seen in this, though still being only mild to moderate degree of disability. The disability scores were 1.39, 1.63, 1.35.

E. Global Disability: This was the interviewer's assessment of the overall disability on a 4 point scale. The highest score of 1.16 was in the 5th year of follow-up. The scores in the 4th and 6th years were 1.11 and 0.91 respectively.

F. Course of Disability: Table 2 shows the changes in disability scores over a two year period. It can be observed that disability tends to be stable in more than

Table -2
Change in Disability

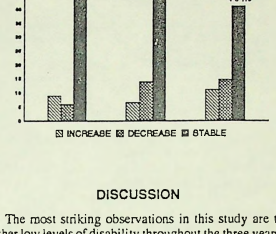
YEARS	INCREASE	DECREASE	STABLE
4 - 5	9 (13.2%)	6 (8.8%)	53 (77.9%)
5 - 6	7 (10.3%)	14 (20.5%)	47 (69.1%)
4 - 6	11 (16.1%)	15 (22.0%)	42 (61.7%)

60% of the patients. The difference between those who had an increase and a decrease in disability was not substantial.

G. Relationship between Disability and Course of Illness: The relationship between disability and relapses was studied. Between the 4th and 5th years of follow-up, 19 patients had recorded a relapse, while only 9 showed an increase in disability. 14 patients had relapsed between the 5th and 6th years of follow-up, but only 7 had an increase in disability scores.

This seems to indicate that disability scores are not related to the clinical pattern, especially with regard to relapses.

FIG.1 CHANGES OF DISABILITY



DISCUSSION

The most striking observations in this study are the rather low levels of disability throughout the three years it was measured. This could be due to several factors, the most important being that it was a closely followed up and well treated cohort. At Madras, most patients were seen once in two weeks or at least once a month by the same investigator (RT), and hence it was possible in many cases to avert severe relapses. Besides, in all these patients, treatment had been initiated early in the course of the illness, between 3 and 24 months after the onset.

This is in contrast to the findings of rather high disability in a Madras based community study, wherein the average duration of illness was longer, about 35% of the cohort was untreated and attrition rates were higher (Rajkumar, 1990).

The highest disability was in the area of occupational functioning. We have found that the informants are able to respond more precisely to questions on this area of functioning, since it is more objective and less hypothetical. It is also true that loss or lack of gainful activity could be perceived as more disabling than deficiencies in certain other activities such as communication, self care etc. It is also interesting to note that the course of disability tends to be stable over a three year period. Other studies have also found similar results (Giel et al, 1984).

In order to gain a true picture of the course of disability in schizophrenia, it would be ideal to start with acute, first onset cases, and to follow them up at steady intervals. This would gave a clearer picture of the 'plateauing off' effect of disability.

In any case, the finding that disability tends to stabilize after a 5 year period is relevant to the planning of intervention programs for the chronically mentally ill. What appears to be important is the area of disability, rather than mild fluctuations in the total scores themselves. Hence, intervention personnel would do well to focus their energies on specific areas of dysfunction, such as occupation etc.

The findings of this study cannot be generalized to that of any chronic schizophrenic cohort for the reasons pointed out. Nevertheless, it is an indicator of the trends in disability research.

CONCLUSIONS

This study of social disabilities in a prospectively followed up cohort reveals mild to moderate disability scores, with occupational functioning being the area of maximal disability.

Disability tends to be stable over a period of 3 years and seems to be independent of fluctuations in clinical course. The findings are relevant to planning intervention programs for the chronic mentally ill.

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Mental Illness

A New Perspective of Disability: Chronic Mental Illness

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Abstract

While disability caused by physical illnesses, sensory deprivation and mental retardation have long been recognised by professionals, public and policy planners, it is only in the last decade that attention has been focussed on chronic mental illness as one of the conditions which can produce severe disability.

This paper discusses the conceptual issues of chronic mental illness, the extent of the problem in India, the nature of the disabilities produced and the factors which have limited their understanding. The need to determine and measure disability for the implementation of various intervention programmes is stressed upon.

Introduction

Traditionally, disabilities have been associated with conditions, physical and mental where a handicap or impairment has been tangible and obvious such as physical and sensory handicap and mental retardation. In the recent past, however, certain chronic illnesses are being increasingly recognised as a source of great disability to the individual as well as the community. Cardiac diseases, arthritis, and chronic mental illnesses are among the most prominent of these.

Disabilities are defined as inability or limitation to perform tasks expected of an individual within a social environment. The disabilities of persons with mental illnesses such as schizophrenia can be very severe encompassing the entire gamut of

an individual's personal, social and occupational functioning. The need to measure, quantify and understand disability gave rise to a major WHO initiative of a multisite study. One of the important contributions of this study has been the development of the instrument Disability Assessment Schedule (DAS) which has since then undergone two revisions. (Jablensky, 1980). The DAS has been modified by the author to the Indian setting as the Schedule for Assessment of Psychiatric Disability. (Thara 1988).

Mental health professionals find the profile of disabilities caused by chronic mental illness to be essentially similar to that caused by mental retardation, though there may be qualitative differences. Social and occupational disabilities form a major cluster of behaviours that both reflect and influence the course and outcome of a psychiatric disorder.

The fact that mental illness can produce severe disability is not well appreciated both by the general public as well as the policy planners. This is borne out by the general lack of understanding and sympathy towards the mentally ill—almost a denial of the problem, and the lack of any disablement benefits for this group of people in India. While the State has been quick to recognise the disability experienced by the mentally retarded, it has only been in the very recent past that chronic mental illness has succeeded in focussing attention onto itself.

Chronic Mental Illness?

Chronic mental illness essentially includes psychotic disorders, primarily schizophrenia. According to WHO estimates, upto two-fifths of all disability in the world is related to psychiatric conditions. 74% of the 540 patients identified in the WHO study on "Assessment and reduction of psychiatric disability" had a clinical diagnosis of schizophrenia. These patients suffer from a wide spectrum of personal, social and occupational disabilities.

After recovery from the acute phase of the illness, they could encounter major difficulties in socialisation, maintaining a peer group, holding on or acquiring a job and in the general process of reintegration into the main stream of society. The stigma attached to the illness, the negative attitude of the family and the community at large only serve to compound the problems.

The relative isolation of psychiatry from other medical disciplines has also limited its access to advances in disability work and research. Agreed concepts in the area of disability are still lacking with unclear clarification of the relationship between psychiatric illnesses on one hand and resultant or associated disabilities on the other. This is because of the lack of a sharp differentiation between psychiatric symptoms, especially the negative symptoms and the resultant disability.

Nevertheless, research in the last 5 years has clearly established:

1) Disability in chronic mental illness is a reality, as much as it is in physical illnesses and developmental defects.

2) Disability caused by CMI is more often all encompassing, affecting the individual's personal, social and occupational functioning.

3) The extent of disability is related to the duration of illness and treatment, though not always to the clinical state.

4) It is possible to identify a group of severely disabled individuals who will require some kind of support for their entire lifetime and others for a shorter period.

New Initiatives for the CMI

Considered in the background of the information provided in terms of the extent and gravity of the problem vis-a-vis the relative inaction in this field, the need to develop initiatives for the CMI cannot be over-emphasised. These should broadly encompass prevention, treatment and care, rehabilitation and increased community participation.

Prevention

Since the exact causal mechanisms of the chronic mental illness, especially schizophrenia have yet to be identified, primary prevention has a limited role. The two main areas of work could be:

1) Increasing awareness about mental illness in general with the specific focus on early signs and symptoms so that detection of the illness is not delayed for too long. This would facilitate prompt treatment and would go a long way in preventing/reducing disability. THIS SHOULD BE AN IMPORTANT AREA OF OPERATIONS—not merely the NGO's dealing with mental health, but all others working in primary care and general health.

2) Genetic counselling has a limited applicability in certain disorders with discouragement of consanguineous marriages.

Care and Rehabilitation

While acute care for the mentally ill is provided by hospitals and private medical facilities, it is aftercare or rehabilitation which is the sheet anchor of any strategy aimed at reducing psychiatric disability. The clinical practice of this, just like its counterpart in physical rehabilitation, is comprised of two intervention strategies:

1) Client skill development.
2) Environmental support development.

Psychiatric rehabilitation practice is guided by the basic philosophy of rehabilitation: disabled persons need skills and environmental support to fulfil the role demands of their living, learning, social and working environments.

Family support and intervention is a key element in this process. It is even more relevant in India, where 90% of the patients continue to live with their families, which have different kinds of stresses to cope with apart from the mentally ill individual. Family interventions have generally been:

1) Educational—designed primarily to provide information.

2) Skill training—designed primarily to develop skills.

3) Supportive—to enhance the family's emotional capacity to cope with stress.

Advocacy Groups

The most dramatic innovations in the role of the family in recent times has been the development of advocacy and self-help groups. NAMI in the USA with more than 80,000 members has become a powerful spokesman for the CMI. In India, unfortunately, this is still very much in its infancy, although the need to strengthen it is greater. One such group is ASHA working with the Schizophrenia Research Foundation in Madras.

Public Education

While this is one of the key elements in any programme targetted at the prevention/reduction of disability, its importance is increased manifold in the case of chronic mental illness, where the exact causal factors have not yet been clearly identified. Hence early detection becomes crucial to the prevention of chronicity and disability.

Multi-media mass oriented programmes are the need of the hour and this again is best handled by NGOs than the government. The stage has come to regard psychiatric disability on par with other disabilities and initiate a concerted effort of professionals, NGOs, Government agencies and the community. The barriers are not architectural, but attitudinal and programmatic.

Employers, landlords, teachers, and neighbours possess the capacity to unleash the talents of persons with psychiatric disabilities—if only they would unharness themselves from their prejudices.

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THE SCHEDULE FOR ASSESSMENT OF PSYCHIATRIC DISABILITY – A MODIFICATION OF THE DAS – II

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SUMMARY

Measurement of Disability is one of the off–shoot projects of the major multicentred study on 'Factors Affecting Course and Outcome of Schizophrenia' being held at Madras, Vellore and Lucknow. As part of this study, modification of the Disability Assessment Schedule (II) was carried out at the Madras centre. Certain items of the DAS were deleted and the rest were regrouped into 4 main areas of personal, social, occupational and global disability. This modified instrument called the Schedule for Assessment of Psychiatric Disability (SAPD) was administered to 30 patients each of the 3 groups of psychoses, neurotics and diabetics. It was found that the SAPD effectively discriminated the psychotic group from the other 2 groups. The authors recommend this instrument for measurement of disability in an outpatient psychiatric population.

Introduction

Disability may be defined as disturbances in the performance of social roles that would normally be expected of an individual in his habitual milieu, arising in association with a diagnosable mental disorder (Jablensky, Schwarz and Tomov 1980). As an essential ingredient of any chronic mental disorder disability has lent itself to measurement, although several attempts at developing instruments to measure disability have not met with any great degree of international agreement (Wing 1961, Cheadle and Morgan 1972, Morgan and Cheadle 1974, Owens and Johnson 1980).

In an attempt to evolve a conceptually satisfactory instrument which could be used in culturally different settings, the W.H.O. developed the Disability Assessment Schedule (D.A.S.). This has gone through 3 revisions and the D.A.S. III is currently in use.

In the ongoing ICMR project on 'Factors Affecting Course and Outcome of Schizophrenia', measurement of Disability is one of the offshoot projects at Madras and Vellore centres. During the course of this project, our experience with DAS II at the Madras centre has revealed that it is not entirely culture free and required certain modifications. The outcome of this effort was the modified instrument 'Schedule for Assessment of Psychiatric Disability' (SAPD).

Why Disability?

Psychiatric Disability has emerged to be an increasingly important area of research because of its role:–

(i) in understanding the nature of the illness, especially its chronicity.

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(ii) in planning intervention programme for the chronically mentally ill.

Disability Assessment was recommended as priority area by the National Advisory Committee on Mental Health (1980). The WHO realising the importance of disability assessment initiated a multicentred study on assessment and reduction of disability in 1976.

Need to modify DAS

The DAS used in the WHO multicentred study on 'Assessment and Reduction of Disability' initiated in 1976 was designed specially for the assessment of the patient's behaviour and social functioning in his particular social and cultural context.

It consists of 5 main parts on Overall Behaviour, Social Role Performance, Patient in hospital, Modifying factors and Global evaluation. Part III was not used in this study, as the sample consisted of outpatients only. On administering DAS II to 25 Out Patients at Department of Psychiatry, Government General Hospital, we found that most of Sec. IV on modifying factors revealed very little useful information. The concept of a patient's "asset" or "liability" being different from what is perceived in the west, scoring on items such as average assets, hobbies or artistic activities was very difficult. The scores on most of these items were as low as 0/55 to 2/55.

The section on Home atmosphere (4.3) though dealing with an important aspect of expressed emotions does not contribute to the measurement of disability and is not related to the rest of the schedule by any particular set of classificatory ideas or rules. Hence it was deleted.

The other item of DAS which elicited a minimal positive response was the one on Hetrosexual relationship (Section 2.5) probably because they are not really applicable to the existing socio–cultural norms in India.

Therefore, before deleting these items from the DAS, we thought it necessary to compare the scores of the schizophrenics on these sections with 2 other samples: a group of neurotics and diabetics. We chose diabeties because of its chronic nature requiring prolonged, if not life long, treatment, likely to cause disability in several spheres of functioning (Murawski 1971).

Pilot Phase: 25 neurotics and 25 diabetics fulfilling the following criteria were chosen.

The former were selected from out–patients attending the Dept. of Psychiatry, Govt. General Hospital, Madras and the latter from the Dept. of Diabetes & Metabolism of the same hospital.

Group	Inclusion Criteria
Psychotics :	Duration of illness; 2 years fulfilling ICD (9) Criteria 295 & 296.
Neurotics :	Satisfying ICD (9) Criteria (300). Minimum duration of illness 6 months.
Diabetics :	Currently diabetics, on treatment minimum duration of illness 6 months. No overlying emotional or psychological problems.

Results

It was found that in all the three groups, the mean scores on on sections 2.5, 4.1, 4.2, and 4.4 were rather low. Besides these items failed to discriminate psychotics from neurotics and diabetics (Table–1)

Further changes were required in the

SAPD – FOR OUTPATIENTS

Part I	Overall Behaviour	0	1	2	3	4	5	9
1.1.	Self Care							
1.2	Spare time activity							
1.3	Speed of performance							
1.4	Interest and Information							
1.5	Emergency Situation							
Part II	Social Role							
2.1	House-hold Activities							
2.2	Communication							
2.3	Social Contact Friction							
2.4	Marital – Affective							
2.5	Marital – Sexual							
2.6	Parental Role							
Part III	Occupational							
3.1	Performance							
3.2	No. of days of working							
3.3	Occupational Interests							
Part IV	Overall Disability							

Table 1

Item No.	Group		
	Psychotic** (N = 25) Mean ± SD	Neurotic** (N = 25) Mean ± SD	Diabetic** (N = 25) Mean ± SD
4.1	0.04 ± 0.19	0.04 ± 0.20	0.08 ± 0.27
4.2	0.08 ± 0.27	0.04 ± 0.20	0.08 ± 0.27
4.4	0.04 ±0.20	0.0 ± 0.0	0.04 ± 0.20
2.5	0.0 ± 0.0	0.0 ± 0.0	0.0 ± 0.0

** Not Significant.

form of regrouping of the items in order to produce more workable results.

We divided the entire schedule under 4 main areas.

1. Personal Disability : We felt that 'Interests and Information' and 'Patient in Emergency Situation' are more indicative of personal than social disability under which the DAS II had grouped it. These 2 items were hence included in this section.
2. Social Role Disability was sub divided into A & B, section B covering marital functioning. This had to be done since this was not applicable to all patients (60% of the sample).
3. Part III is on Occupational Disability. This is the same as in DAS II.
4. Part IV is on overall disability – This would be the subjective assessment of the global disability.

0 – no disability; 1 – mild; 2 – moderate; 3 – severe. This modified instrument consisting of 3 sections and a rating of global disability is called the 'Schedule for Assessment of Psychiatric Disability' (SAPD).

Final study

The SAPD was now administered to 90 patients, each of the three groups of Schizophrenics, Neurotics and Diabetics consisting of 30. The patients were selected using the same diagnostic criteria. Using Chi-Square (X^2) analysis, it was found that these 3 groups were essentially similar as far as age, sex distribution and duration of illness (Table–2).

Disability was assessed by interviewing both the key informant and the patients. The mean disability score for each of the individual items was calculated, unpaired 't' – test was employed to study the significance of the difference between the mean scores of disability in the individual areas, as well as that of global disability.

Inter–rater reliability exercises were done for every 3rd case i.e., for a total of 30 cases. The inter–rater reliability at Madras was 0.92 (kappa index of agreement).

Table 2

	Variable	Psychotic Group (N = 30) M ± S.D.	Neurotic Group (N = 30) M ± S.D.	Diabetic Group (N = 30) M ± S.D.	Statistical findings
Sex	male	32.94 ± 10.69	29.43 ± 10.97	33.84 ± 13.00	NS
	Female	31.31 ± 9.77	31.06 ± 10.05	34.73 ± ±7.53	
Age	< 30years	23.14 ± 4.21	20.43 ± 3.62	22.1 ± 4.53	
	30-45 years	37.54 ± 3.84	37.57 ± 5.10	36.56 ± 4.21	NS
	> 45 years	51.67 ± 6.02	48.5 ± 1.5	54.75 ± 5.26	
Duration of illness	<2 years	0.75 ± 0.25	0.92 ± 0.34	1.17 ± 0.33	
	2-5 years	3.68 ± 0.98	3.25 ± 1.09	3.47 ± 1.19	NS
	> 5 years	9.57 ± 4.76	10.38 ± 4.50	9.63 ± 4.02	

Table 3

Item No.	Psychotic Group (P)		Neurotic Group (N)		Diabetic Group (D)		't' – test Values		
	n_1	Mean ± Sd	n_2	Mean ± SD	n_3	Mean ± SD	PVSN	P VS Δ	N VS Δ
1.1	30	0.60 ± 0.95	30	0.23 ± 0.50	30	0.07 ± 0.25	1.67 N.S.	2.92 P<.01	1.62 N.S.
1.2	30	1.87 ± 1.52	30	0.40 ± 0.71	30	0.30 ± 0.46	6.88 P<.01	5.32 P<.01	0.64 N.S.
1.3	30	1.50 ± 1.36	30	0.76 ± 0.90	30	1.06 ± 0.23	2.64 P<.01	1.74 N.S.	2.06 P<.05
1.4	30	1.53 ± 1.65	30	0.43 ± 0.76	30	0.23 ± 0.50	3.25 P<.01	4.06 P<.01	1.19 N.S.
1.5	30	2.30 ± 2.07	30	0.67 ± 0.91	29	0.21 ± 0.41	3.89 P<.01	5.26 P<.01	2.45 P<.05
2.1	30	1.47 ± 1.67	29	0.31 ± 0.70	30	0.27 ± 0.57	3.40 P<.01	3.66 P<.01	0.24 N.S.
2.2	30	1.60 ± 1.40	30	0.40 ± 0.85	30	0.30 ± 0.53	3.95 P<.01	4.67 P<.01	0.54 N.S.
2.3	30	1.03 ± 1.35	30	0.20 ± 0.60	30	0.10 ± 0.30	2.88 P<.01	3.62 P<.01	0.80 N.S.
2.4	15	1.07 ± 1.57	18	0.50 ± 0.90	17	0.12 ± 0.32	1.26 N.S.	2.36 P<.05	1.61 N.S
2.5	14	1.14 ± 1.60	16	0.75 ± 1.30	11	0.36 ± 0.48	0.71 N.S	1.50 N.S	0.91 N.S
2.6	14	0.93 ± 1.15	18	0.28 ± 0.65	17	0.12 ± 0.32	1.94 N.S	2.66 P<.01	0.87 N.S
3.1	25	1.76 ± 1.80	29	0.55 ± 0.72	26	0.58 ± 0.84	3.26 P<.01	2.97 P<.01	0.12 N.S
3.2	25	2.24 ± 1.99	28	0.57 ± 1.08	26	0.69 ± 1.17	3.78 P<.01	3.34 P<.01	0.39 N.S
3.3	28	1.75 ± 1.95	29	0.52 ± 0.81	29	0.17 ± 0.46	2.89 P<.01	4.08 P<.01	1.95 N.S
4	30	1.80 ± 1.01	30	0.87 ± 0.56	30	0.70 ± 0.78	4.34 P<.01	4.63 P<.01	0.93 N.S

Results

The age and sex distribution of the patients in the 3 groups was not significantly different from each other. The duration of illness which varied from 1 to 8 years was also similar in the 3 groups (Table 2). Table – 3 shows the mean scores ± S.D of the three groups of patients on each of the items of the SAPD. The psychotics have mean scores ranging from 0.6 to 2.3 with the lowest score being on self care (1.1) and marital role functioning (2.4 – 2.6). The highest disability scores are seen in the areas of occupational functioning (3.1 to 3.3) and some items of personal disability (1.2 & 1.5) which are greater than that of other 2 groups (significant at 0.01 level).

It is clear from the table that both

Table 4
Mean Disability score and one way Anova

	Psychotic Group (PG) M ± S.D.	Neurotic Group (NG) M ± S.D.	Diabetic Group (DG) M ± S.D.	d.f		F Ratio	Significant
				Between Groups	Within Groups		
Personal Disability Score in all groups (N = 30)	1.50 ± 1.20	0.49 ± 0.49	0.29 ± 0.29	2	87	21.09	P<0.001
Social Role Score in all groups (N = 30)	1.36 ± 1.28	0.44 ± 0.79	0.24 ± 0.36	2	87	13.05	P<0.001
Occupational disability Score in all groups (N = 30)	1.78 ± 1.81	0.55 ± 0.63	0.51 ± 0.66	2	84	10.55	P<0.001
Overall Disability score in all groups (N = 30)	1.80 ± 1.01	0.87 ± 0.56	0.70 ± 0.78	2	87	15.66	P<0.001

Table 5

Disability Scores (Mean)	Psychotic	Neurotic	Diabetic
Personal Disability	1.50	0.48	0.29
Social Role	1.36	0.44	0.24
Occupational Role	1.77	0.55	0.51
Critical Difference	0.52	0.60	0.81

Critical Difference (C.D) $= \sqrt{\frac{2S_E^2}{n}} \times {}^{1}0.01$ for error d.f.

Where $\sqrt{\frac{2SE^2}{n}}$ in the standard error of the difference between any two group means.

neurotics and Diabetics have low scores on all items. There is no significant difference between the scores of these 2 groups exception 2 items (1.3 & 1.5). Table 4 shows the results of the Analysis of variance Technique (One–way classification) using F–test. This was done for each of the 3 area of disability as well as overall Disability. One can readily appreciate the fact that psychotics have significantly higher scores than Neurotics and Diabetics in all the 4 areas (P <.001). This table also shows the overall mean and SD scores of the 4 areas of Disability while Table–3 indicates scores on individual items. The highest mean disability score is in global disability followed by occupational disability (1.8 & 1.78 respectively).

Table – 5 has the mean disability scores arranged in decreasing order of magnitude. The difference between the scores of psychotics and neurotics is statistically significant since it is greater than the critical differences. The difference between Neurotics and Diabetics is however less than the critical difference. This clearly indicates that the SAPD effectively discriminates between Disability in psychotics from that of neurotics and Diabetics.

Discussion

The distribution of scores of disability in the 3 groups show that Schizophrenics have significantly greater disability scores

than neurotics and diabetics in all areas except marital role functioning. It can therefore be concluded that the SAPD is able to effectively discriminate schizophrenic disability from others (criterion validity).

However concurrent validity has not been studied as the SAPD was not compared with other standardised instruments measuring disability. This was not done because of the paucity of conceptually satisfactory tools to measure disability in several areas. The existing rating schedules used to describe social disability or maladjustment lack a conceptual framework by which disabilities can be classified (Cooper 1980). Besides the SAPD is only a modification of the parent schedule DAS and not a totally new one.

It can be seen that disability among the neurotics is similar to that in diabetics. This finding has interesting connotations as to the nature of Diabeties Mellitus itself, its status as a somato psychic disorder (Treuting 1967). It will be worthwhile to carry out a more intensive study of disability in the various sub groups of neuroses which has not been done in this study.

The reliability of the instrument is also high and we felt it appropriate to recommend the use of this schedule as a reasonably valid and reliable instrument for measuring disability in outpatient schizophrenic population. There are however certain limitations in this instrument. As also in the DAS, the assessment of occupational functioning needs to be differentiated between housewives, unmarried girls and those not pursuing a regular job from those holding a regular job with a constant income.

The SAPD can be used only as an instrument to measure disability and will not contribute towards the study of factors affecting it, such as expressed emotions etc. These factors however could encompass the entire gamut of clinical, personal and socio demographic data and hence cannot be incorporated in the assessment schedule. In fact, this paper is the first of a series of reports of a study of disability and factors affecting it being conducted as an offshoot of the ongoing ICMR project at Madras, Vellore and Lucknow. The ensuing paper will deal with other aspects of Disability.

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World Health Forum

Leon Eisenberg

Preventing mental, neurological and psychosocial disorders

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Leon Eisenberg

Preventing mental, neurological and psychosocial disorders

Mental, neurological and psychosocial disorders constitute an enormous public health burden. A comprehensive programme directed against their biological and social causes could substantially reduce suffering, the destruction of human potential, and economic loss. It would require the commitment of governments and coordinated action by many social sectors.

In the early decades of the twentieth century, claims that the mental hygiene movement would prevent adult psychiatric disorders proved to be unfounded. Even today we know so little about such disorders as schizophrenia, parkinsonism and senile dementia that we cannot design programmes for their prevention. Nevertheless, prevention is important in some areas. At the turn of the century, mental hospitals were full of patients with general paresis and pellagra; today, both diseases are rare in the developed world, the first because of effective treatment for syphilis and the second because of improved diet. Many other neuropsychiatric disorders can be tackled effectively. In the schizophrenias and affective disorders, the frequency with which there is troublesome behaviour or a chronic inability of patients to look after themselves can be reduced if the health team, community and family respond promptly and constructively. The public should be educated about the nature and extent of mental health problems and, where possible, about their treatment and prevention. Without an informed public there is little hope of persuading governments to make the necessary policy decisions.

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An underestimated problem

The magnitude of the mental, neurological and psychosocial disorders is usually underestimated because:

— vital statistics measure mortality rather than morbidity;

— even where morbidity is recorded, the extent of neuropsychiatric morbidity is not properly monitored;

— the tabulation of causes of death according to disease entities does not indicate the underlying behavioural

causes, e.g., alcohol abuse as the cause of cirrhosis or motor vehicle accidents.

Mental and neurological disorders

Mental retardation. The prevalence of severe mental retardation below the age of 18 is 3–4 per 1000; that of mild mental retardation is 20–30 per 1000. In the developing world in particular, faulty delivery methods can lead to birth traumas and the central nervous system can be damaged by bacterial and parasitic infections. Of particular importance is the mild mental retardation and maladaptation associated with severe social disadvantage.

Acquired lesions of the central nervous system. Damage to brain tissue resulting from trauma, infection, malnutrition, hypertensive encephalopathy, pollutants, nutritional deficiency and other factors is a major source of impairment. It has been estimated that 400 million persons suffer from iodine deficiency; their offspring are at risk of brain damage *in utero (1).* Particular attention must be paid to the debilitating effects of

It is wrong to use potentially toxic drugs when what is needed is social support, or to rely on institutional care for patients who can be restored to function while in the community.

cerebrovascular accidents secondary to uncontrolled hypertension, a rapidly increasing problem in developing countries. Cerebrospinal meningitis, trypanosomiasis and cysticercosis are major causes of brain damage. Persistent infections, even when the brain is not directly invaded, impair cognitive efficiency.

Peripheral nervous system damage. Inadequate or unbalanced diet, metabolic diseases, infections, traumas and toxins can cause incapacitating peripheral neuropathies with numerous social and psychiatric consequences.

Psychoses. The prevalence of severe mental disorders such as schizophrenia, affective disorders and chronic brain syndromes is estimated to be not less than 1%; somewhat more than 45 million mentally ill persons suffer compromised social and occupational function because of these conditions. The annual incidence of schizophrenia is approximately 0.1 per 1000 in the population aged 15–54 years. The rate for depressive disorders is several times higher.

Dementia. Dementia can be caused by metabolic, toxic, infectious and circulatory diseases. The burden on health services rises as an increasing proportion of the population survives to older ages and becomes vulnerable to senile dementia of the Alzheimer type.

Epilepsy. The prevalence of epilepsy in the population is 3–5 per 1000 in the industrialized world and 15–20 or even 50 per 1000 in some areas of the developing world. This tenfold difference in prevalence provides a measure of what could be accomplished by a comprehensive programme of prevention in the developing countries. The extent of social handicap resulting from epilepsy varies with its type, the adequacy of medical management, and community acceptance of or support for patients.

Emotional and conduct disorders. Such disorders are estimated to affect 5–15% of the general population. Not all cases require treatment but some can lead to major impairment. Disorders of conduct, which are frequent

among schoolchildren and interfere with learning in the classroom and with social adjustment, often respond well to simple treatments (e.g., behaviour therapy and the counselling of parents), although recurrence is common. Learning disorders, whether or not they are associated with other psychiatric symptoms, require special help in the classroom in order to avoid secondary emotional problems and occupational handicaps.

Behaviour injurious to health

Alcohol-related problems. Recent decades have witnessed considerable increases in alcohol consumption and a parallel increase in alcohol-related problems, including cirrhosis of the liver, difficulties at work and home, and alcohol-related traffic accidents. Alcohol abuse by the individual has devastating effects on the family. A particularly tragic consequence of drinking during pregnancy is the fetal alcohol syndrome.

In the WHO European Region, the number of countries with an annual per capita intake of more than 10 litres of pure alcohol increased from three in 1950 to 18 in 1979. Countries in the WHO Western Pacific Region have reported that there were sharp increases in alcohol-related health damage, crime and accidents during the 1970s. Although some countries in Europe and North America are now reporting a levelling off or even a modest decline in alcohol consumption, the global trend is still upwards, with particularly sharp increases in commercially produced alcoholic beverages in some developing countries in Africa, Latin America and the Western Pacific. However, it is notable that in Australia between 1978 and 1984 a 10% reduction in per capita consumption of alcohol was accompanied by a 30% reduction in deaths caused by alcohol.

Drug abuse. Drug abuse and dependence have increased in most countries *(2)*. There are some 48 million drug abusers in the world, including 30 million cannabis users, 1.6 million coca leaf chewers, and 1.7 and 0.7 million people dependent on opium and heroin respectively. Cocaine abuse is widespread and increasing. Amphetamines, barbiturates, sedatives and tranquillizers are consumed in most countries and their abuse, as well as multiple drug abuse, is increasing throughout the world in parallel with their increasing availability. Large regions have become dependent on the income derived from growing cannabis, the opium poppy and the coca shrub, and this adds to the difficulty of implementing control measures.

Mental deterioration in the elderly can also be prevented by avoiding unnecessary hospitalization.

Psychotropic drug abuse. The ready availability of psychotropic substances, insufficient and often misleading information and unjustifiable prescribing practices have led to the overuse and abuse of psychotropic drugs.

Tobacco dependence. Smoking is a socially induced form of behaviour maintained by dependence on nicotine. It causes a high proportion of cases of cancer, chronic bronchitis and myocardial infarction. Between 1976 and 1980 tobacco consumption decreased annually by 1.1% in the industrialized countries but increased by 2.1% annually in the developing countries. Besides premature deaths, which have been estimated at over 1 million per annum, innumerable cases of debilitating diseases, such as chronic obstructive lung disease, are

caused by smoking. The proportion of women of reproductive age who smoke regularly, already high in most industrialized countries, has been increasing rapidly in the developing world.

Conditions of life that lead to disease

Many health-damaging circumstances are beyond the control of the individual: homelessness, unemployment, lack of access to health and social services, the loss of social cohesion in slum areas, forced migration, racial and other discrimination, forced idleness in refugee settlements, war, and the threat of nuclear war.

In addition to these factors, individual life-styles can influence the risk of disease. Although the significance of excess animal fat in the diet, insufficient physical exercise and psychosocial stress in the epidemic of cardiovascular disease affecting the industrialized world cannot be precisely quantified, most authorities agree that these are important risk factors. Behavioural patterns certainly influence disease pathogenesis and it is important to make full use of our knowledge of mental health and our psychosocial skills to design interventions aimed at preventing disease that is secondary to unfavourable behaviour.

Disorders of conduct are frequent among schoolchildren and often respond well to simple treatments.

In this connection, methods of dealing with excessive stress merit further study; stress becomes a pathological agent when it is intense, persistent, and beyond the coping capacity of the individual.

Violence. Violence, including accidents, homicide and suicide, is one of the main causes of death in most countries. Psychosocial factors and mental disturbance play an important role in its occurrence. Child abuse and wife battering are among the particularly dramatic indicators of violence in the family.

Excessive risk-taking by young people. Experimenting with drugs and alcohol, sexual activity without precautions against sexually transmitted diseases, adolescent pregnancy, driving at excessive speed, and challenging established guidelines for health and safety result in serious morbidity and mortality. Pregnancy in girls aged 15 or less leads to a cycle of disadvantage. The immature mother is unable to care properly for her child, while her maternal responsibility is a barrier to the education and employment essential for her own development.

Family breakdown. Family breakdown interferes with the upbringing of children. A household headed by a woman is more likely to be below the poverty threshold than one headed by a man, adding to the mother's difficulty in raising a family. Weakened family units also contribute to community disorganization and a variety of psychosocial and other health problems.

Somatic symptoms resulting from psychosocial distress Many patients who consult primary health care workers either have no ascertainable biological abnormality or, if they have one, complain disproportionately about their discomfort and dysfunction. Unless the psychosocial source of physical symptoms is recognized, the people affected are likely to be inappropriately investigated and treated, cause excessive cost to the health system or themselves, and become chronic

patients vainly seeking relief. The inclusion of basic mental health care as part of primary care reduces the cost of treatment and improves its outcome.

Proposals for action

It should be noted that intersectoral coordination is essential for the success of the measures outlined below.

Measures to be undertaken by the health sector

Success in carrying out preventive and therapeutic measures depends greatly on the psychosocial skills of primary health care workers, i.e., on their sensitivity, empathy and ability to communicate, as well as on a thorough knowledge of the community, its culture and its resources. Training in these skills is therefore no less essential than is the customary technical training. In their absence, diagnostic errors multiply, adherence to treatment recommendations declines, health workers exhibit "burn-out", and the health facility fails to achieve its goals.

Prenatal and perinatal care. In view of the need to protect the fetus and the newborn child and to provide optimum conditions for development, and given the high mortality and morbidity associated with prematurity and low birth weight:

- high priority should be given to the provision of adequate food and to education about nutrition to all pregnant women;
- direct counselling of pregnant women should be practised to reduce the prevalence of developmental anomalies and low birth weight caused by cigarette smoking and the consumption of alcohol during pregnancy;
- in areas where neonatal tetanus is prevalent, pregnant women should receive tetanus toxoid after the first trimester and birth attendants should be trained in sterile techniques for cutting the umbilical cord;
- in iodine-deficient areas, women of child-bearing age should be given iodized oil injections or iodized salt in order to prevent the congenital iodine deficiency syndrome;
- birth attendants should be trained to recognize high-risk pregnancies and to refer deliveries that are expected to be complicated to specialist facilities, since the prevention of obstetrical complications can reduce the number of children with central nervous system damage;
- the promotion of breast-feeding should be an integral component of primary health care.

Programmes for child nutrition. These should be a major component of prevention because malnutrition can impair cognitive and social development.

Immunization. The immunization of children against measles, rubella, mumps, poliomyelitis, tetanus, whooping-cough, and diphtheria could make an important contribution to the prevention of brain damage.

Family planning. Child development is adversely affected when mothers have too many children at unduly short intervals or when they are too young or too old. Education on family planning and access to effective means of contraception are therefore essential elements in maternal and child care.

Measures against abuse of and dependence on psychoactive substances

Primary health care workers should routinely counsel patients against smoking. Although only 3–5% will respond by stopping smoking, there is a large gain from the public health standpoint because of the high prevalence of the habit. Repeated efforts to quit have cumulatively higher rates of success and a low initial response should not discourage subsequent efforts.

Health workers can be trained to recognize the early stages of alcohol and drug abuse, using WHO manuals and guidelines. Brief counselling can help a significant number of patients to alter their behaviour before dependence and irreversible damage occur.

Crisis intervention in primary health care

In the event of acute loss (e.g., the death of a spouse, which increases morbidity and mortality among survivors), there is some evidence that group and individual counselling of the bereaved can diminish risk. Self-help and mutual aid groups can improve health at minimum cost to the health services. Well-trained crisis intervention units can handle a variety of acute mental health problems and thus prevent chronic difficulties.

Prevention of iatrogenic damage

Failure to diagnose and correctly treat psychosocial disorders results in iatrogenic damage. Thus it is wrong to use potentially toxic drugs when what is needed is social support, or to rely on institutional care for patients who can be restored to function while in the community.

Health workers can be trained to inquire routinely about psychosocial problems in the course of evaluating new patients. This enables them to recognize symptoms that indicate psychological distress and to avoid the overuse of psychotropic and other drugs and the iatrogeny that results from such practices. Brief counselling and, where necessary, referral to social welfare or mental health workers can significantly diminish the number of clinic visits.

Behavioural disorders that are the iatrogenic effect of prolonged or repeated hospitalization can be prevented by minimizing the hospitalization of children, encouraging family participation when hospital care is unavoidable, and introducing certain organizational arrangements in hospitals (e.g., assigning a primary nurse to each child). Mental deterioration in the elderly can also be prevented by avoiding unnecessary hospitalization.

Although measures to prevent dementia must await the results of further research, cognitive impairment resulting from depression and infection can be reversed by prompt treatment. At present, the distinction between dementia and depression in the elderly is not recognized by the family doctor in four out of five cases. A relatively short period of training can enable physicians and other health workers to improve their diagnostic skills in this area.

Minimizing chronic disability

Education of primary care workers in the recognition of sensory and motor handicaps in children, the use of prosthetic devices to minimize handicaps, and the referral of handicapped children to the educational authorities can prevent both cognitive underachievement and social maladjustment. Properly-fitted spectacles and hearing aids can reduce the likelihood of mental and social handicap in children.

Because the incidence of cerebrovascular disease can be reduced by the effective treatment of hypertension, primary care workers should be trained in the diagnosis and treatment of hypertensive disease; similarly, acquired lesions of the central nervous system can be reduced by prompt treatment of, for example, meningitis.

Health workers should be trained to manage febrile convulsions, recognize epilepsy, and control seizures with low-cost anticonvulsant drugs in order to minimize damage to the central nervous system, as well as reduce accidental injury and reduce the psychosocial invalidism and isolation that result when treatment is not provided. An uninterrupted supply of drugs of assured quality is of paramount importance.

Primary care workers should be trained to recognize schizophrenia and to manage it with low-dose antipsychotic drugs, to counsel relatives with a view to minimizing chronicity and avoiding the social breakdown syndrome, and to diagnose and treat patients suffering from depression. Such patients, who commonly present multiple somatic symptoms, may be inappropriately investigated and treated for somatic disorders, and are at risk for suicide. Effective treatment with antidepressants and prevention using lithium salts can be provided at relatively low cost.

Action at community level and in other social sectors

Better day care for children. Retarded mental development and behavioural disorders among children growing up in families that are unable to provide suitable stimulation can be minimized by early psychosocial stimulation of infants and by day-care programmes of good quality, particularly if the parents participate. However, day care must be of adequate quality; child-minding in crowded quarters by people who are too few in number and inadequately trained may retard development, not facilitate it. Among useful measures that could be taken are:

— surveys of existing day-care facilities and assessment of the need for them;

— establishment of quality standards and appropriate regulatory measures;

— setting of targets for quality and for training staff in the psychosocial development and needs of children.

Upgrading long-term care institutions. Although the use of institutions for long-term care can be minimized by providing alternatives in the community, they will continue to be necessary. The quality of the institutional environment is a major determinant of the way the patients function. It is therefore important to subject such institutions to regular evaluation and to improve their architectural design and the content of work programmes where necessary.

Self-help groups and support services. Self-help groups, organized by lay citizens, are effective in reducing the chronicity of certain disorders (e.g., Alcoholics Anonymous), in enabling the handicapped to improve their functional ability (e.g., societies that help epileptics), in educating the community about the nature of disorders, and in advocating changes in

In Australia between 1978 and 1984 a 10% reduction in per capita consumption of alcohol was accompanied by a 30% reduction in deaths caused by alcohol.

legislation, better resource allocation, and satisfaction of the needs of people with specific disorders. Furthermore, community self-organization for local development has been shown to reduce the psychopathology associated with anomie (a state of alienation from the community) and helplessness *(3)*.

Support services provided at community level can enable people to care for relatives with chronic illnesses who would otherwise require more expensive and less satisfactory institutional care. An excellent example is the organization of "home beds" for chronically handicapped mental patients in China: neighbourhood volunteers who are retired workers care for patients while their relatives are away at work. To maintain residual function and to avoid institutionalization, chronic mental patients must be provided with housing, opportunities for sheltered employment, and recreation.

Schools. The progressive extension of compulsory schooling provides new opportunities to broaden people's understanding of how they can protect their health. At the same time it leads to the identification of child health problems not previously known to health authorities.

A variety of risks to mental health and psychosocial development can result from a lack of parental skills and from parents' insufficient knowledge of their children's needs. Urbanization and other social changes result in a growing number of young parents not possessing such skills. Education for parenthood may well have to become a public responsibility. Creches and nursery schools can be sited next to secondary schools, whose students can be assigned to work in them under supervision. Trained leaders for groups of new mothers can guide discussion on child-rearing and thus provide a valuable form of self-help.

Instruction about family planning, sex, child development, nutrition, accident prevention and substance abuse are among the subjects that are most frequently recommended for inclusion in school curricula. A particularly promising way of preventing substance abuse among early adolescents is to encourage them to acquire the behavioural skills necessary to resist pressure to use cigarettes, drugs and alcohol.

If trained properly, teachers can identify children with sensory or motor handicaps or with mental health problems that have not been detected by the health sector. Collaboration between teacher, parent and health worker is central to the rehabilitation of children with chronic handicaps and to the avoidance of social isolation and other untoward consequences.

Public health measures for accident prevention. In view of the high mortality and morbidity resulting from accidents and poisoning, measures for their prevention must be given high priority. Brain damage caused by toxic substances in the workplace can be prevented by imposing strict limits on exposure; untoward effects of shift work can be avoided using the principles of chronobiology; child-proof safety caps on medicine bottles and containers of household chemicals can reduce the ingestion of poisons and consequent damage to the central nervous system; lead poisoning in children can be prevented by prohibiting paints containing lead for household use and by decreasing the lead content of petrol.

The media. Radio, television, newspapers and comic strips can play a major role in public health education—for the better (e.g., by explaining why sanitation is essential for health) or for the worse (e.g., by advertising cigarettes).

Cultural and religious influences. Cultural factors are among the principal determinants of human behaviour. A knowledge of cultural and religious forces can be applied by health workers in their efforts to reduce health-damaging practices.

Government action

Prevention works only if governments want it to work: action must be planned not only in the health sector but in all other sectors important for health, such as education, agriculture, environment, etc. Any country undertaking a prevention programme should have a national coordinating group on mental health with the authority to assign tasks to the appropriate sectors. The coordinating group should have at its disposal an information centre that can collect and feed back data on changes in the nature and trends of problems and on the effects of intervention and task performance. One of the first duties of the centre should be to conduct a comprehensive review of legislation affecting such matters as mental health, family life, health services, drug control and schools.

In the area of prevention, government actions in various spheres may have implications for health; housing projects may worsen mental health because of bad design; industrial development projects may destroy local culture and lead to family disruption, child neglect and substance abuse; and the widespread use of pesticides without safeguards may lead to brain damage.

There is a need for research into the causes and mechanisms of disease in order to develop new and better means for prevention and control. Data on prevalence and the effectiveness of interventions frequently do not exist, particularly in developing countries. The extrapolation of results obtained in one country to another may be entirely misleading. It is therefore important to foster research programmes of two kinds:

— studies on the distribution of problems in specific populations and on changes in the pattern with time;

— investigations to enable assessments to be made in particular countries of measures that have been proposed for large-scale application.

Both types of study should be carried out at the national or subnational level. An urgent task that should be included in programmes of technical cooperation between countries is the development of methods for conducting such studies. The involvement of institutions in developing countries in multi-centre research, research training courses and information exchange should be used to create and/or strengthen the basis for a further growth of knowledge in this field. □

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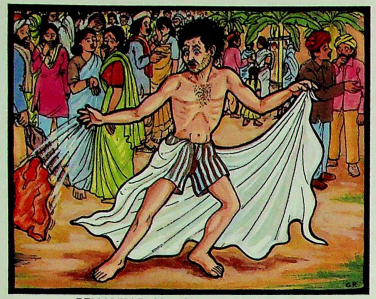
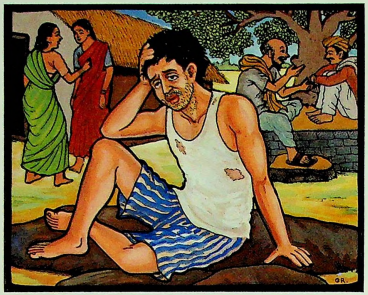


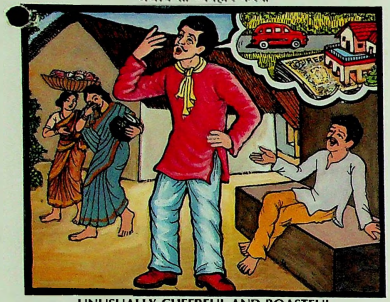
BEHAVING IN A STRANGE MANNER
अजीब सा व्यवहार करना



BECOMING MOODY AND WITHDRAWN
गुमसुम व दूसरों से अलग-अलग रहना

SEEING AND HEARING THINGS WHICH OTHERS DO NOT SEE OR HEAR
वो चीजे दिखाई व सुनाई देना जो दूसरो को सुनाई व दिखाई नहीं पड़ती है

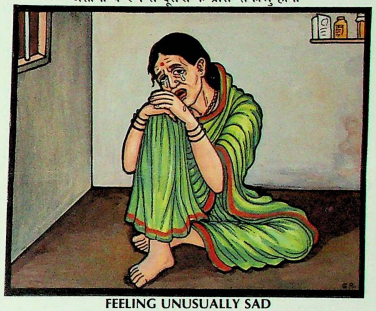
ABNORMALLY SUSPICIOUS OF OTHERS
असामान्य रूप से दूसरों के प्रति शंकाल् होना



UNUSUALLY CHEERFUL AND BOASTFUL
असामान्य रूप से प्रसन्न होना व शेखी बघारना

FEATURES OF MENTAL DISORDERS

मानसिक रोगों के विभिन्न लक्षण

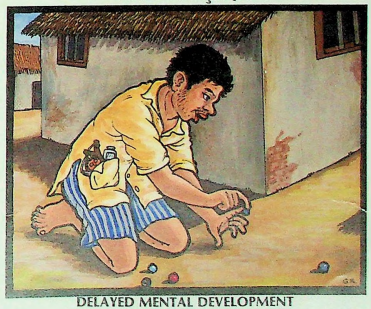


FEELING UNUSUALLY SAD
असामान्य रूप से दुखी होना

HAVING SUICIDAL TENDENCIES
आत्महत्या करने की प्रवृत्ति का होना

BEHAVIOUR ATTRIBUTED TO BLACK MAGIC
जादू-टोने के कारण माने जाने वाला व्यवहार

SUFFERING FROM FITS
दौरों से पीड़ित होना



DELAYED MENTAL DEVELOPMENT
मानसिक विकास का धीमा होना

ICMR CENTRE FOR ADVANCED RESEARCH ON COMMUNITY MENTAL HEALTH, NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BANGALORE 560 029. CONTACT: OFFICER-IN-CHARGE.
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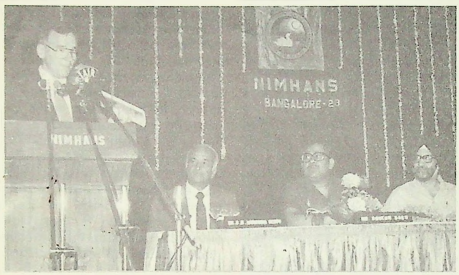

INDO-US SYMPOSIUM (*Oct – 27–30, 1987*) **Dr. Frank Sullivan, leader of US team addressing the inaugural session. Others in the picture are** (*L to R*) Dr. G. N. N. Reddy, Mr. Gautam Basu and Mr. S. S. Dhanoa. (*Bottom*) A view of the gathering.

NIMHANS Designated WHO Collaborative Centre

National Institute of Mental Health and Neuro Sciences (NIMHANS) Bangalore, has been collaborating with World Health Organisation (WHO) in a number of research projects, fellowships and training programmes. The faculty members of NIMHANS have also been assisting the WHO as short-term consultants and members of the Mental Health Expert Advisory Panel.

From December 2, 1986, NIMHANS has been designated as WHO Collaborating Centre for Research and Training in Mental Health for four years. The activities of the centre would include: i) Psychosocial factors in the promotion of health and human development (early childhood stimulation, adolescent problem behaviour and its prevention, indicators of mental health, psychosocial problems in PHC), ii) Prevention and control of alcohol and drug abuse (career studies, health damage, biological risk factors and outcome studies), iii) Prevention and treatment of mental disorders (disease markers, prevention programmes, disability interventions, indicators of quality of psychiatric care and training materials).

Dr. G. N. N. Reddy, Director, NIMHANS, is the Head of the Centre. □

In this issue

REACHING THE UNREACHED

ICMR Centre for Advanced Research on Community Mental Health NIMHANS, Bangalore.

EDITORIAL

Indo–US Symposium on Community Mental Health

The Indo–US Symposium on Community Mental Health is the **fourth** in the series of symposia organised at NIMHANS, Bangalore as part of the NIMHANS–ADAMHA Collaborative Agreement. The earlier symposia focused on 'Schizophrenia', 'Affective Disorders' and 'Alcohol and Drug Abuse'.

The topic of community mental health is most appropriate for the Symposium as currently there is a serious effort all over the world to understand the community care of the mentally ill persons. The issue has raised many questions about the need, the scope and limitations. As a topic for exchange between India and USA it is important. India is entering into the second decade of community mental health programmes while USA has over four decades of experience of organising community mental health programmes.

The Symposium was organised around six central themes, namely:

1. **Mental health planning and policy development,**
2. **Integration of mental health with primary health care,**
3. **Para-professionals and non-professionals in mental health care,**
4. **Family and social support systems,**
5. **Alternative patterns of care for the mentally ill,** and
6. **Mental health care of special groups.**

Each of the sessions began with a key paper from an Indian and an American professional. This was followed by responses of 2–3 professionals as discussants. Discussion involving the members of the audience, the key presenters and discussants followed. Each session was of two hours duration. The special aspect of the Symposium was that the key papers and discussants responses were available to the registered participants about two weeks prior to the Symposium. This arrangement facilitated time for discussion and active contributions from the participants. In fact, the discussion following each session highlighted the controversies and areas for future work.

The participants of the Symposium included 15 US delegates, 16 Indian speakers, 50 registered delegates from different parts of India, and over 70 faculty staff of the NIMHANS, Bangalore. In addition, the post-graduates of NIMHANS were participants.

As part of the Symposium field visits were organised to the primary health care facilities, schools, child care centres, half-way-home and home care programme to provide opportunity for outstation delegates to experience the community care programmes in India.

The proceedings of the Symposium would be published as a monograph (expected by Dec. 1988) which would include the key papers, discussants responses, the discussion of each session, summing up comments; and a brief account of the community mental health care in India and USA.

The current issue of CMH News **brings together the highlights of the symposium. It is hoped that the issues identified and discussed would receive the efforts of the professionals, planners, and the people in the years to come.**

Dr. R. SRINIVASA MURTHY
Editor.

Inauguration

"In developing mental health care, community mental health programmes ought to be given high priority" Mr. S. S. Dhanoa, Secretary, Ministry of Health and Family Welfare, New Delhi said while inaugurating the Indo US Symposium on Community Mental Health. Decentralised health care was one of the answers to the massive health care problems in the country and the community had a major role to play in this he added. The Union Government was in the process of setting up a **National Mental Health Advisory Group** to coordinate the mental health programme in India. NIMHANS and the Central Institute of Psychiatry, Ranchi will be the 'focal point' for implementation of NMHP for which Rs. 10 million has been allotted in the Seventh Plan.

Mr. Gautam Basu, Secretary, Ministry of Health and Family Welfare, Karnataka State suggested changes in the medical curriculam with accent on mental health in the frame work of public health. Citing the success of NIMHANS' programmes in Gulbarga and Mysore divisions, he said the State had a great responsibility in community health programmes.

Dr. Frank J. Sullivan, leader of the US team said the human resources development attempted by NIMHANS, involving professionals and non-professionals in the care of the mentally ill, particularly in the villages is very important innovations. Later, he released the book on **Affective Disorders** which is the proceedings of Second Indo-US Symposium 1985.

Dr. G. N. Narayana Reddy, Director, NIMHANS, welcomed the gathering and Dr. S. M. Channabasavanna, Medical Superintendent, NIMHANS,

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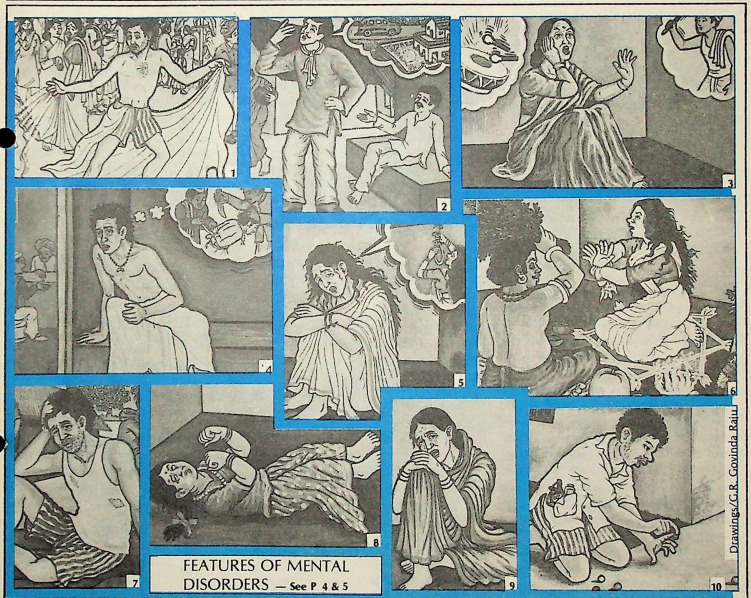


Drawings: G.R. Govinda Raju

FEATURES OF MENTAL DISORDERS — See P 4 & 5

In this issue

REACHING THE UNREACHED

ICMR Centre for Advanced Research on Community Mental Health
NIMHANS, Bangalore.

Mental Health Act 1987

The mental health professionals of India have been actively working towards the amendment of the Indian Lunacy Act 1912 since 1948. **As early as 1960, a revised draft mental health bill was prepared and considered by the First Workshop of Superintendents of Mental Hospitals held at Agra.** A draft bill was introduced for the first time in Lok Sobha in 1978. Thus the Mental Health Act 1987 has become a reality after nearly four decades of efforts.

Salient features of the Mental Health Act, 1987 are:

1 The terms like 'lunacy' 'insanity' 'asylum' have been replaced by mental disorder, mentally ill person and psychiatric hospital.

2 **The Act defines a mentally ill person as a person who is in need of treatment by reason of any mental disorder other than mental retardation.**

3 The Central Government shall establish an Authority for mental health. **The Authority shall be incharge of regulation, development, direction and coordination with respect to mental health services under the central government and supervise the psychiatric hospitals and psychiatric nursing homes and other mental health services under the control of the central government. Mental Health Services include in addition to psychiatric hospitals and psychiatric nursing homes, observation wards, day care centres, inpatient treatment in general hospitals, ambulatory treatment facilities and other facilities, convalescent homes and half-way homes for mentally ill persons.**

4 No person can establish or maintain a psychiatric hospital or psychiatric nursing home unless with a valid licence. The psychiatric hospital or psychiatric nursing home will be under the charge of a medical officer who is a psychiatrist. The licensing authority can revoke the licence if the facility is not maintained in accordance with the provisions of the Act (Sections 6, 8, 11).

5 In every psychiatric hospital or psychiatric nursing home, provision shall be made for such facilities as may be prescribed for the treatment of every mentally ill person, whose condition does not warrant this admission as an inpatient or who, for the time being, is not undergoing treatment as inpatient (Section 14).

The Mental Health Act 1987 received the assent of the President on 22nd May 1987. It consolidates and amends the law relating to the treatment and care of the mentally ill persons, to make better provision with respect to their property and affairs and for matters connected therewith and incidental thereto.

6 Any person (except minors) who considers himself to be a mentally ill person and desires to be admitted to any treatment facility may request the medical officer in charge for being admitted as a voluntary patient (Section 15). Voluntary patients should be discharged with 24 hours of the receipt of request, except when such discharge is not in the interest of the patient, can within 72 hours, constitute a Board consisting of two medical officers and seek its opinion whether the voluntary patient needs further treatment. On the recommendation of the board patient can be continued for treatment for a period of upto 90 days at a time (section 18).

7 Any mentally ill person unable to express his willingness for admission as a voluntary patient, can be admitted on application by a relative or a freind, if the medical officer in charge is satisfied. This admission can be upto a period of 90 days (section 19).

8 Admission by reception order issued by magistrate. Such request by a relative will need two medical certificates. Any consideration of the application by the magistrate will be held in camera (section 20, 21, 22).

9 Police Officers can take into protection any person found wandering at large and found to be mentlly ill, either unable to take care of himself or there is reason to believe to be dangerous by reason of mental illness. Such persons, should be produced before the nearest Magistrate within 24 hours for reception orders (section 22).

10 Every officer in charge of a police station, or a private person, who has reason to believe that any person is mentally ill and not under proper care and control, or is ill-treated or neglected by any relative or other person can report the same to the magistrate (section 25).

11 The state government or the central government shall appoint for every psychiatric hospital not less than **five visitors**, of whom at least one shall be a medical officer, preferably a psychiatrist and two social workers. Not less than three visitors will visit at least once a month and make a joint inspection of every part of the facility. (Sections 37, 38).

12 The medical officer in charge may grant leave of absence to the mentally ill for a maximum period of sixty days (Section 45).

13 Sections 50–73 relate to judicial inquisition regarding alleged mentally ill person possessing property, custody of his person and management of his property.

14 Where a mentally ill person is not represented by a legal practitioner in any proceeding under this Act before a District Court or a magistrate and he has not sufficient means to engage a legal practitioner, the court can assign a legal practitioner to represent him at the expense of the State (section 91).

15 The Indian Lunacy Act 1912 and the Lunacy Act 1977 are repealed. □

Summary by **R. SRINIVASA MURTHY.**

Training for Medical and Psychiatric Social Work Teachers

The first Training Programme in Community Mental Health for Medical and Psychiatric Social Work Teachers was held at NIMHANS, Bangalore from 6 to 10 July, 1987.

Community Mental Health, in social work parlance, is application of methods of social work especially, group work, community organisation, social action and social work research for the promotion of mental health, early diagnosis and treatment of mental ailments and rehabilitation of mentally ill and handicapped in the community.

Considering the relevance and importance of incorporation of community mental health in social work curriculum, the experts who participated in the **National Seminar on Psychiatric Social Workers role in implementation of National Mental Health Programme for India, held at NIMHANS, Bangalore, on 27th and 28th March, 1986, made the recommendation that Medical and Psychiatric Social Work Teachers need to be provided an in-service training programme in community mental health.**

The main objectives of the in-service training programme were:

i) to provide background to the historical perspectives of community oriented mental health programme.

ii) to highlight on the National policies on health, mental health and allied community programmes.

iii) to focus on issues like community participation, collaboration with other sectors like education and social welfare, and

iv) to evolve practical means of incorporating the community orientation in the medical and Psychiatric Social Work Training.

Based on these aims and objectives, the contents of the training programme focused on developments in institutional and non-institutional modalities of treatment, psychiatric social work in community mental health, student enrichment programme, village leaders' orientation and involvement, training and research programmes in community mental health, and other specific programmes like psycho-social components of Bellary District Mental Health Programme. Efforts were also made to minimise the lectures and maximize the participatory learning. Follow up action was much emphasised in the programme.

To enable the participants to incorporate the elements of community mental health in their classroom teaching as well as field work training programmes each one of them was given 35 documents related to Medical and Psychiatric Social Work issues in practice of community mental health.

On the last day of the programme, the participants were divided into 3 groups to intensively discuss on social work aspects of field work practice, teaching curriculum, research activities and projects and develop recommendations. □

Dr. R. PARTHASARATHY
Asst. Professor
Dept. of Psychiatric Social Work
NIMHANS, BANGALORE - 29.

RECOMMENDATIONS

The recommendations made by the participants of the training are as follows:

1. As far as possible, the contents of the field work practice in social work need to be enriched with community oriented health programmes in general and mental health programmes in particular.

2. All the teachers dealing with medical and psychiatric social work should have the opportunity to get an exposure to the modern trends in community mental health.

3. Trainees in social work should be placed in agencies extending community health and mental health services.

4. Trainees in social work should be guided to undertake simple and suitable service oriented research projects as part of their training.

5. Teachers in social work need to be provided with opportunities for improving their knowledge and updating their professional skills by centres like NIMHANS.

6. Collaboration between NIMHANS and Schools of social work in India need to be strengthened in such a way that it leads to achievement of the objectives of the National Mental Health Programme.

7. Schools of social work should think of updating their syllabi based on the modern trends in mental health care in community settings.

8. Information pertaining to the persons/ trainers/policy makers/ administrators/being oriented in mental health care could be passed on to the participants, so that they could initiate collaborative efforts in the respective places.

9. New ideas and research reports should be regularly made available to the teachers so that they could update their knowledge on community mental health.

10. Review workshops should be organised periodically to assess the activities being carried out as a result of the training in community mental health. □

PARTICIPANTS

In the July '87 Programme, 16 Medical and Psychiatric Social Work Teachers from different schools of social work participated. They are: Mrs. Aruna Khasgiwala (M.S. University of Baroda, Baroda), Dr. Ahmad Saghir Inam Shastri, (Kashi Vidyapith, Varanasi), Mrs. Anila Gangrade, (Indore School of social work, Indore), Ms. Cecilia Thangarajan (Stella Maris College, Madras), Mr. Joseph Injodey (Rajagiri College of social Sciences, Kalamassery), Mrs. Katy Y. Gandeira (Tata Institute of Social Sciences, Bombay), Mr. M. Kannan, (Madurai Institute of Social Work, Madurai), Mr. Mosala Sunil Kumar (National Institute of Social Work and Social Sciences, Bhubaneswar), Dr. M. M. Mukherjee (Visva-Bharati, Sriniketan), Dr. (Mrs.) Promila Maitra (M.S.University of Baroda, Baroda), Dr. TBBSV Ramanaiah (Chatrapati Shahu Central Institute of Business Education and Research, Kolhapur), Mrs. Sulakshana Malhotra, (Tripude College of Social Work, Nagpur), Ms. Rekha Taunk, (Institute of Social Work, Nagpur), Mr. A. Relton (Bishop Heber College, Tiruchirapalli), Mr. K. Shanmugavelayutham (Loyola College, Madras), and Dr. P.D. Misra (Lucknow University, Lucknow). □

DEVELOPMENT OF MENTAL HEALTH EDUCATION MATERIALS

Features of Mental Disorders

The ICMR Centre for Advanced Research on Community Mental Health has outlined the development of appropriate public mental health education materials as one of its aims (ICMR-CAR-CMH, 1984). There is an urgent need in making available suitable public education materials, as seen from the implementation of National Mental Health Programme (DGHS, 1982), at various centres in different states. As a first step, among the various mental health education aids, the centre took up the development of the Flip chart on **Features of mental disorders** for the following reasons: (i) To facilitate the health workers enquiry at field level regarding the identification of mentally ill cases. (ii) To provide a visual presentation of different features of mental illness for the lay public and, (iii) To assist the health workers enquiry to be systematic in using the method given in the manual of Mental Health for Multi-purpose Workers. (CMH News, Issue 1, p. 6)

Strategies in development

The above described cards (*See Box*) were sketched out in Indian ink on demy size ivory art board and was field tested. The objective was to understand how the rural public visualise them. The field testing was carried out in Solur and Anekal PHC areas of Bangalore District. Two groups of respondents were considered as subjects for the first and second field tests. Group 1, consisted of 35 community health guides, and group 2, consisted of 35 resident trainees of Gruhini programme in a Christian Hospital training centre. The method of field test adopted was the group approach, wherein, the cards were shown to the respondents for a minimum of 30 seconds to a maximum of 60 seconds each. After this the respondents were requested to describe the content of the picture in writing in a given response sheet.

Based on the content analysis of the responses on black and white line drawings from group 1, the material was coloured and was presented to group 2. Completion of the second field test brought out the limitations of the group interview procedure. Hence, for further field testing it was decided to adopt an indepth individual interview method. Further revision of the charts were made based on the responses of Group 2 and was presented to 20 respondents of a third group in a village in Anekal PHC area. An indepth interview method was adopted during this field test. Among these twenty, only fifteen respondents agreed to the request.

Following the field test activity, the field tested material along with the responses and the script was presented to the State Health Education Department personnel and two members of the Scientific Advisory Committee of the ICMR Centre for Advanced Research on Community Mental Health, who are pioneers in health education (Dr. V. Ramakrishna and Dr. L. Ramachandran). All the technical flaws and suggestions pointed out by them were corrected and incorporated.

The revised material alongwith script was given to six health workers who were asked to demonstrate the aid to the general public in the field area. Following the exercise a selected range of audience were interviewed and it was found to be useful in terms of the main idea being communicated and comprehended. The animators opinion on this exercise was also obtained. They too felt it is practical to communicate the mental health information through this aid which is informative and well done.

Following the above activities,

DESCRIPTION OF THE MATERIAL

Aim	:	To provide a visual comprehension of features of mental disorders.
Reference	:	Manual of Mental Health for Multi-purpose Workers – page 50.
Media	:	Audio-visual
Format	:	Flip-book – demy one-fourth size.
Target group	:	Rural, illiterate, Indian population. The maximum number addressed with the aid would be 5–10 at a time.
Users	:	Health workers, block health educators and other health personnel who have received basic mental health training.
Nature of visual material	:	Line and shade composition in multicolours.
Number of cards	:	Eleven

CONTENTS OF THE MATERIAL (CARDS): (See cover page of this Issue)

1. **Who talk nonsense and act in the strange manner and considered abnormal?**
2. **Who have become unusually cheerful, crack jokes and say that they are very wealthy, and superior to others when it is really not so?**
3. **Who claim to hear voices or see things others cannot hear or see?**
4. **Who are very suspicious and claim that some people are trying to harm them?**
5. **Who talk about suicide or has made an attempt at suicide?**
6. **Who get possessed by God or spirit or who is said to be the victim of black magic or evil power?**
7. **Who has become very quiet and does not talk or mix with people?**
8. **Who suffers from fits or loss of consciousness and fall down?**
9. **Who have become very sad lately, and cry without reason?**
10. **Who are dull, not mentally grown up like others of their age and slow since birth?**
11. **A collage of all the above said ten cards.**

copies of flip charts were produced in multi-colour printing with written material at the back of each card. The flip charts were distributed to 193 multi-purpose health workers and 69 medical officers all trained in mental health care. The opinion of these health personnel were collected in a specially designed proforma attached to the flip chart. The overall reaction towards the material by health personnel was found to be positive and of value in terms of the main idea of communication, likes and dislikes, believability and reaction to the message, educational aspects, feeling towards the material and practicability in using the material in the field situation. Changes in the visual material was suggested by 21% of the health personnel. Tangible revisions were effected in the final revision.

Results and Discussions

The results of the field testing and development is given in Table 1. The process of modification is illustrated with one card, namely card No. 1 (Charts 1, 2 and 3).

The mean desired identification rate of cards during the three field testing increased considerably from 2.5 to 7 cards. Card No. 1 depicting 'socially unacceptable activity' showed very low desired responses during the first two field tests (6% and 9% respectively). The picture depicted, mostly elicited the responses such as drunken behaviour of a normal person rather than a socially unacceptable activity (see chart 1). In the third field testing, when the content of the card was changed (chart 2), 87% were able to identify in a desired manner. After scrutiny of this chart by the technical experts suggested to tone down the background depiction. The feedback by the 262 health personnel who used the material suggested to depict a middle age person rather than an adolescent. It was reported by them that the target group comprehended the message that socially unacceptable activity was associated with adolescents rather than others. Hence, the change was effected in the final revision (Chart 3).

TABLE 1: Responses for the cards during field testing.

CARD NO.	FIELD TEST 1 (N-35) DESIRED %	FIELD TEST 1 (N-35) UNDESIRED %	FIELD TEST 2 (N-35) DESIRED %	FIELD TEST 2 (N-35) UNDESIRED %	FIELD TEST 3 (N-15) DESIRED %	FIELD TEST 3 (N-15) UNDESIRED %
1	06	94	09	91	87	13
2	34	66	69	31	73	17
3	09	91	11	89	20	80
4	09	91	14	86	20	80
5	34	66	60	40	87	13
6	06	94	06	94	93	07
7	66	34	51	49	87	13
8	34	66	37	63	60	40
9	43	57	60	40	87	13
10	06	94	06	94	87	13
TOTAL	25	75	32	68	70	30

Mean desired identification for field test 1 = 2.5
Mean desired identification for field test 2 = 3.2
Mean desired identification for field test 3 = 7

Chart–1

Chart–2

Chart–3

The current effort has brought to focus the problems in developing material for public education regarding mental disorders. The present material could be used for the production of multi-channel communication aids. □

Dr. K. SEKAR
Lecturer in Psychiatric Social Work
ICMR Centre for Advanced Research on Community Mental Health, NIMHANS.
(Detailed report of the development of the material can be obtained on request).

A health worker demonstrating the Features of Mental Disorders with the help of a Flip Chart. (Sangighatta PHU, Solur.)

"The health personnel engaged in such mass campaigns must be trained to tackle all health problems in any area while the overall supervision for particular disease may require special attention through specialists in rural area. It is neither possible nor desirable to have separate agencies to deal with separate diseases".

– MUDALIAR COMMITTEE (1982)

An attractive multi-colour poster on Features of Mental Disorders is available on request. Write to **Officer in Change, ICMR Centre for advanced Research on Community Mental Health, NIMHANS, Bangalore–560 029.**

Workshop on Research Issues in Psychiatric Epidemiology in India

RECOMMENDATIONS OF THE WORKSHOP

1.1 The group recognises the importance of epidemiology for purposes of planning and delivery of mental health services, understanding the causation, determining the individual risks, to complete the clinical picture, delineation of new syndromes and for studying historical trends of mental disorders in communities. These aspects are specially relevant in India as there is a need to have Indian data on all the above aspects.

1.2 The group recommends the continuation of support for ongoing projects and suggests that fresh projects be initiated to meet the above needs. Special support is needed for incidence studies and longitudinal studies. These projects could be initiated in all the States/UTs to understand the locally relevant mental health problems both individually and in collaborative manner. Future epidemiological studies can be linked with ROME field practice areas of medical colleges which can result in longitudinal studies.

1.3 An important need in the area of psychiatric epidemiology is the training of professionals. It is recommended that a 4 to 6 weeks course be started for mental health and related professionals in psychiatric epidemiology and biostatistics in suitable centres.

1.4 The Medical Council of India should be requested to make a course in psychiatric epidemiology and biostatistics mandatory for post-graduate students in psychiatry.

2 The efforts in the past, especially in the area of community surveys have included 'all mental disorders' which have limited the generalisation of the findings. The group recommends that future research efforts should have their focus on specific diagnostic groups and special problems. It is anticipated that such an approach would lead to more appropriate use of screening instruments, mental status examination tools and diagnostic criteria. General studies should be undertaken only in some centres with adequate resources and with longterm studies as the focus.

The ICMR Centre for Advanced Research on Community Mental Health organised a workshop on "Research Issues in Psychiatric Epidemiology in India" between July 21–25, 1987 at NIMHANS, Bangalore. Prof. K.C. Dube (Agra) delivered the keynote address reviewing the developments of the last 30 years. Dr. S.M. Channabasavanna and Dr. Mohan K. Isaac (NIMHANS) Dr. Biswajit Sen (Girindra Sekhar Clinic, Calcutta), Dr. B.B. Sethi (Sanjay Gnadhi Post-Graduate Institute of Medical Sciences, Lucknow), Dr. A.K. Agarwal (K.G's Medical Colege, Lucknow), Dr. Shobha Srinath (NIMHANS), Dr. T. Madhavan (National Institute for Mentally Handicapped, Secunderabad), Dr. C.R. Chandrashekar and Dr. C. Shamasunder (NIMHANS), Dr. Murugappan (Institute of Mental Health, Madras), Dr. S. Rajkumar (Madras Medical College, Madras), Dr. Shiv Gautam (SMS Medical Colege, Jaipur), Dr. V.G. Kaliaperumal and Dr. R. Srinivasa Murthy (NIMHANS) presented key discussion papers in the workshop. More than 50 mental health professionals from different mental health centres in India participated in the workshop. Full report of the proceedings of this workshop is available as a separate publication.

3.1 The wider use of epidemiology as a research approach requires the development of screening tools with high validity. These should be simple, easily applicable to the population, appropriate for use by research staff with varying educational backgrounds. Past research experience has been with questionnaires, checklists, item sheets and semi-structured interviews. The group has identified that systematic efforts should be made to reach satisfactory levels of reliability and validity of a limited number of research tools like the SRQ, GHQ and relevant sections of the IPSS. The standardisation of the above instruments should receive priority for immediate research support.

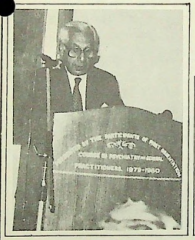
3.2 The group recommended that standardized semi-structured diagnostic tools are necessary for mental status examination like the PSE, and the IPIS. However, it should be noted that mental disorders vary in their presentation and such variation can be identified only with flexible diagnostic approaches like the 'goodness of fit' etc. Adequate attention should therefore be paid towards standardizing these instruments in the context of suitability to local needs.

3.3 The use of diagnostic criteria is a must for epidemiological studies. Classification systems to be used should also be based on internationally accepted systems. However, to incorporate the variations in clinical presentation and to explore newer clinical syndromes, modification in criteria and diagnostic process need to be made. These must be such that the final system is compatible and comparable with the international systems. The 'goodness of fit' ratings may be of considerable value in assessing the need for these modifications.

4 In psychiatric epidemiology, the study of the relationship of the prevalence of mental disorders and socio-economic and cultural factors in the country has been attempted. However, no uniform findings have been reported or specific hypotheses emerged. This appears to be a reflection of (i) the difficulties in categorisation of these variables, (ii) difficulties in collecting the information, (iii) the lack of relationships of one variable with the other variables, (iv) the possibility that association with the mental disorders should not be examined globally but with specific diagnostic

groups or categories. Future efforts should be made to study a limited number of relevant variables, which should be adequately standardised for the purpose. The possibility of linkage with other data sources like census tables can be considered.

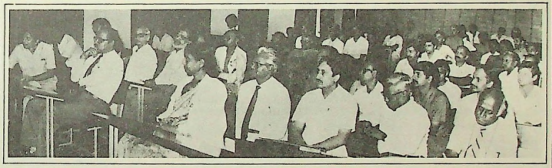
5 The group took note of the vital role of statistical analysis and urges that future researchers adopt the statistical plan of analysis prior to launching a study and use better sampling techniques and study problems by case-control studies and cohort studies. To interpret this data, use can be made of life table techniques, covariate and multivariate analysis etc. With the availability of data analysis facilities like computers should be utilised to a larger extent.



6 The group considered the possibility of utilising the routinely collected data in a uniform manner 'from hospital and other sources of secondary data' in a prospective manner. The group recognised that there have been problems in the past efforts in this area and in view of this sufficient care should be taken in the planning of reasearch in terms of funding, training of personnel, coordination, analysis of data and related issues.

7 Child Psychiatric epidemiology has been a neglected area. The group considered the needs in the area of epidemiology of childhood mental disorders and felt that initial efforts should be focused in their coverage and need to be very broad. In addition, such groups of children such as child labourers, institutionalised children, slow learners and female children should be considered as priority groups. The positive aspects of child mental health and needs of gifted children should also be studied.

8 There is a need to consider the three childhood age groups namely, 0–5, 6–10 and 11–15 years, as separate groups for the epidemiological study of developmental norms as well as psychological problems with different instruments for screening, clinical evaluation and diagnostic systems. This is an important area requiring the efforts of the mental health and related professionals for the standardisation of the appropriate screening and diagnostic instruments.



Dr. K C Dube deleverying the keynote address in the inaugural session of the workshop.

9 The group noted that in the area of mental retardation the needs are not so much of general prevalence studies but more of studies to understand the etiology (for example, nutrition, consanguinity etc.), needs assessment of families and assessment of assets and liabilities.

10 In the area of child mental health services, including mental handicap, there is need for developing intervention strategies and identifying the levels of care that can be provided as well as age levels in which such intervention should be initiated. In view of the current levels of the mental health professionals, alternative approaches should be the primary goal. Such innovations can be undertaken with active involvement of the Departments of Education, Social Welfare, Health and other related departments.

11 The group considered the needs of school and college students and their mental health. The latter group is of high vulnerability and interventions need to be very effective. Against the need, there are very few studies in this area. This area should be investigated along with intervention models with teachers as primary care providers.

12 In India, the general practitioners (GPs) form a major group providing primary health care. Research and development of models to enhance mental health skills of the GP can bring about a dramatic increase in mental health manpower in this country. The experience of the last 10 years should be utilised to develop suitable training materials and assessment tools.

13 The group recognised that there is a growing need for prevalence studies of psychiatric disabilities and intervention strategies in the geriatric population due to the demographic shift of the country. Future projects should focus on developing simple screening and diagnostic tools. It is equally stressed, the importance to develop service oriented research programme in collaboration with personnel in related medical field, and community development projects.

14 The group reviewed the past longitudinal studies undertaken in the country and recognised that the 'course and outcome'

reported justifies future work in this area. These studies can result in understanding the nature and course of mental disorders in the country. The group recommends initiation of studies, in this area with special emphasis on (1) community studies, 2) studies starting with fresh cases, 3) assessment using standardised tools, 4) using clear categories of patients. These studies should be both in urban and rural areas. The above efforts requires tool development to assess outcome, disability, impact on the family, methods to combine multiple data for outcome assessment. These studies should be more and more effective with longer period of follow up.

15 Delivery of services and evolution forms an important need in view of the National Mental Health Programme. Only preliminary efforts have been made in this direction. The areas that should be focused in future research are: (i) selection of priorities (ii) identification of indicators of mental health care (iii) record system (iv) monitoring mechanisms, and (v) role of different levels of personnel in mental health care.

16 The group reviewed the ethical aspects of epidemiological work and evaluation studies and recommends that all such studies should have an essential service component built into the project during and after the project period.

17 The group reviewing the 3 decades of research in psychiatric epidemiology in India, recognised the key role of ICMR in this research effort. The group recommends that there should be continued support for future work from ICMR and other funding agencies like NIPCCD, NCERT, ICSSR, DST etc. as part of their research plans.

18 The group considers the current workshop as being useful and recommends that a review workshop be planned in 5 years. □

NEW DELHI

Training for Mothers of MR Children

Most of the mothers learn skills of child rearing from the older women in their families. These skills are generally applicable to children with normal intelligence. When a mentally retarded child is born in the family, these age old skills do not work effectively. As, a mentally retarded child either fails to develop the skills so essential to everyday life or takes a much longer time to acquire skills than a normal child. With special methods of training mentally retarded children can be trained effectively. These special methods of training are based on the principles of behaviour modification.

Role of Parents

Parents are becoming more active and assuming more active roles in the teaching of their retarded children. Due to lack of resources in the form of trained professionals, parents and others concerned with the child, need to be adequately trained. Training retarded children usually requires a long period of time and must essentially be carried out in the child's natural and everyday environment i.e. at home. Parents being the most significant people in the child's life and a potent source of reinforcement to a child, hence by training, they can become better equipped to deal with present and future problems.

For these reasons an ICMR funded project was started by Dr. M. Mehta at the Department of Psychiatry, AIIMS, New Delhi to provide training for mothers of mentally retarded children, to become behaviour modifiers of their own children. A second objective of the project was to evaluate variables which have a bearing on the outcome of training programmes.

Training programme

Mothers were trained in specific techniques of Behaviour modification. Three broad categories of behaviour are mainly dealt with: 1. Self help activities, 2. Preacademic skills and 3. Control of problem behaviour. The total training programme consisted of 6–8 sessions initially and later 4–5 sessions in the follow-up phase. Each session was of 1 hour duration. The experience has shown the importance of training parents and the vital role played by them in the total case. □

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COMMUNITY MENTAL HEALTH NEWS
Issue No. 8, July-Sept 1987

The **Community Mental Health News** is published by the ICMR centre for advanced research on community mental health, to keep the professionals, planners, administrators and the interested public informed about the development of community mental health care programme.

Copies of **Community Mental Health News** are mailed free on request by interested professionals and institutions.

We are interested in exchanging a few copies of this journal, on reciprocal basis, with other medico-health publications. We would like to obtain information on projects/research findings/field work reports relating community mental health programmes in our country.

Letters, comments and communications should be addressed to: **The Editor, Community Mental Health News, ICMR Centre for Advanced Research on Community Mental Health, NIMHANS, Bangalore – 560 029, (India).**

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COMMUNITY MENTAL HEALTH NEWS

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Sri. Rajiv Gandhi, Prime Minister, releasing the document National policy on Mental Handicap on 14th Jan. 1988. Others in the Picture are : Smt. Kumudben Joshi, Governor of Andhra Pradesh (left) and Mr. Thakur V Hariprasad (standing).

MENTAL HEALTH

Organised and planned mental health care activities are vital for obviating the ill-effects of major socio-economic changes. A beginning in this direction is proposed in the Seventh Plan by according priority to strengthening the existing psychiatry departments, promotion of community psychiatry by provision of drugs and services through the primary health care system and organisation of training programmes. □

— Seventh Five Year Plan (1985–90) Vol–2 Chapter 11, p 268

NMHP REVIEWED

The National Mental Health Programme for India formulated in 1982 by the Government of India was reviewed as part of the meeting of the Health Secretaries on November 3, 1987 at Nirman Bhavan, New Delhi. Dr. G. N. Narayana Reddy and Dr. R. Srinivasa Murthy were invited for the meeting. Dr. Reddy presented the NMHP and the progress achieved in implementing the same in the last five years. This is the first time that the NMHP has been discussed at the level of Health Secretaries subsequent to recommendation (August 1982) by the Central Council of Health and Family Welfare. □

In this issue

REACHING THE UNREACHED

ICMR Centre for Advanced Research on Community Mental Health
NIMHANS, Bangalore.

EDITORIAL

Public, Professionals, Planners, Press, Politicians and Mental Health Care

The begninning years of the current decade (1980's) has seen the emergence of a growing awareness among the public, press, planners, politicians and Professionals (5 Ps) of the needs of the much neglected groups of individuals in the society. This is referring to the **revolution in mental health care** in India.

MENTAL HEALTH AND MEDIA

In the last few years, parents and public have repeatedly brought to the general awareness of the needs of the mentally ill and mentally handicapped individuals. These have been both efforts to organise services (*CMH News*, Issue 3 & 4) and to draw attention to the problems of the mentally ill in the mental hospitals (*CMH News*, Issue 6 & 7, p. 16). The most recent and vivid attempt is the coverage of the 'world of mentally ill' in the National TV under the serial titled **Kasauti.** This serial is significant as for the first time some of the images which were 'haunting and horrifying' were presented on National TV in a detailed manner.(See p. 7)

SEMINAR ON MENTAL HANDICAP

One such effort by the voluntary organisations to develop a policy for the mentally handicapped – National Seminar to frame a **National Policy for the Mentally Handicapped** was held at Hyderabad from February 3–6, 1987. This seminar was coordinated by the Thakur Hariprasad Institute of Rehabilitation for the mentally handicapped children, Hyderabad. Renowned subject matter experts, representatives of the planning commission, the Government of India, the State Governments, and the voluntary organisations participated in the policy document development. The discussion sessions considered the areas of : (i) basic rights, social security, legislation and taxation, (ii) health, and (iii) education and employment. The recommendations proposed at the seminar was developed into a policy document.

The National Policy on Mental Handicap was released by Hon. Prime Minister Sri. Rajiv Gandhi on 14 January 1988. We in this issue carry a condensed version of the full document (See p. 3–5). It is gratifying to hear that this policy is receiving support from planners and politicians in the form of specific administrative action. One of the first results expected is the formation of a **National Trust** for the mentally handicapped.

POLICY FRAMEWORK

CMH News has covered the National Mental Health Programme (*CMH News* Issue 1, p. 2) as well as the Education and National Health Policy (*CMH News*, Issue 2, p. 6). In a way, the above four policy documents along with the Mental Health Act, 1987 (*CMH News*, Issue 8, p. 2) provide the broad framework for the development of Mental Health programmes in the coming years.

At the international level, World Health Assembly (1987) concluded :

"Mental, neurological and psychosocial disorders constitute an enormous public health burden for both developing and developed nations. Review of the evidence demonstrates that the implementation of a comprehensive programme on prevention based methods currently available could produce a substantial reduction in the suffering of mentally ill, destruction of the human potential and the economic loss they produce. Such a programme would attack both the biological and the social causes which underlie these disorders. For success, it requires a national commitment, coordinated action in many social sections and coordination at an international level".

RESPONSIBILITIES OF THE PROFESSIONALS

In the above remarkable developments of the decade, the role played by the public and press have been very vital. It is creditable that the public concern has found a responsive chord in the minds and actions of the planners and politicians. The future depends to a large extent on the **Professionals.** The professional groups with interest in the broad area of mental health care, will have two major responsibilities. **Firstly,** to recognise the vital role played by the public, press, planners and politicians and actively work with them in developing and implementing the policies. **Secondly,** they have to provide the technical know-how for the programme in terms of advances in mental health skills, methods to transfer skills,mechanisms of evaluation and support. Without these twin responsibilities by the professionals the best of the policy documents would only remain on paper. The mental health and related professionals have a unique opportunity to shape events for the future.

In this connection it is appropriate to refer to what Dr. Norman Sartorius, Director, Division of Mental Health, WHO, Geneva, has to say:

"Righting the twentieth century is the best prescription of a better twenty-first century. There is so much to do that starting anywhere will be richly rewarding. The guarantors of improvment in the future are people : the fact that in many countries people have started to think about ways to make the mental health policies and programmes for the twenty – first century useful is an important first step; others are bound to follow. We should be happy that there is so much that we can contribute to the development of better programmes for tomorrow, but time is short and we must start right now".

Here lies the challenge and road ahead to reach the unreached. □

R. SRINIVASA MURTHY.
Editor

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National Policy on Mental Handicap

Mental handicap forms a significant problem affecting the lives of the mentally handicapped individuals and their families. The nature of mental handicap, that is, arrested or delayed development, means that there is both a limited level of functioning as well as a need for addtional supports from the family and community over long periods of life.

Till recently mental handicap was not considered a significant problem in planning of services. This was a reflection of the importance given in the planning towards life threatening illnesses of public health importance. Currently there are many reasons for focusing attention on the needs of the mentally handicapped individuals. **Firstly,** there is growing evidence and studies about the magnitude (about 2% of population) of the problem. **Secondly,** with the universal coverage of education, the problems of mentally handicapped children are getting the attention of teachers and families. **Thirdly,** the breaking-up of the joint family system and the decreasing natural social supports are placing greater burden on the immediate family to care for the mentally handicapped individuals. **Fourthly,** the rapid social change and increasing demands on individuals would make the adjustment of the mentally handicapped persons more difficult and would require special provisions to avoid discrimination. **Lastly,** in the country, there is widening in the coverage of services to include the needs of oppressed, minorities, socially disadvantaged and as a part of this welfare approach it would be appropriate that the welfare benefits reach the mentally handicapped individuals and their families.

The growing awareness of the needs of the individuals, the availability of growing number of professionals for care provision, advances in the care of mentally handicapped people and a new welfare approach in the policy making in the country all add upto the need for a national policy towards the mentally handicapped individuals. In short, a **mentally handicapped person should also have all the rights and privileges in line with the normal human rights in general.**

Present Status

The National Policies reflect the recognition of the problem of mental handicap and approaches to provide services.

The National Health Policy (1982) outlines approaches that have components of comprehensive net work of services. The National Policy on Education (1986) gives special emphasis to removal of disparities and to equalise educational opportunities to one and all including women, backward sections of the society, minorities, handicapped and those living in backward areas. In regard to the **HANDICAPPED persons, the policy aims to integrate the physically and mentally handicapped individuals with the general community as equal partners**. To achieve the above objectives the policy outlines the following measures: (i) integrated education of handicapped with other children, (ii) special schools with hostels at district headquarters, (iii) vocational training, (iv) reorientation of teachers training programmes to deal with the handicapped children, and (v) encouragement of voluntary efforts.

At present there are a little over 200 institutions with facility for care of about 10,000 individuals. The inadequacy of the services is clear as the current services do not cover even one percent of the mentally handicapped persons. The meagre services currently available are unevenly distributed in the various parts of the country. The services for the severely and multiple handicapped persons are almost not available in the country.

Against the background of large number of individuals with mental handicap and limited resources and

One of the biggest hurdles which is faced by the handicapped persons is apathy of the general public towards them. There is a widespread belief that a mentally handicapped person is a liability to the family and society and is unable to fend for himself. However, through training and education mentally retarded persons do attain a considerable degree of self-dependence and are able to learn certain skills so that they become productive. Most mentally handicapped persons have dexterity of hands and can be taught a vocation. However, specialised education is not enough. There is a need for more integrated education for the mentally retarded children so that they can become a part of the mainstream.

– DR. R. K. BAJPAI, Union Welfare Minister (All India Seminar on National Policy for Mentally Handicapped, Hyderabad, Feb 3, 1987)

facilities for care, there are some recent positive developments. At the level of services development, the starting of parent training programmes at Delhi, Vellore, Chandigarh and Bangalore and Self-help Group movement in a number of centres in the country can have major impact. The Self-Help Group movement is an expression of the potential for helping each other among families with mentally handicapped individuals. The initial results reported about the integration of mental health care with primary health care from different centres again offer the possibility of the health sector playing an important role. The District Rehabilitation Centre (DRC) is another new programme which offers a decentralised and deprofessionalised care for the handicapped persons. Other innovations relate to integrated education of the mentally retarded children and foster-parent programme. All these efforts point to a positive trend to examine alternatives for the needs of the country.

Need for National Policy

Mentally handicapped individuals require the efforts of a number of disciplines, namely, health, welfare, education, law, rehabilitation, nursing along with efforts of voluntary agencies. The other aspect of mentally handicapped individuals is the need for longitudinal, in most persons, life-long support of one form or the other. These twin aspects of multi-disciplinary inputs and long-term care call for well coordinated efforts. Such a programme cannot occur without a national policy.

The development of approaches for the needs of the mentally handicapped persons in the country has shown a gradual and definite shift towards the family as a unit. This change in focus of care has been the outcome of the difficulties in providing continuous care in the institutional settings. The cost of comprehensive care by professionals is not only expensive but difficult to link it across all the developmental stages. This would mean that the needs of the family receive appropriate attention from the point of identification in terms of professional expertise and social security. Experiences in India have demonstrated the capacity of the family to form primary care providers with appropriate training, continuous professional help and administrative supports.

DECLARATION ON THE RIGHTS OF MENTALLY RETARDED PERSONS

Resolution Adopted by the General Assembly of the United Nations (on the report of the Third Committee [A/8588] 2856 (XXVI) 20 Dec. 1971.

1. **The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.**
2. **The mentaly retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.**
3. **The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.**
4. **Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.**
5. **The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.**
6. **The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.**
7. **Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.**

The aim of the medical services needs to be chiefly preventive although diagnostic and therapeutic services are essential for the affected. Early and complete diagnosis, not only of the defects and disabilities, primary and secondary, but also of the capabilities and aptitudes of the retarded child should be the first priority. He needs to be rehabilitated and converted into a useful, productive citizen.

– Ms. SAROJ KHAPARDE
Union Minister of State for Health & Family Welfare. (All India Seminar on National Policy for Mentally Handicapped, Hyderabad, Feb 3, 1987)

Objectives

(1) To evolve a policy concerning health, education, social security and legislative measures for improving the quality of the life of the mentally handicapped persons in the country.

(2) To ensure availability and accessibility of basic care for all the mentally handicapped persons in the foreseeable future, and

(3) To promote community participation and stimulate efforts towards self-help in the families of the mentally handicapped individuals.

Strategies for action

Recent advances have provided some insights into the causes of mental handicap and many of them are preventable. In India, there is an urgent need to improves pre-natal and post – natal care, to prevent mental handicap.

Early identification: The damage to the brain and the delayed develop-

FAMILY AS THE UNIT

It has been internationally emphasised that the organisation of services for the mentally handicapped citizens should have the family as the focus. This would mean that: (i) family should be the unit receiving care, (ii) regardless of the type of services proposed, parents should not be penalised economically and socially for keeping their child at home, and (iii) the social costs of mental handicap should form the basis of planning of services on how to deal with the problem and not any other consideration.

These principles enunciated in early 1950's have a special relevance to the country due to the family structure, geographical distribution and the current economic and social development.

— From *National Policy on Mental Handicap.*

ment is best recognised at the earliest time possible. There is sufficient experience to show the value of stimulation programmes begun early in life. It has been now recognised that home-care is the most appropriate method of maximising the capacities of the child. Against this background, it is recognised that the different categories of health personnel like community health volunteers, Bala Sevikas, MPWs, health supervisors, medical officers and pediatricians can be oriented to intensify their efforts towards prevention, early identification and guidance for home-care.

Care including rehabilitation: The approach to provide services to all the mentally handicapped persons would bringforth the needs for rehabilitation programmes beyond those provided by home training, special schools and vocational training. Specific efforts are to be made for rehabilitation at the district level, along the lines of DRC with active community participation.

National Trust: The care of the persons with mental handicap requires to be organised with a national perspective to achieve social security and bring together mechanisms to ensure quality of life. This would require the formation of a **National Trust** for the welfare of mentally handicapped as a means to provide social security. The objectives of the Naional Trust will be to provide guardianship, foster care, mobilisation of resources to strengthen the family and the community.

Special school units: As a first step, there is need to start special school units at the district level all over the country. In order to provide services for individuals with multiple handicaps, those with severe retardation, school units should also have limited residential facilities. There is need for providing wider opportunities by encouraging voluntary agencies in terms of aid, land etc. to start special schools for the mentally handicapped individuals. Priority should be given to States and Union Territories where such facilities are at present limited or not existing. Steps should be initiated to improve the standards of all training schools. As an immediate measure, there is need to provide short-term courses for all those working in special schools, welfare personnel, untrained teachers and teachers of normal schools.

Pilot programmes: In the last 40 years of planning of services for the mentally handicapped persons, the focus has been on special schools, special institutions for residential care resulting in a very limited coverage of mentally handicapped persons. In line with the current health and welfare policies of the government to provide services with universal coverage and accessibility as focus, it is necessary that pilot programmes be initiated. These pilot programmes should examine the feasibility as well as the operational details.

The new Twenty-point programme (1986) includes the needs of the handicapped citizens as part of the health programme (point 8) as follows: 'Pay special attention to programmes for the rehabilitation of the handicapped'. Thus, the government is already committed to provide services for the mentally handicapped individuals and a comprehenive policy can emerge against the above existing policies and programmes.

From *National Policy on Mental Handicap.*

Community Participation: The scope for community participation is significant in this area. Activities of the voluntary agencies, individuals and groups can lead to prevention of mental handicap. They also have an important role in development of community based programmes, supporting self-help groups, organising mobile services and to act as a pressure group to bring about policy and programme changes. Community participation should not only be supported but encouraged to form the backbone of the services development.

A National information and documentation centre should be established at the central and later at state levels. There is need for **research** to be an important part of the development of the care programme. The following areas should receive urgent attention: (i) Impact of mentally handicapped member on the family, (ii) Effectiveness of preventive measures to decrease mental handicap, (iii) Impact of public education and awareness activities, (iv) Comparative evaluation of different models of care (v) The effect of school integration on handicapped children, (vi) Genetics of mentally handicapped, especially community studies in consanguinous marriages, and (vii) Utility of Yoga for mentally handicapped persons. □

Summarised from **Report on National Policy on Mental Handicap**, Thakur Hariprasad Institute of Rehabilitation for the Mentally Handicapped Children, Vivekananda Nager, Hyderabad – 500 660.

National Seminar on Voluntary Agencies and Mental Health Care

During the last four decades a number of developments in the mental health field have emphasised the values of community care and community participation. Some of these are: (i) the negative effects of institutional care leading to breaking down of social ties of patients and their families and loss of social skills among patients, (ii) results of longitudinal study of patients' illness showing patients in the developing countries have a better prognosis as compared to those in developed countries, (iii) importance of social supports in recovery from stress related emotional problems, (iv) important role of family members play in the care of persons with mental handicap, drug dependence and chronic mental disorders, and (v) identification of activities in the community for promotion of mental health (*CMH News*, Issue No. 3 & 4).

RECOMMENDATIONS

1 The group reviewed the National Mental Health programme for India in detail and found it to be an appropriate approach for providing mental health care services to the community. The participants reviewed the activities of the voluntary agencies and noted that the different developmental and related activities are already promoting mental health, preventing mental disorders and caring for mentally ill persons. The Group also endorsed the significant role identified for the voluntary agencies in the implementation of the National Mental Health programme for India.

2 The Group recognised the special role the voluntary organisations can play in mental health care programmes specifically in the rehabilitation and after care of chronic mentally ill, child and school mental health services, services for drug and alcohol problems and welfare services for mentally retarded persons.

3 Recognising the need for removing the stigma attached to the mental health problems, the group recommends that systematic efforts need to be undertaken by voluntary agencies in educating the public at different levels. All support should be provided to voluntary agencies for undertaking this activity.

4 Considering the need for better rehabilitative services, it is recommended that privillages similar to those offered to other categories of handicapped be extended to the mentally disabled.

5 The Group recommends that essential components of mental health care be formulated and suitably incorporated into the basic and continuing training programmes for the personnel of health, welfare, police, educational and developmental sectors. It is also important to provide opportunities for professionals and staff of voluntary agencies similar training.

6 It is recommended that the government agencies be persuaded to recognise the potentialities of voluntary agencies and to involve them in the delivery of all types of mental health services. All mental health programmes and activities should have components of voluntary action and community participation.

7 In the interest of prevention of disabilities, the Group recomends that community based prevention programmes be initiated, support system be strengthened, and suitable linkages be established with specialised professional services and voluntary agencies.

8 Recognising the potentials of voluntary agencies in developing innovative approaches to mental health care, the Group recommends that such efforts be offered adequate funding and professional support from Governmental and quasi-governmental agencies.

9 Realising the need for better linkages among the voluntary agencies involved with various aspects of mental health care, it is recommended that efforts need to be focused at greater coordination and communication between such agencies and resource centres. As a first step, a comprehensive Directory of Voluntary Agencies should be compiled.

10 The Group recognises the value of current seminar and keeping in view of the utility of the coming together of voluntary agencies, for exchange of ideas and experiences and better communications, it is recommended that such meetings be held periodically.

In consonance with such developments, the National Mental Health Programme for India formulated in the year 1982, aims at **'promoting community participation in mental health service development and to stimulate efforts towards self-help in the community'.**

Role of voluntary agencies

It has been the experience of many experts in the fields of mental health and neurosciences that without involving voluntary agencies, it is impossible to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly, to the most vulnerable and underprivileged sections of population.

In this direction, a three-day programme was jointly conducted by NIMHANS, Bangalore and Schizophrenia Research Foundation (SCARF) India, Madras, at Madras on 21–23, January 1988. A large number of representatives from voluntary agencies (about 40) working in the areas of health, welfare, development, education and allied fields of humanitarian services participated in the programme.

Objectives of the Seminar

The specific objectives of the National Seminar were as follows: 1) To review the ongoing mental health activities undertaken by the voluntary agencies, 2) To sensitise the voluntary agencies to the community care of mentally ill/neurologically disabled and mentally retarded persons, 3) To orient the voluntary agency personnel in respect of the National Mental Health Programme for India, and 4) To develop suitable mechanisms for future activities by the voluntary agencies for the welfare of mentally disabled persons.

The **recommendations** of the Seminar are given in the *box* and list of participant **agencies** in the next page.□

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FILMS ON MENTAL HEALTH

KASAUTI

The 'world of the mentally ill' and 'the different images of mental health' were the subject matter of two of the episodes of **Kasauti** serial aired by the National TV in January 1988.

Mr. Ramesh Sharma, director of the film said, "Basically, Kasauti was trying to focus on marginalised people, people who did not normally come under the scrutiny of everyday life, whose plight was *real*, and whose problems should be given a larger voice. In identifying areas, we felt that mental health was one area that people had so many misconceptions about, there were so many stigmas attached to it, that it was almost like putting these people away from society. Everyone treats mental health patients the way they treat lepers, people who should be in a separate colony. Invariably what has happened is that because of the stigma attached to mental health, in Ranchi, for example most of the patients come from the lower middle class and a rural background. There is almost an attitude of treating them as the scum of the earth, locking them up and forgetting them. We thought that we should research and investigate and find out what actually was the state of mental health in India"[1].

The two episodes focused on: (i) the limited mental health care in India, (ii) the poor conditions of the mental hospitals, (iii) the problems of chronic inmates of the mental hospitals, (iv) poor community acceptence of the recovered mentally ill, (v) the types of abuses that can occur in the institutions, (vi) the limitations of the legal provisions, (vii) the help seeking by the emotionally disturbed from traditional healers, the temples of healing etc., (viii) the role of Ayurvedic system of cure, and (ix) the inadequate undergraduate medical education in mental health.

Part of the programme looks at the **alternative approaches** that are being developed. The most important of these are: (i) the active involvement of the family as a support system, (ii) integration of mental health care as part of primary health care in order to provide services in a decentralised, deprofessionalised manner to destigmatise and demystify mental health care. The ongoing work in the Solur PHC of the **ICMR Centre** for Advanced Research on Community Mental Health was used as an example in the second episode, and (iii) development of active, rehabilitative efforts at all levels especially in mental hospitals with public involvement and voluntary organisations.

In many ways, as the commentary notes, the world of mentally ill reflects the complexity of the large society with many pluses and minuses. The team itself found, "In many ways, the making of this programme was an eye-opener because although we had known and heard about the callous state of affairs in our mental health asylums, we were shocked beyond words to see that it was even worse than what we thought it was. In spite of the fact that over the years there have been a lot of medical advances, and the categories in mental health have been so well defined, you find that antiquated ideas of a mental health patient as a chronic looney, as someone to be locked away, still prevail. **We found that in the bleak scenario that we were travelling through, there were a lot of people with a lot of courage, a lot of conviction, and a lot**

THE KYOTO PRINCIPLES 87*

The participants at the International forum believed that, in the absence of a clear set of international standards for the protection of the mentally ill, it would be useful to define a set of basic principles. These were accepted unanimously by all at the forum and were signed on their behalf by the panellists. They are:

1. **Mentally ill persons should receive humane, dignified, and professional treatment.**
2. **Mentally ill persons should not be discriminated against by reason of their mental illness.**
3. **Voluntary admission should be encouraged whenever hospital treatment is necessary.**
4. **There should be an impartial and informal hearing before an independent tribunal to decide, within a reasonable time of admission, whether an involuntary patient needs continued hospital care.**
5. **Hospital patients should enjoy as free an environment as possible, and should be able to communicate with other persons.**●

* Recommendations of the International Forum on Mental Health Law Reform, Organised jointly by the Japanese Society of Psychiatry and Neurology and the International Academy of Psychiatry and Law, Kyoto, January 1987 (From **Lancet** March 21, 1987 p. 676–677).

AGENCIES REPRESENTED IN THE SEMINAR

1. **St. Joseph's Bala Sadanam,** Trichur 2. **Dr. Durgabai Deshmukh School and Training Centre for Mentally Retarded,** Madras. 3. **Samadhan,** New Delhi. 4. **Nandavan, School for Mentally Retarded Children,** Nagpur. 5. **Vikas M.M. Farms,** Bangalore. 6. **Medico-Pastoral Association,** Bangalore. 7. **T. T. Ranganathan Clinical Research Foundation,** Madras. 8. **Sneha,** Madras. 9. **Chetna,** Lucknow. 10. **Federation for the welfare of the mentally retarded,** New Delhi. 11. **Assseciation for the Mentally Handicapped,** Bangalore. 12. **Snehasadan,** Bombay. 13. **Indira Memorial Institute for Effective Thinking and Human Relations Society,** Guntur. 14. **Family Service Centre,** Bombay. 15. **Rotary-Save the Children Fund,** Visakhapatnam. 16. **Kiriya Pushpa Family Helper Project,** Mysore. 17. **Vivekananda Girijana Kalyana Kendra,** Mysore. 18. **Young Women Christian Association,** Coimbatore. 19. **Enedsa,** Mysore. 20. **Janatha Kendra,** Mangalore. 21. **Elmhrist Institute of Community Studies,** Santiniketan. 22. **Nehru Institute of Youth Affairs,** Bhubaneswar. 23. **Young Women Christian Asssciation,** Madras. 24. **Directorate of Health & Family Welfare,** Madras. 25. **Indian Institute of Youth Welfare,** Nagpur. 26. **Youth for Unity and Voluntary Action,** 8, Bombay. 27. **Don Bosco Illam,** Madras. 28. **Abhaya,** Trivandrum. 29. **Sanjivini Society for Mental Health,** New Delhi. 30. **Manovikas Kendra,** Bangalore. 31. **Atma Shakti Vidyalaya,** Bangalore. 32. **Fraternal Life Service Home,** Pondicherry. 33. **Clarke's School for Mentally Retarded,** Madras. 34. **Concern** (India), Madras. 35. **Punjab Association,** Madras. 36. **Schizophrenia Research Foundation** (SCARF) Madras. 37. **National Institute of mental health & Neuro Sciences,** Bangalore. ●

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of committment who were moving in the right direction".

The national broadcast of **Kasauti** is one reflection of the willingness of the society to examine issues and confront them in their true reality. □

1. *Health for the Millions*, Vol. 14, No.1, 1988, p. 24-25.

Forgotten Millions

The topic of care of mentally ill in four countries formed the subject matter of the UK–ITV broadcast "Forgotten Millions" (March 31, 1987). The broadcast covered the problems and prospects of mental health care in Japan, USA, India and Egypt. The Japan section of the feature, focused on the problems of the large numbers of persons admitted to mental institutions (250 for every 1,00,000 pop.) The issue has been the focus of many enquiries and recommendations. (Kyoto principles p. 7).

The other side of the mental health care issue is the deinstitutionalisation in USA. For example in New York the number of inpatients has fallen from 93,000 in 1960 to less than 20,000 in 1987. As a result of this, now thousands of mentally ill, 'wander the streets with no hope of getting treatment or ever finding accommodation'. The issue focuses on premature closure of mental hospitals and the lack of adequate community care facilities.

The Indian section of the feature highlights the problems of poor conditions of the mental hospitals in India as well as the extremely limited facilities (20000 beds for 750 million pop.). The second part of this section describes two innovative approaches of NIMHANS, Bangalore. These are the 'Satellite Clinics' and efforts to integrate mental health with primary health care. The latter experience refers to the project MENTAL HEALTH IN PRIMARY HEALTH CARE of ICMR Centre for Advanced Research on Community Mental Health at NIMHANS, Bangalore. Dr. Narayana Reddy, Director, NIMHANS, expressed the view that all the professionals in institutions for the mentally ill should spend one day a week working in the rural areas. Dr. R. Srinivasa Murthy in an interview session shared "we use drugs in lesser quantities and for lesser duration than in the hospital. Secondly the community itself forms part of therapy. We are making it possible for people to pick up their life without symptoms, so that society will accept them rather than drugging them to be quiet in the community".

The Egypt experience focuses on the innovative work at the MOKATTAM HOSPTIAL with emphasis on community activity.

The feature was directed and co produced by Dr. David Cohen. The other coproducer was Ms. Joan Shenton. The 7 member ITV team spent 3 days in the villages of Bangalore district filming for the telecast. Dr. Cohen noted that **there is a kind of vicious circle surrounding the problem of the mentally ill. Every generation proclaims a magical new solution, but these solutions in turn create unexpected difficulties'.** Further, **'the need is for efforts to go into pursuing community care and putting the money, imagination and local variations into it that make it work. This requires less negativism and more optimism'.** □

(Based on reports from **Lancet,** March-21, 1987 and the **Listener,** 2 April 1987).

Members of ITV crew (inset) **in action at Banavadi village (Solur).**

COMMUNITY MENTAL HEALTH NEWS
Issue No. 9, Oct-Dec, 1987

The **Community Mental Health News** is published by the ICMR centre for advanced research on community mental health, to keep the professionals, planners, administrators and the interested public informed about the development of community mental health care programme.

Copies of **Community Mental Health News** are mailed free on request by interested professionals and institutions.

We are interested in exchanging a few copies of this journal, on reciprocal basis, with other medico-health publications. We would like to obtain information on projects/research findings/field work reports relating community mental health programmes in our country.

Letters, comments and communications should be addressed to: **The Editor, Community Mental Health News, ICMR Centre for Advanced Research on Community Mental Health, NIMHANS, Bangalore – 560 029, (India).**

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COMMUNITY MENTAL HEALTH NEWS

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EDITORIAL

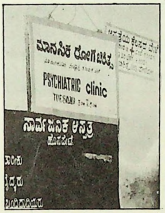
District Mental Health Programme

During the last ten years the development of models for mental health care have gradually become more and more sophisticated in terms of methodology. The initial studies related to small groups of 30 to 40 thousand population. These studies illustrated the feasibility of integrating mental health care with general health services with adequate support and supervision from the professionals. But critical examination of these experiences by experts showed that models with these ranges of population would be too limited for wider application and the inputs from mental health professionals were excessive.

Against this background the starting of District Mental Health Programme at Bellary is a major development in the mental health planning in our country. Currently, we not only have plans for an average size district of over 1.5 million population but also have the details of the type service, level of care and the mechanisms for monitoring the programme.

This issue of **Community Mental Health News** brings together the evolution, strategy of action and results of the first three years of the Programme for wider circulation among the mental health professionals and planners.

– **Dr. R. SRINIVASA MURTHY**
(Editor)



Top left: **A sign board of the newly started psychiatric clinic at Hospet Gen. Hospital.** *Right:* **A female health worker visits a patient's home.** *Below:* **Dr. Venkatesh Murthy, Med. Officer of Karur PHU, Siruguppa, interviewing a patient and her family members.**

In this issue

ICMR Centre for Advanced Research on Community Mental Health NIMHANS, Bangalore.

District Mental Health Programme at Bellary

BELLARY AT A GLANCE

Area	: 9,907 Sq. Kms.
Population	: 14,03,311 (1981 census)
Taluks	: 8
Major Towns	: 2; Bellary (Pop. 2,01,579); Hospet (Pop. 1,40,130)
Places of Historic Importance	: Hampi – the famous Capital of Vijayanagar Empire.
Other places of interest	: Thunga Bhadra Dam.

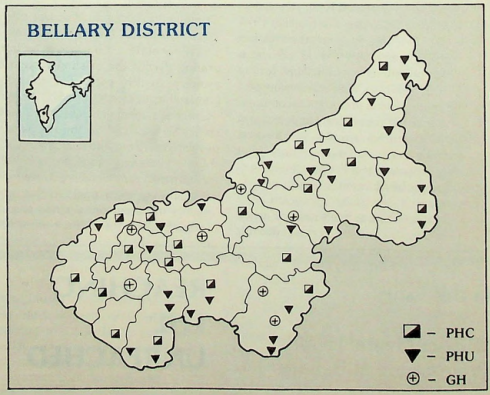
Introduction

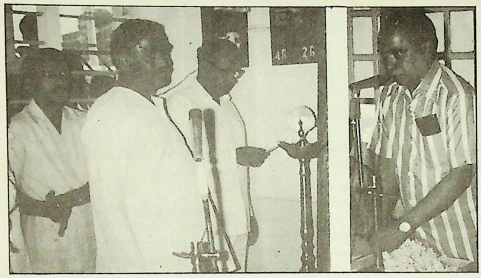
Care of the mentally ill, in most of the developing countries including India, particularly in the rural areas, has been neglected. It is widely believed that mental illnesses are caused by demons, spirits and black magic and that they are cured only by religious, magical and other traditional methods. Health planners, administrators and the medical professionals too are unaware of the wide prevalence and suffering caused by mental disorders. The wide ranging misconceptions and ignorance of the population has resulted in poor demand for modern services. In a broader context, public health services are receiving a low priority in terms of resource allocation and mental health in particular has had the least share of public health expenditure. Most of the limited currently available services are institution based and situated in urban areas — either in large custodial and archaic mental hospitals or in psychiatric units attached to general hospitals.

The past 30 years have witnessed many remarkable developments in the care of the mentally ill in India. *(CMH News,* Issue No 1) The various general population surveys of mental illnesses carried out in different parts of the ountry during 1960's and 1970's, demonstrated that these illnesses are as common in India as it is elsewhere and are equally common in rural as well as urban areas. The surveys indicate that the number of people suffering from serious and incapacitating neuropsychiatric condition needing urgent attention, in the whole country, are in the range of several millions (*CMH News,* Issue No 2). During the same period from the 'Mental Hospital' base, the care of the mentally ill slowly shifted to the general hospital setting. This brought on a new type of care for larger number of mentally ill persons mostly from the urban areas. General hospital psychiatric care meant shorter hospitalization and more active involvement of the family members in the care as against the well known long-term custodial care in the mental hospitals without involvement of the family.

Steadily increasing (though slow) number of trained mental health professionals, improved facilities, especially in the urban areas have assured better care. However, this has been only for those who have access to these available services. Currently, early recognition, management with appropriate psychopharmacological agents and properly organized rehabilitation programmes can control symptoms as well as prevent secondary handicap for most mental disorders. However, unfortunately this 'mental health know-how' has not reached over 90 percent of those who are urgently in need of it due to the highly centralised and professionalised nature of the existing mental health care services as well as the paucity of resources and lack of public awareness.

To bridge the wide gap between the enormous mental health care needs of the country and the meagre resources (trained personnel, beds, finances etc.) available in the country, **integration of mental health with the existing general**





Dr. H.L. Thimme Gowda, Minister for H & FW, inaugurating DMHP at Bellary on 20 July 1985. Others in the Picture are Mr. M. Ramappa, MLA, Bellary and Dr. V.G. Shetty, DHO Bellary. *Right:* Dr. J.L. Javare Gowda, DHS, speaking on the occasion.

health care services, was thought of as a feasible and appropriate approach. The growing consensus amongst experts in the field — national and international — is , 'decentralisation and integration of mental health services with the general health services by training the existing general health care personnel to provide basic mental health care'.

An expert committee of the WHO on 'Organisation of Mental Health Service in Developing Countries' which met in 1974 (WHO 1975) urged the member states to recognise mental disorders as a problem of high priority for the individual, for the community and for national development and made several important recommendations. The committee recommended that: **"Countries should, in the first instance carry out one or more pilot programmes to test the practicability of including basic mental health care in an already established programme of health care in a defined rural or urban population".** It further recommended that "training programmes, including a simple manual for the training of health workers should be devised and evaluated".

During 1975-76, major community mental health care experiments were launched at Bangalore and Chandigarh to test the feasibility of shifting the care of the mentally ill from the 'hospital' to the 'community' and from the 'mental health specialist' to the 'primary care physician'.

Community Mental Health Unit at NIMHANS

The Department of Psychiatry at National Institute of Mental Health and Neuro Sciences (NIMHANS) focused its attention on extending mental health services into the community as early as 1975. A specially designated and staffed 'Community Psychiatry Unit' was established. **The main aim of the Unit was to extend mental health services by integrating it with the existing system of primary health care.** For this, the primary health care staff had to be trained in basic mental health care. More specifically, the task of the unit was to develop, carry out and evaluate suitable short-term training programmes in basic mental health care for different categories of health care personnel, so that after training, these personnel could provide mental health care in their respective areas of work.

A rural community mental health and training centre was established at **Sakalawara** (Anekal Taluk) near Bangalore in 1976. Initially a service programme was developed and feasibility exercises were carried out in the villages around Sakalawara. Based on these experiences, simple manuals of instructions and short-term training programmes for medical officers and multipurpose workers of PHCs were developed (*CMH News* Issue No. 1). Pilot training programmes were carried out and evaluated at Primary Health Centres at Malur and Anekal (Kolar and Bangalore Districts, Karnataka State). These pilot programmes helped the unit to crystallize the educational objectives for the mental health training of PHC personnel and meaningfully revise and rewrite the manuals of instructions in basic mental health care.

Since 1982, every month, regular training programmes for medical officers and health workers, working in various PHCs and/or PHUs of Gulbarga and Mysore divisions (Karnataka state) and deputed by the Department of health and family welfare are held at the rural mental health centre at Sakalawara. These are held in small batches of 5-15 persons and are residential. The health workers' training is for a period of 6 days while the medical officers' training is for 12 working days. The training is routinely evaluated by pre and post-training assessments. So far, more than 400 medical officers and 600 health workers have participated in this training.

The regular monthly training programmes and their evaluation facilitated frequent reviews and whenever necessary, revisions of the 'training package', namely, education objectives, methodology of training, time allotment for various activities, manuals of instructions, tools of pre and post-training assessments and simple records for mental health care at PHCs. After several revisions, the rewritten 'Manual of Mental Health for Multipurpose Workers' and 'Manual of Mental Health for Medical Officers' are currently available in printed form for wider use (*CMH News*, Issue No. 1). Similarly, the instruments for evaluation of the training also have been standardized.

Evaluation of work carried out by trained PHC personnel

While it is acceptable that the mental health training can be evaluated in a limited way by pre and post-training

Need for Developing a District Model for delivery of Mental Health Care

1. **Earlier efforts to integrate mental health with PHC involved only population of 40,000 to 60,000 and personnel of one PHC**
2. **Field level evaluation of trained PHC personnel highlighted the need for developing a district model.**
3. **NMHP envisages implementation of the programme atleast in one district of every state in the country, within a specific period of time.**
4. **All health care and welfare programmes are implemented and monitored at a district level.**

assessments which would give an indication of the knowledge gained by the trainees, the ultimate criteria for evaluation will have to be the ability of the primary health care team to recognize and manage the mentally ill in their PHCs thus bring down the overall neuropsychiatric morbidity. In a few 'micro level' pilot research projects carried out in either in part of or a whole PHC involving a limited number of personnel, it had already been shown that mental health care can be provided at the PHC level by trained PHC personnel.

Following the training, when a follow-up visit was made the doctors and health workers in the centres visited had undertaken mental health care activities to varying extent. Some of the centres and personnel had done excellent work while others had done very limited amount of work.

There appeared to be problems because of the small number of health workers trained from each PHC. Population coverage wise, they accounted only for a small percentage of the total population of the PHC. In some PHCs the trained doctors talked to all the health workers to identify, refer and follow-up cases and impart mental health education. Many of the cases presently being managed by the doctors, were identified by themselves from their daily clinics.

None of the health care personnel interviewed felt that their work load had increased because of this programme, while many feared that as the number of cases identified and managed increases, the work load too might increase. It was noticed that the work of the health personnel could have been better if several of their following administrative and supervisory needs were fulfilled: (i) provision of minimum number of essential psychotropic and antiepileptic drugs on a regualr basis, (ii) provision of simple recording and reporting method, (iii) involvement of all the health care personnel, of the PHC/district belonging to various categories, (iv) regular supervision and monitoring of the programme at all levels, namely, PHC, district, division etc., (v) availability of specialist referral facilities, (vi) provision of material for public mental health education, (vii) facilities for continued learning of trained personnel (refresher courses), and (viii) to improve public understanding and acceptance of PHC as places of treating mentally ill and epileptics. **The field level evaluation of trained PHC personnel highlighted the need for planning mental health care at a district level.**

Genesis of the Bellary District Mental Health Programme

By 1983-84 in addition to the ongoing work of the community mental health unit at NIMHANS, few other projects had practically demonstrated that primary health care system can provide mental health care at the community level. Notable amongst these are the "Strategies for Extending Mental Health Care" a WHO multicentre collaborative study with a collaborating centre at Chandigarh and the ICMR-DST (Indian Council of Medical Research - Dept. of Science and Technology) 'Severe Mental Morbidity Project' carried out at 4 centres in the country, namely, Bangalore, Calcutta, Baroda and Patiala. Few other experiments from centres like Vellore, Lucknow, Jaipur and Hyderabad also added to the growing evidence for community based mental health care by general health staff. By then, the 'National Mental Health Programme' (NMHP – 1982) for India was also approved by the Central Council of Health and family welfare for countrywide implementation (*CMH News*, Issue No. 1).

A result of these developments was the increasing realization that further work was needed to consolidate the gains and achievements of the previous few years. The existing know-how of integrating mental health with primary health care had to be operationalized and applied to larger areas and target populations. The already proven methods of training, the PHC personnel, manuals, curricula, training aids of different types and methods of evaluation had to be applied in a wider setting. The district level psychiatric facilities of referral and consultation by the PHC Teams had to be developed. Above all, the National Mental Health Programme, already approved for implementation, envisaged the operationalization of the programme 'in at least one district in every State and Union Territory, and in at least ½ of all the districts in some States within five years'. It is proposed by the NMHP that specialized psychiatric services be made available at the district level. It would be the responsibility of specialist health personnel at the district level to provide training and supervision to the workers at the primary health centre level. So, it was in the light of all these specific issues and as the next logical step in the implementation of the National Mental Health Programme that the 'district mental health programme' was developed by the community mental health unit of NIMHANS.

During the field level evaluation visits in 1983 to several peripheral health care institutions by a team of the community mental health unit of NIMHANS, headed by Director and Senior Officers of Department of Health and Family Welfare, Karnataka, many health workers reported that, while they had identified

and referred many cases of mental illnesses and epilepsy, most of them had not actually come to the PHCs and PHUs for assessment and initiation of treatment. Since the number of neuropsychiatric patients seeking treatment at the peripheral health institutions were low, many PHC doctors including their supervisory officers like the District Health Officer (DHO) had doubts about the actual prevalence of these disorders in the rural community. Therefore, aimed at demonstrating to the rural public that mental illness and epilepsy could be assessed and managed at health institutions close to their villages by trained health personnel and demonstrate to the medical officers and their administrators like the DHO that large number of persons suffer from these conditions in their own PHCs, mental health camps were conducted in one of the districts of Gulbarga division, Bellary.

Information about these camps were given to the public by the health workers and these mental health camps were actually organized and conducted by trained PHC staff with the assistance of resource persons from NIMHANS. Such camps were held at Siruguppa, Hadagally, Harappanahally (Taluk Hq. towns) and Bellary from 18.09.1983 to 01.10.1983 and large number of mentally ill and epileptics (ranging from 135 to 300 at each centre) were examined and treatment initiated. They were advised to visit PHCs/PHUs where trained personnel worked, close to their villages for follow-up. This opportunity was also utilized for public education by group meetings and exhibitions on mental health. A major outcome of these camps was the sensitization and increased awareness of health officials particularly the DHO (Dr. K.B. Makapur) of Bellary District regarding the need for organizing mental health services in the periphery — both at the district headquarters and the peripheral health institutions.

Following the above experience, District Mental Health Programme (DMHP) was developed over a period of several months during 1984-85. The decision to take up Bellary as the district for developing implementing and evaluating DMHP emerged following the evaluation of April 1983 and the mental health camps in several places in the district in Sept-Oct. 1983. Following a series of meetings of NIMHANS team with the district health office team and the Deputy Commissioner of Bellary, it was decided that the DMHP be taken up as a joint project of Dept. of Health and Family Welfare, (Govt. of Karnataka) District Administration, Bellary and NIMHANS. At a meeting, held at Bellary in May 1985 attended by Dr. G.N. Narayana Reddy, Director NIMHANS, Dr. C.Prasanna Kumar, Joint Director (Health Programmes & Planning), Directorate of Health and Family Welfare, Govt. of Karnataka and Mr. Sudhir Kumar, Deputy Commissioner, Bellary and their respective teams, the joint project was formalized.

HEALTH CARE FACILITIES IN BELLARY DISTRICT

Medical College	:	1
Primary Health Centres	:	23
Primary Health Units	:	28
General Hospitals (Taluk)	:	7
Govt. Allopathic Dispensaries	:	18
Urban Family Welfare Centres	:	6
National Leprosy Control Centres	:	4
No. of Medical Officers	:	77
No. of Health Workers (Male – 268; Female – 353).	:	621

It was agreed that NIMHANS will continue to offer technical inputs in terms of training, monitoring and evaluation of the programme, the district administration will ensure the funding for adequate and regular supply of drug requirements (estimated expenditure Rs. 50,000/- per year) and printing of records for health personnel and the Directorate of Health and Family Welfare services will implement the programme through its existing infrastructure and personnel. In addition the directorate also agreed to spare the services of one of its medical officers (Assistant Surgeon) with experience of programme administration to oversee the DMHP at the district level (Programme Officer) and meet his transport needs (Vehicle, driver and POL) to tour the district regularly.

The DMHP was formally inaugurated at Bellary by the then Health Minister of Karnataka Dr. H.L. Thimme Gowda on 20th July 1985. The inaugural function was attended, in addition to a large number of the general public, by members of the legislative assembly from the District, Mr. B.Shivarama Reddy, Mr. M.Ramappa and Mr. C.M. Revana Siddaiah, Dr. J.L. Javare Gowda, Director of Health Services, Dr. G.N. Narayana Reddy and Mr. Sudhir Kumar.

Aims and objectives of the DMHP

The general aim of the District Mental Health Programme is to extend mental

Advantages of planning mental health care at a district level

1. **The district is an independent administrative unit with district commissioner as the head.**
2. **DHO, has powers of planning activities in the district.**
3. **Monitoring of programmes occur at the district level.**
4. **Inter-sectoral coordination is possible at the district level.**
5. **Mobilisation of additional resources is possible.**
6. **All existing staff can be best utilised by involving the total district for care programme.**
7. **A district, not a PHC, is the planning and implementation unit for most other health and welfare programmes.**

health services to the severely mentally ill persons in the district through the existing health care personnel and institutions. The more specific objectives of the Programme are:-

1) **To develop and implement a decentralized training programme in mental health for all categories of health personnel, appropriate to their levels of functioning with least disruption to the ongoing general health care activities.**

2) **To provide a minimum range of essential drugs for treatment of severely mentally ill persons at all peripheral health care institutions.**

3) **To develop a system of simple recording and reporting of care by health care personnel.**

4) **To monitor the effect of the service programme in terms of treatment utilization and outcome with treatment.**

5) **To develop mechanisms of community participation in the mental health care programme through planned activities.**

6) **To study the cost-effectiveness of the programme.**

Towards achieving these objectives the DMHP has several components, namely, (i) Training of personnel, (ii) Provision of Drugs, (iii) Simple recording system, (iv) District level programme officer & his team (v) District Mental Health Clinic, (vi) Review cum training as part of visits to the periphery, (vii) Weekly mental health clinics in the periphery, (viii) Monthly reporting, monitoring and feedback, (ix) Community participation, and (x) Field Training for MH professionals.

Training of Health Personnel

Services for the mentally ill can become an integral part of the general health services, only if all categories of personnel are trained to carry out routinely, the mental health care tasks assigned to them.

It would not be possible to effectively and meaningfully launch a mental health programme, if most of the personnel in the district are not trained within a reasonable period of time. Deputation of large numbers of these personnel to Bangalore can cause disruption of their routine ongoing work. The 2-week training module has no planned facility for refresher inputs to the trainees to clarify their doubts which arise after their using the knowledge gained through the initial training. Continuous 'on-the-job' inputs though of short duration can be very beneficial to trained personnel. Therefore, a 'decentralized training' strategy was developed.

The training was to be carried out for different categories of personnel separately and wherever the numbers were high, in batches of manageable numbers. The broad approach of training was to impart to the trainees not only new knowledge about mental illnesses but also the ability to identify and manage all the mentally ill in their community. The educational objectives of the training were to teach the personnel to carry out various tasks already identified. The training was to be decentralized and carried out at the district headquarters and taluk headquarters towns. It was to be divided into 3 different sessions of 1 to 3, each held at intervals of few months. This would enable the trainees to bring back difficulties in implementation of the programme, so that they could be discussed and clarified. Manuals of instructions (for doctors and health workers) already developed for this purpose, would be made use of for the training.

Thus, the training for PHC personnel at a district level was as follows:

a) ***Medical officers:*** Total trianing days - 9, in 3 sessions of 3 + 3 + 3 days with an interval between sessions of not less than 3 months, and in batches of not more than 25.

b) ***Multipurpose workers:*** Total training days 4 - in 3 sessions of 1 + 2 + 1 day with an interval between sessions of not less than 3 months. One batch could consist of all the health workers in a PHC and venue of the training may preferably be the PHC itself.

c) ***Health supervisors*** (health inspectors and lady health visitors): Total training days - 4, in 2 sessions of 2 + 2 days with an interval period between sessions of not less than 3 months. The training can be either at district headquarters or one or two taluk headquarters. In addition, the supervisors would be expected to attend the training for multipurpose workers.

d) ***Community health volunteers:*** Two days of training preferably during their initial 3 months training period. The CHVs should be called for a 2 day training at the PHC level to be carried out by trained medical officers, and health supervisors.

e) ***Block health educators:*** The block health educators of each PHC (generally, one in each PHC) could join the programme of health supervisors i.e., 4 days in 2 sessions of 2 + 2 days.

In addition to the above mentioned formal training for larger groups of personnel, informal 'on the job' training inputs will continue for personnel of PHC by a district mental health team visiting PHCs regularly once in two or three months, preferably on a fixed day of the week which could be designated as the weekly 'Mental Health clinic' day when most of the old and new patients of the PHU/PHC could visit the centre for their follow-up consultation.

While training in mental health for medical officers, multipurpose workers and other functionaries is important for identification and management of the needy population, the programme would be successful only if it is regularly supervised and monitored at the district and sub-divisional levels by the DHO and ADHOs. Therefore, even the supervisory officers at the district level were appropriately oriented and sensitized to the mental health needs of the population.

Training for Medical Officers

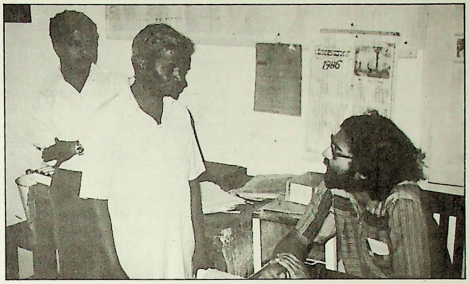
The total number of medical officers practising the allopathic system, working in various health institutions of the district and coming under the administrative con-

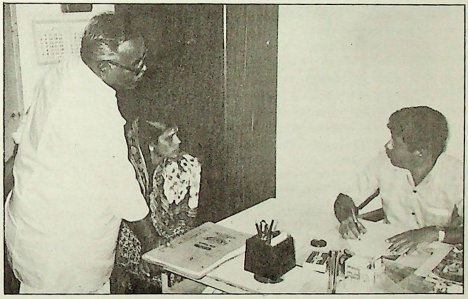
trol of district health officer in Bellary in 1984-85 is around 75. The doctors were trained in 3 batches for 3 consecutive days at Bellary. The training was carried out by a faculty of two psychiatrists from the community mental health unit, NIMHANS.

The primary objective of the training was to sufficiently sensitize the medical officers to mental health problems in the community and demystify the management of common psychiatric problems. They were told about the extent of mental health problems in the community, need and strategy of integrating mental health with primary health care and their role in its implementation. Of the three training days available, the first day's morning was spent for these topics. In addition, a pre-training assessment of their present mental health knowledge was also carried out during the 1st day morning. They were shown short video recorded interviews of the patients suffering from different psychiatric conditions and were asked the diagnosis, management and prognosis.

During the afternoon session of the first day, the basis of normal human behaviour was discussed, reviewing the structure and functions of the brain and the factors contributing to the understanding of behaviour — biological, psychological and sociocultural. In the light of this understanding of normal human behaviour, the various abnormalities that can take place to produce mental illnesses of different types, were then discussed. The various features, types, causes and treatment of mental disorders in general was also covered.

The whole of second day was utilised for teaching 'psychosis'. After discussing their (the trainees) general reactions to a severely mentally ill patient, the approach





Top: **Dr. Sekar Seshadri, Lecturer in Psychiatry, NIMHANS, reviewing the diagnoses of a patient at Mariammanahally PHC. Dr. Krishna Murthy, MOH, is also seen.**

Middle: **Dr. Muralidhar, Former Programme Officer, DMHP, examining a patient at District Clinic at Bellary.**

Below: **Three Lady Medical Officers taking the history of a patient during a training session at Bellary.**

to a psychotic patient — history taking and examination — was discussed, followed by clinical features, types and practical management of psychosis. The emphasis was mainly on giving the doctors to diagnose and satisfactorily manage psychotic conditions, and hence the practical work of interviewing and diagnosing as many actual cases as possible was given the maximum priority in the allotment of training of the second day. Carefully prepared video recordings of interviews with psychosis patients highlighting the symptomatology, and clinical presentations were also demonstrated and discussed.

On third day, the morning session was spent for discussion on epilepsy. The doctors' basic pre-training knowledge regarding epilepsy seemed to be much better than their knowledge of mental illness and hence there were large number of questions, doubts and clarifications. Although neurosis, mental retardation and other childhood problems are to be covered in detail during the second phase of training, are also briefly touched upon. The afternoon is mainly made use of for discussion on the problems which are likely to come up in the implementation of the mental health care programme all over the district. There is no post-training assessment. The doctors were assured about the availability of drugs at the PHCs and PHUs.

Following the initial training, all the medical officers were to identify and manage cases from their clinics as well as cases referred by the health workers from the community. They were also required to maintain simple records, follow-up the cases regularly and refer cases which they could not manage to the District headquarters. Essential drugs were made available at all peripheral institutions. The progress of the mental health care programme was reviewed every month during the monthly conference of medical officers.

The second phase of the training was carried out after a few months. This 3-days training begin with an assessment of the doctors' knowledge of mental health care. The assessment was carried out to ascertain how much of mental health care knowledge the doctors had retained, after the initial phase of training and accordingly develop the curriculum and methodology for the second phase of training. The doctors had difficulty in differentiating schizophrenia, reactive psychosis and depression. While they knew the common drugs and their dosage, they were unsure of dosages and duration of treatment for specific conditions.

To facilitate development of diagnostic and management skills, most of the time during the 3 days was used for practical demonstration of cases and discussion of cases worked up by each of the trainees. Emphasis is also laid on nonpharmacological management of non-psychotic psychiatric disorders.

Provision of Drugs

Earlier efforts at integrating mental health with primary health care had shown that availability of five basic psychotropic drugs (Tab. Chlorpromazine 50 mg./100 mg., Tab. Imipramine 25 mg., Tab. Trihexyphenidyl 2 mg. Inj. Fluphenazine and Tab. and Tab. Phenobarbitone 60 mg.) at the primary health centre/unit was very essential for the successful implementation of the programme following the training of the health care personnel. All these drugs are routinely not available in the PHCs and these drugs are generally not included in the supplies to the periphery from the state level general medical stores. Therefore specific efforts were made to generate the necessary funds to supply minimum amounts of essential drugs during the first one or two years of the programme to every peripheral health care institution, in Bellary district.

This crucial assistance for the starting of the district programme — initially Rs. 20,000 and later Rs. 50,000 annually came from the district administration from the district development funds, and was sanctioned in 1984-85 by the then Deputy Commissioner of Bellary district Shri Sudhir Kumar. The availability of these funds helped in the launching of the programme all over the district. Subse-

Community Awareness and Participation Activities

For any effective community oriented programme we need to look into the 4 Ps: Political or Planners' commitment, Professional commitment, Progress in the mental health know-how, and Participation of the community (Srinivasa Murthy, 1985). Community participation, according to NIPCCD Manual (1984) is a coglomeration of activities which enable the community to: (a) be aware of its needs and problems, (b) enrich the knowledge about services and facilities in operation, (c) get conviction about the efficacy and usefulness of those services, (d) develop an understanding about its participation and contribution, and (e) involve consciously and actively in the implementation of new strategies for practice.

Considering its value and importance, all efforts have been taken from the very inception of Bellary District Mental Health Programme to ensure community awareness and strengthen its participation in a wide range of activities related to mental health care.

Mental Health Camps: The mental health camps organised at Siruguppa, Hadagally, Harappanahally and Bellary in the year 1983 had sown the seeds of public awareness about mental health problems and services. Large numbers of mentally ill, ranging from 135 to 300 were examined and teatment initiated. The overall effect of these camps was the increased awareness of the public about mental health problems in their community, and the facilties for treatment available near their homes. It also sensitized the health officials regarding the need for organising mental health services beyond the District Headquarters setting.

District Mental Health Committee: A District Mental Health Committee was formed as part of the District Health and Family Welfare Committee. This committee headed by the Deputy Commissioner having the representatives from different departments like Education, Social Welfare and Development enhanced the process of

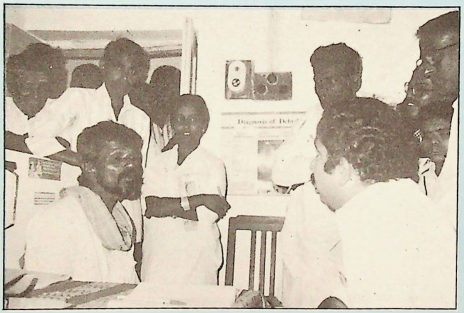
communication and interaction between health and other departments which in turn represents the intersectoral cooperation at higher levels of administration.

Orientation to Media Personnel: It is important that personnel involved with mass media activities — Newspapers, magazines, A.I.R., News agencies, State and Central wings of Publicity are oriented towards the facts of mental health problems as well as newly introduced services in the district. Accordingly, one day programme was organised for the representatives of the mass media personnel. they were adequately helped to incorporate the mental health matters into their day-to-day media activities. As a result of such efforts, the mass media personnel gained scientific awareness about mental health problems and transmitted the same to the public through their respective media.

Interaction with Social Welfare Personnel: Social welfare personnel like superintendents, teachers, case workers, supervisors, wardens and others working in the Remand Home, Junior/Senior Certified schools, and other institutions were met and group discussions were held. During such sessions, the focus was made on issues related to mental health risks of delinquents, orphans, deserted individuals, destitute women and physically handicapped. Later, the welfare personnel were met periodically to strengthen the impact of orientation programmes conducted initially.

Contact with Voluntary Agencies: In order to enlist the support from the Voluntary agencies for mental health programmes, professionals' participation in the meetings of Rotary Club, Lions Club, Croftons (Ladies) Club, Youth Clubs, Mahila Mandals and other allied agencies was proved to be fruitful. Initially, these collaborative activities with voluntary agencies would seem to be challenging, but in due course of time with the continuous and consistent efforts of the professionals, they became rewarding and enriching experience.

Orientation to Zilla Parishad Members: Initial efforts were taken to discuss with the Chief Secretary and the Deputy Commissioner and later with the President of Bellary Zilla Parishad regarding the issues related to mental health services in the district. Their positive responses and support, in fact gave a fillip to the programme. Subsequently, a brief orientation programme was arranged to other members of the Zilla Parishad. The details pertaining to the beneficiaries, the nature of help, the importance of public involvement and related issues were briefed to the august gathering of the MLAs, MPs, Zilla Parishad members, VIPs of the Bellary District, Mass Media personnel and the public in the monthly meeting of the Zilla Parishad. As a result of such interactions, the Zilla Parishad members felt that these orientation programmes need to be held at Mandal Panchayat level so that local involvement could be intensified.



Dr. R. Parthasarathy, Asst. Prof. of PSW, NIMHANS, demonstrating symptoms of a patient to a group of HWs at Hollalu.

Booklets: Specific booklets both in Kannada (6,000 copies) and in English (1,000 copies) on District Mental Health Programme were printed for the communication to the Youth Clubs, voluntary agency members, staff of Welfare institutions, teachers, Mandal and Zilla Parishad members, MLAs, and MPs and others interested in the programme. This method helped them to understand the details of the programme and the scope of their participation.

Films: The District Health Education Wing continued to screen NIMHANS' films on mental health in the villages along with other films on family planning, health activities etc. It has been observed that the movies on 'Child and its mind' and 'Towards Light' became popular among the rural folks in the district. The villagers started realising the value of modern treatment for mental ailments and their increased convictions led to increased utilisation of the services.

Cinema Slides: Cinema slides were prepared with the help of local agencies like Lions Club, Rotary Clubs and Union Bank of India. These were shown in the theatres to create awareness about the features of mental illnesses, mental retardation and Epilepsy and the available services in the Government Hospitals, PHCs and PHUs.

Educating the Educators: Considering the fact that not less than 40 percent of the beneficiaries of the mental health services offered by the PHC system being children and adolescents, the discussion was later focussed on the modalities of the involvement of th eight Assistant Educational Officers and of the District. Documents like *Mental Health perspectives of the new system, Mental Health problems of students, play activities: pathways to an integrated personality, Learning Difficulties: Causes Remedies and How to get along with people* were sent to them. They served as background material for discussions and interactions resulting in the active collaboration with Schools and teachers in Bellary District.

Satisfied Consumers: Effors have been made to offer systematic education to the family members of the patients. The patients who dropped out were followed-up. Home visits were made, reminder letters were written emphasising the regular follow-up. This was given much emphasis and importance with the understanding that the satisfied beneficiary would be the best agent of education and community participation. □

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quently during the first annual review, when the programme was reviewed by the Director of Health Services along with the Deputy Commissioner of Bellary and Director of NIMHANS, it was decided that for the routine running of the programme, part of the drugs would be supplied from the General Medical Stores and the remaining could be purchased locally by the District Health Officer from the discretionary funds available to him for purchase of drugs. Currently, all the essential psychotropic drugs are made available in every peripheral health care institution of Bellary district. The amount of drugs available in each institution is related to the number of cases being managed and the indenting and regular supply of drugs all over the district is monitored by the programme officer.

Recording and Reporting System

A simple recording and reporting system is designed to be maintained at various levels.

Health worker's records

Patient identification cards: As soon as the health worker identifies a patient with psychiatric illness, he issues a card to the patient or to the family members which has to be presented to the doctor in the hospital.

Record book: A record book is maintained by the health workers. This record consists of minimum details of the patients and their symptoms on one side and columns to record the follow-up details on the other side of the sheet. This record is checked by the supervisory staff at regular intervals regarding completion and appropriateness of the information.

Doctor's records

Four different proformas are designed for the doctors to collect information about patients with psychoses, neuroses, mental retardation and epilepsy. The follow-up details are recorded in the cards.

A separate monthly report form was to be filled up by the doctor in which he gives minimum details of the new cases identified in that month, the drug position and the number of drop-outs etc.

Essential Drugs for Primary Health Institutions

Tab. Chlorpromazine	50 mg.
Tab. Imipramine	25 mg.
Tab. Phenobarbitone	60 mg.
Tab. Trichexyphenidyl	2 mg.
Inj. Fluphenazine	25 mg.

Records of Research Team

The research team will keep a record of all the cases registered in every peripheral institution of the district, at the district head-quarters. This will be essentially an extract of the case cards maintained by the medical officers in various institutions. These will be obtained during regular visits to the periphery by the research team after scrutiny and review with the medical officer and his staff at each of the institution. The research team will also keep a note of the overall quality of mental health care delivered in each of the institutions with special mention of any lacunae observed.

Records of DHO and DHS

Monthly statistics of all types of case identification, case holding and case cure, drug consumption, and list of mentally disabled people who are certified for dispensation of social benefits etc. is maintained properly at the DHO and DHS level.

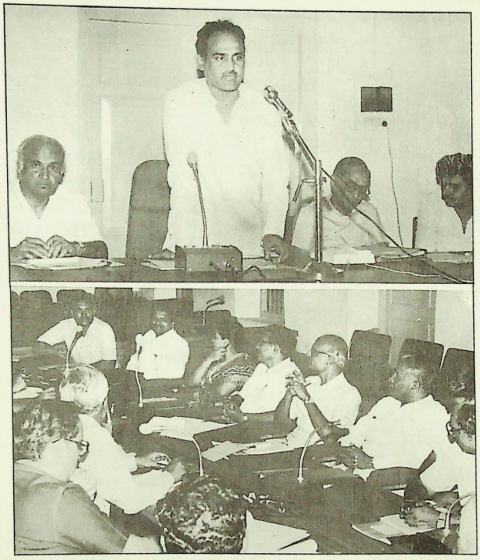
Programme Officer and the District Team

The various national health care programmes like Family Welfare Programme, National Malaria Eradication Programme, (NMEP) Tuberculosis Control Programme, Leprosy Control Programme etc., are monitored and supported at the district headquarters level by programme officers who work under the DHO. These personnel are often medical officers who have several years of service and administrative experience or those who have specialised in this area. During the initial planning of the DMHP, it was agreed by the Directorate of Health and Family Welfare that a programme officer for the DMHP would be appointed from 'leave cum deputation reserve' pool. Hence one of the assistant surgeons with many years of experience in various capacities in the district and with interest in mental health was appointed as the programme officer. He was deputed to NIMHANS for a 6-week training to gain proficiency in clinical psychiatry and thus be able to monitor and supervise the other PHC doctors and health workers. During this period, he worked like a resident both in outpatient and inpatient settings and participated in all the teaching programmes at NIMHANS. Following the successful completion of the training he returned to Bellary to run a regular mental health clinic at the district health and family welfare office campus (District TB Centre) in addition to organising the DMHP.

The office of DMHP was also opened at the District TB centre, Bellary. In addition, a health assistant (MPW) was also deputed to assist the work of the programme officer.

One of the assistant surgeons of the district (Medical Officer of PHC,Ittigi) got interested in psychiatry after attending the initial pilot decentralised training in mental health held in Bellary. He pursued this interest to seek admission for a two year post-graduate diploma in psychiatry at NIMHANS and later successfully completed the course (1984-86) and returned to Bellary. He assisted the DMHP as a trained psychiatrist at the district headquarters and later took over as programme officer, when the services of the first programme officer was withdrawn.

The programme officer is assisted by district level research team consisting of 3 assistant research officers — one each in psychology, Social Work and statistics. This team is appointed by NIMHANS and funded by NIMHANS research grants. Although DMHP was formally inaugurated in 1985, the first staff joined in September 1986, and full team of 3 persons was available only from October 1988. The team assists the programme officer in running the district clinic, monitoring the programme by regular field visits, routine data collection from the periphery and its analysis. The psychologists, in addition, certifies the mentally retarded individuals and assist in their management and the



Mr. Bhavi Bettappa, President ZP, Bellary speaking during the Second Annual Review Meeting of DMHP at Bellary. Others in the picture are Dr. G.N.N. Reddy, Dr. Prasanna Kumar and Mr. Nattakarlappa. *Bottom:* **Annual Review Meeting in progress.**

social worker initiates community participation activities in the district.

Reporting, Monitoring and Feedback

Medical officers of all the peripheral institutions are expected to send the monthly reporting forms giving the details about the number of cases on hand, cases newly identified during the month, and cases attending follow-up during the month. The monthly reporting form gives various details of all the new cases identified during the month (name, age, sex etc.) and also details about the drugs position. The DMHP is reviewed along with all other progammes during the monthly meeting at the PHCs and also during the monthly meeting of medical officers held at the district headquarters by DHO. The medical officers are given a feed back on their work based on their monthly reporting forms. Monitoring and supervision are also carried out by the programme officer and his team by regular field visits to the peripheral institutions.

District Mental Health Clinic at Bellary

The programme officer and his team run an outpatient mental health clinic at Bellary. During the initial period (first one and half year) this was a daily clinic, but later it was reduced to three days a week to facilitate the team to tour the periphery on the other days. This clinic caters largely to people from Bellary and villages nearby including, people from adjoining Andhra Padesh. When patients belonging to other PHCs register here, they are assessed and referred to the trained medical officer closest to their villages. The simple records for psychosis, epilepsy, mental retardation and neurosis are maintained for all registered patients.

The efforts are going on to develop the district mental health clinic as a model for the peripheral institutions. It partly fulfills the need for a referral centre at the district headquarters for the peripheral doctors.

Field Visits by the District Team

While the district clinic is an important constitutent of the DMHP, the success of the district programme will be determined by the work of peripheral institutions and personnel working there. In addition to monthly reporting of work by each centre and the review at the monthly medical officers meeting at the district level the crucial factor which enhances the quality of work at peripheral health care institutions is the regular field visits by the district team, on many occasions, also accompanied by persons from NIMHANS. These visits facilitate cross checking the diagnosis and management of a certain number of cases on treatment at the PHCs and PHUs, understanding the problems which doctors and health workers face in managing cases, maintaining records etc., and assisting the health personnel to promote comunity participation. The lack of availability of an independent vehicle for the DMHP during the initial two years hampered to some extent, achieving of the targets of field visits set initially.

Community Participation in DMHP

From the very inception of the DMHP, it was recognised that community participation should be developed to form the backbone of the programme. Various activities have been undertaken towards achieving this during the past three years and a summary report is given elsewhere in this issue. *(See p 8 & 9)*

Training for Mental Health Personnel

NIMHANS has a 4-week 'Training of Trainers of PHC personnel in Mental Health Care' programme for mental health professionals desirous of initiating community based programmes. These programmes are conducted a few times a year and many mental health professionals from different parts of the country as well as other developing countries attend the programmes. Field visits to Bellary and some of the health institutions in the district lasting 3-4 days, and discussions with various persons connected with the programme like PHC personnel, the DC, DHO and programme officer have now become an integral component of the 'Training of Trainers' programme.

This visit has been rated as one of the 'most useful' activities of the programme by many participants. Many such visits were carried out several times during the last 3 years. The participants of these programmes include senior professionals like superintendents of mental hospitals, professors and assistant professors of psychiatry. During the past three years, participants have come from almost all the states and union territories of the country as well as from other developing countries in the region like Bangladesh. These visits have been found to be very useful by the participants as they acquire a first hand experiential understanding of the DMHP as the field level realities and constraints.

Results and discussion

Table 1 to 8 and the bar diagrams show certain aspects of the Bellary District Mental Health Programme particularly the utilisation pattern and outcome of treatment in an illustrative manner.

The data presented in these Tables refer to the period from the beginning of the programme till 31st July 1988. It specifically refers to **5852** cases identified and registered at the district clinic as well as all the peripheral health care institutions of the district, and reviewed by the district team.

The number of all categories of patients being identified managed has been con-

TABLE – 1 : Talukwise total case detection per 10,000 population *(Bellary District)*

Taluk	Population	Cases detected			Rate per 10,000 population		
		1985-86	1986-87	1987-88	1985-86	1986-87	1987-88
Bellary	3,85,714	737	1,545	2,257	19.10	40.05	58.51
Sandur	1,26,658	154	277	429	12.15	21.86	33.87
Siruguppa	1,48,929	225	357	499	15.10	23.97	33.50
H.B. Halli	98,814	173	220	280	17.50	22.26	28.33
Harapanahalli	1,57,627	333	494	716	21.12	31.33	45.42
Kudligi	1,65,679	331	438	601	19.97	26.43	36.27
Hospet	2,29,290	272	460	613	11.86	20.06	26.73
Hadahalli	90,600	262	325	457	28.91	35.87	50.44
	14,03,311	2,487	4,116	5,852	17.72	29.33	41.70

TABLE – 2 : Talukwise detection of cases from 1983 to July 1988

Taluk	Doctor in position	Epilepsy	Psychosis	M.R.	Neurosis	Total	%
Bellary	13	886	664	201	506	2,257	38.56
Sandur	4	322	48	17	42	429	7.33
Siruguppa	9	301	119	15	64	499	8.52
Hospet	12	463	100	26	24	613	10.47
H.B. Halli	6	229	34	12	05	280	4.78
Kudligi	11	496	71	21	17	605	10.33
Harapanahalli	12	547	85	63	21	716	12.23
Hadahalli	10	280	81	28	64	453	7.74
Total	77	3,524	1,202	383	743	5,852	100

TABLE – 3 : Mode of referral of cases

Model of referral	Epilepsy %	Psychosis %	M.R. %	Neurosis %
MPW & other health staff	454 (12.88)	145 (12.06)	96 (25.06)	63 (8.47)
Doctors (Govt., G.P., Dist. Hosp.)	306 (8.68)	267 (22.21)	13 (3.39)	225 (30.26)
Other patients	240 (6.81)	124 (10.32)	36 (9.39)	74 (9.95)
Identified in the clinic	178 (5.05)	58 (4.82)	10 (2.61)	34 (4.57)
Self (Patient or his family)	1,220 (34.62)	284 (23.62)	85 (22.19)	191 (25.70)
Others (Camp, village leaders)	144 (4.08)	147 (12.22)	106 (27.67)	99 (13.22)
No clear information about referral	982 (27.86)	177 (14.72)	37 (9.66)	57 (7.67)
Total	3,524 (100)	1,202 (100)	383 (100)	743 (100)

Figures in paranthesis show percentage

TABLE – 4 : Distance from Institutions

Distance from the Institution	Epilepsy No.	Psychosis No.	Neurosis No.
Within 5 km.	2,516 (71.39)	694 (57.74)	451 (60.60)
6 - 10 km.	505 (14.33)	127 (10.56)	48 (6.46)
11 - 30 km.	353 (10.01)	109 (9.08)	61 (8.20)
More than 30 km.	150 (4.24)	272 (22.61)	183 (24.50)
Total	3,524 (100)	1,202 (100)	743 (100)

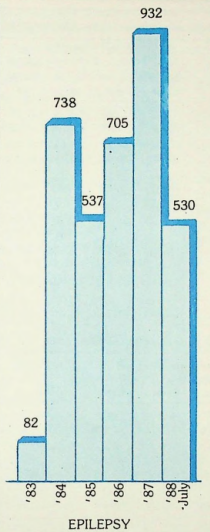
TABLE – 5 : Duration of illness

Duration of illness	Epilepsy No.	Psychosis No.	Neurosis No.
Within 1 month	65 (1.84)	253 (21.05)	109 (14.66)
1-6 months	792 (22.46)	287 (23.95)	179 (24.08)
7 months to 1 year	356 (10.10)	75 (6.24)	59 (7.94)
1 to 3 years	814 (23.09)	218 (18.13)	224 (30.12)
More than 3 years	901 (25.56)	266 (22.13)	106 (14.26)
No definite information	596 (16.91)	103 (8.57)	66 (8.88)
Total	3,524 (100)	1,202 (100)	743 (100)

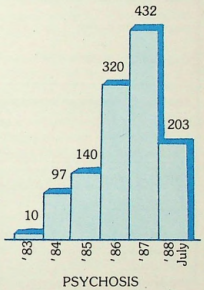
TABLE – 6 : Regularity and outcome of treatment

Regularity & outcome	Epilepsy No.	Psychosis No.
Regular Symptom - free or symptoms reduced with regular medication.	1,899 (53.88)	507 (42.18)
Irregular (Prolonged irregularity or dropout).	1,590 (45.12)	558 (46.49)
Stopped medications on advice	13 (0.36)	118 (9.81)
Died	22 (0.62)	18 (1.48)
Total	3,524 (100)	1,202 (100)

DIAGRAMS OF DIFFERENT DIAGNOSTICS CATEGORIES OF CASES IDENTIFIED
(YEAR-WISE)



EPILEPSY



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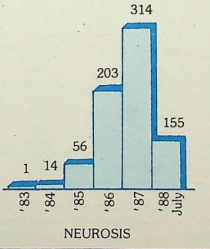
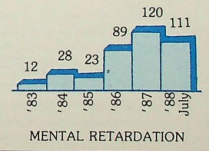


NEUROSIS



MENTAL RETARDATION

stantly increasing, all over the district. During the initial period, the number of epileptics identified and managed outnumbered other types of cases, but recently, the number of persons with psychosis, neurosis and mental retardation has been steadily increasing. It is found that most people who utilize the mental health care facilities reside within a short distance of the institution from where they receive care. Only a small percentage of patients or their families reported that they were actually referred by the health workers. Most of the patients who utilize the services, come either on their own or through referral by other patients who regularly make use of the mental health care facilities. 42 percent of

TABLE – 7 : Comparison between various types of institutions 1983 to July 1988 (PSYCHOSES)

	Dist. clinic No. of cases	G.Hs. No. of cases	PHCs No. of cases	PHU + GGAD No. of cases	Total No. of cases
Total number of cases	632 (52.58)	180 (14.97)	284 (23.62)	106 (8.82)	1,202 (100)
Regular and maintaining improvement	338 (53.48)	71 (39.44)	65 (22.89)	33 (31.13)	507 (42.18)
Stopped drug on advice	64 (10.12)	17 (9.44)	18 (6.34)	19 (17.92)	118 (9.82)
Irregular and dropout	216 (34.18)	90 (50.10)	194 (68.30)	54 (50.94)	554 (46.09)
Cases with duration of illness less than 1 week	38 (6.01)	15 (8.33)	16 (5.63)	15 (14.15)	84 (6.99)
Drug used CPZ + THP	212 (33.54)	70 (38.89)	38 (13.38)	26 (24.53)	346 (28.78)
Drug used CPZ + FPZ + TPH	266 (42.08)	33 (18.33)	30 (10.56)	28 (26.41)	357 (29.70)

TABLE – 8 : Comparison between various types of institutions 1983 to July 1988 (EPILEPSY)

	Clinic (N = 1) Cases	G.Hs (N = 7) Cases	PHCs (N = 23) Cases	PHU & GAD (N = 27) Cases	Total (N = 58) Cases
Total No. of cases	609 (17.28)	957 (27.15)	1,509 (42.82)	449 (12.74)	3,524 (100)
Regular cases*	400 (21.06/ 65.68)	458 (24.11/ 47.85)	781 (41.12/ 51.76)	260 (13.69/ 57.90)	1,899 (100/ 53.88)
Irregular cases	200 (12.58)	490 (30.82)	717 (45.09)	183 (11.51)	1,590 (100)
Regular - controlled	334 (54.84)	399 (41.69)	674 (44.66)	223 (49.66)	1,630 (46.25)
Uncontrolled cases	66 (10.84)	59 (6.16)	107 (7.09)	37 (8.24)	269 (7.63)
Drugs used - phenobarb only	337 (55.34)	907 (94.77)	1,455 (96.42)	420 (93.54)	3,119 (88.50)
Drugs used - phenobarb + DPH	147 (24.13)	34 (3.55)	35 (2.32)	24 (5.34)	237 (6.72)
Fit free - 1 yr.	131 (21.51)	201 (21.00)	316 (20.94)	101 (22.49)	749 (21.25)
Controlled within 6 months	183 (54.79)	268 (67.16)	431 (63.95)	130 (58.29)	1012 (62.08)

* % of regular cases within the district and % of regular within institutions.

the psychotics and 53 percent of the epileptics have been utilizing the services quite regularly and have reported improvement and reduction or disappearance of initial symptoms.

The decentralised training strategy in phases, adopted for the DMHP is a feasible method for training large number of primary health care personnel within a resonable period of time and without major disruption in their routine work. The training, in phases, allows the trainee doctors and health workers to bring back their practical experiences, doubts and difficulties for discussion during a formal training session. The continued 'on-the-job training' carried out during the field visits by the district team and/or NIMHANS team, was found to be invaluable. The frequent mobility of health personnel within the district and out of the district due to transfers, leaves, proceedings for post-graduation, promotions etc., posed a problem as the new staff had to quickly be given the mental health training.

The recording and reporting system for the DMHP were designed based on the previous experiences of the investigators as well as the patterns of certain other national programmes. Though simple, these are found to be complicated and difficult to handle four separate case cards for four separate diagnosis. The record keeping by the health workers and their supervisors was found to be not satisfactory. The monthly reporting form too requires several modifications. The quality of the case records varied from institution to institution and according to the diagnosis. Epilepsy records tended to have more information at most of the centres. The personal details of the patient along with diagnosis and drugs prescribed were available in most records. All details of clinical condition and follow-up details were lacking in many centres.

During the field visits the district team, 'on the job training' was given by examining difficult cases and discussing them with the health personnel. Doubts about management, filling-up of case records and monthly return forms etc., were also classified. While all institutions had neuropsychiatric cases registered, the numbers varied widely from about 20 to more than 200. From the records, discussions with the doctors and examining some of the cases on treatment, the broad diagnostic categorisation and lines of management followed by the trained doctors in regard to typical cases appeared to be adequate. But most of the doctors had problem cases of various types. In some, the problems arose because adequate doses of medications were not started eg., in managing acute psychotics (manics) to control their excitement, or in certain epileptics who needed higher doses or combinations of anti-epileptics to reach a fit free status. In others, the difficulty was in determining the types of fit especially when cases were typical, eg., combination of genuine epilepsy with hysterical attacks, and convulsions other than grandmal. In few cases, doctors had difficulty in suc-

cessfully managing side-effects of phenothiazines. This was complicated on rare occasions by patients developing uncommon side-effects like tardive dyskinesia, rabbit syndrome etc. Several doctors had successfully managed status epilepsy.

In one centre, the medical officer marshalled support from the local community and started rehabilitation of two mentally retarded at his own primary health unit. In many institutions, the team came across patients who had improved considerably or recovered as a result of the treatment.

One general difficulty expressed by all the doctors was that, while their health wokers know about one or more cases in their respective catchment areas, they were unable to successfully persuade them to come to the PHCs. Of the registered cases, about 30 - 40 percent were reportedly irregular and health workers were unable to carry out any follow-up with these patients. The dropouts were more with psychosis patients. Lot of patients went to the PHCs because they had seen other patients improving. It was not possible for the review team to interview many health workers other than the headquarters workers during these periods. From discussions with doctors, it was apparent that the identification, referral, follow-up role given to the health worker was not very effective in most PHCs. Many patients mentioned that they were sent to the PHC/PHU by the health worker of their area. It would be necessary to attend monthly meetings of PHCs to see all the health workes together to review the programme.

All institutions visited had designated a certain day of the week for the mental health clinic. In many institutions, boards displayed the day and time of mental health clinics. While patients were seen on all days, the effort was to see old patients coming for follow-up on a particular day and time.

The review visits to the peripheral institutions highlighted the need for such visits by the District team/NIMHANS team on a regular basis to monitor the programme. These can contribute to the development of confidence and skills of doctors and act as the much needed 'continued on the job training'. The visits will ensure better quality recording which is essential for satisfactory monitoring. The most striking point was the steady increase in the numbers of cases on treatment, the quality of care, the availability of records and a format for reporting of the work to the district headquarters.

The range of drugs available at the institutions depended on the numbers and types of cases on treatment. Phenobarbitone and chlorpromazine were available at all the institutions. Antidepressants and depot phenothiazines were not available at some of the institutions in the district.

The visit by mental health professionals from other states to Bellary district has facilitated their starting similar programmes in their respective states. Currently, a programme similar to the Bellary DMHP is being implemented at Nagpur District in Maharashtra.

Future of the DMHP

The DMHP has completed three years and is presently in its fourth year of implementation. Till the launching of this programme, the experience available in the country as well as elsewhere, of integrating mental health with primary health care, was only from a limited population and health personnel involving either part of or a whole PHC. But the DMHP involving a population of 1.5 million and hundreds of health personnel has substantially increased the mental health professionals' understanding of the general health care services and operational and managerial problems of implementing a new health programme.

It has also been a unique example of collaboration between a district level administrative set up, the state department of health and family welfare and a national institute to develop, implement and evaluate a health service programme. The district health personnel under the

PERSONS INVOLVED IN DMHP AT BELLARY

(Present & past)

DIRECTORATE OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF KARNATAKA

Present:

1. Dr. J.L. Javare Gowda, Director of H & FW Services.
2. Dr. C. Prasanna Kumar, Jt. Director & State level programme officer for Mental Health.
3. Dr. C.R. Krishna Murthy, Divisional Jt. Director, Gulbagra
4. Dr. T. Nizamuddin, District Health & FW Officer, Bellary.
5. Dr. Karur Badri Vishal, Programme Officer, DMHP, Bellary.

Past

1. Dr. A. Narayana Rao, Director of H & FW Services (Retd).
2. Dr. K.B. Makapur, Jt. Director (Formerly DHO, Bellary).
3. Dr. V.G. Shetty, DHO, Chitradurga (Formerly DHO, Bellary).
4. Dr. N. Muralidhar, Asst. Surgeon, (Formerly Programme officer, DMHP).

ZILLA PARISHAD, DISTRICT ADMINISTRATION, BELLARY

Present

1. Mr. Bhavi Bettappa, President, ZP.
2. Mr. Nattakattappa, Vice President, ZP.
3. Mr. B. Lakshminarayan Shetty, Chairman, Health Committee, ZP.
4. Mr. S. A. Patil, IAS, Chief Secretary, ZP.

Past

1. Mr. Sudhir Kumar, IAS, Deputy Secretary, Ministry of Eco. Affairs, Govt. of India (Formerly Dy. Commissioner)
2. Mr. C.S. Surajana, IAS, Formerly Chief Secretary, ZP, Bellary.

NIMHANS

Present

1. Dr. G.N. Narayana Reddy, Director.
2. Dr. S.M. Channabasavanna, Dean & Prof. of Psychiatry.
3. Dr. R. Srinivasa Murthy, Prof. & Head, Deptt. of Psychiatry.
4. Dr. G.G. Prabhu, Prof. & Head, Deptt. of Clinical Psychology.
5. Dr. I.A. Sheriff, Prof. & Head, Deptt. of Psychiatric Social Work.
6. Mrs. Reddamma Raju, Assoc. Prof. & Head, Deptt. of Nursing.
7. Dr. Mohan K. Isaac, Assoc. Prof. of Psychiatry (Co-ordinator, DMHP, Bellary).
8. Dr. C.R. Chandrashekhar, Asst. Prof. of Psychiatry.
9. Dr. R. Parthasarathy, Asst. Prof. of PSW.
10. Mrs. Ahalya Raghuram, Lecturer in Clinical Psychology.
11. Dr. T.G. Sriram, Lecturer in Psychiatry.
12. Mr. Mohan Krishna, Tutor in Psychiatric Nursing.

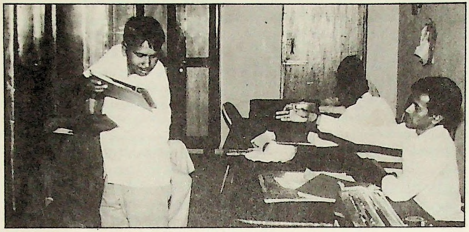
Past

1. Mr. Nagarajaiah, Tutor in Psychiatric Nursing
2. Ms. Nomitha Varma, Formerly Lecturer in Clinical Psychology.
3. Dr. Shekhar Seshadri, Lecturer in Psychiatry.

RESEARCH STAFF AT BELLARY

1. Mr. Arun Naik, ARO Social Work.
2. Ms. Smitha Sanju, ARO Clinical Psychology.
3. Mr. Jayasimha, Statistical Assistant.

ADDRESS: **Programme Officer, District Mental Health Programme, DHO's Office, Bellary, KARNATAKA.**

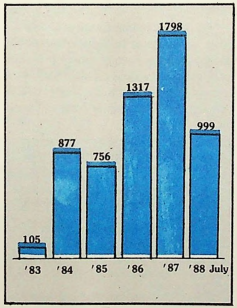


A patient under medication *(Left)* **doing his routine office work in a government office, Bellary**

supervision of the NIMHANS team of investigators have been carrying out the training, monitoring and field level evaluation of the programme. In addition, a district mental health clinic is also being run at the district headquarters. The data generated so far gives certain indications of the nature of utilization, extent of coverage and the outcome of intervention. While this kind of data will continue to be generated during the fourth year of DMHP, it is proposed that various other aspects of the programme also be studied.

Till July 1988, there are more than 1200 psychotics, 3525 epileptics, 750 neurotics and 380 mentally retarded who are registered and on management at different institutions in the district. It is proposed to assess the quality of care being offered to these persons through the DMHP by examining a random number of psychotics/epileptics in detail. This detailed assessment would be carried out by consultants of NIMHANS, who are not associated with DMHP.

Amongst the registered patients, only about 40-50 percent come regularly for follow-up as advised by the medical officers/health workers. It is proposed to carry out a comparison of those persons who are regular to follow-up with those who are irregular and to study factors influencing regularity of follow-up. Similarly, there are noticeable differences in the performance and quality of work of health personnel. Comparing good perfomers versus poor performers amongst these personnel is likely to give insights about



TOTAL CASES IDENTIFIED (YEAR-WISE)

overall performance of primary health care personnel in health care programmes. The already achieved care identification and registration rate (of about 4 per 1000) in the district is lower than what can be expected (about 15 to 20 per 1000) based on published psychiatric epidemiological data. It would mean that there are still large numbers of persons with psychosis, mental retardation and epilepsy in the district, who are not yet identified.

It is proposed to survey certain areas of the district and identify and assess such persons who have so far not made use of the existing mental health facilities. It is also proposed to study the 'pathways' which mentally ill patients take before reaching the health care institutions as well as the time taken from the onset of the illness till consultation at any of the centres.

Conclusion

The NMHP envisages operationalisation of the programme at least in one district of every state in the country within reasonable period of time. Bellary District Mental Health Programme is likely to develop the necessary operational expertise for organising mental health care through the existing PHC set up at a district level and thus usher wider implementation of NMHP all over the country. □

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NIMHANS, Bangalore 560 029
(Coordinator, District Mental Health Programme, Bellary)

COMMUNITY MENTAL HEALTH NEWS

Issue Nos. 11 & 12, April-Sept. 1988

The **Community Mental Health News** is published by the ICMR Centre for Advanced Research on Community Mental Health, to keep the professionals, planners, administrators and the interested public informed about the development of community mental health care programmes.

Copies of **Community Mental Health News** are mailed free on request by interested professionals and institutions.

We are interested in exchanging a few copies of this journal, on reciprocal basis, with other medico-health publications. We would like to obtain information on projects/research findings/field work reports relating community mental health programmes in our country.

Letters, comments and communications should be addressed to: **The Editor, Community Mental Health News, ICMR Centre for Advanced Research on Community Mental Health, NIMHANS, Bangalore – 560 029, (India).**

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COMMUNITY MENTAL HEALTH NEWS

ISSUE Nos. 11 & 12
APRIL-SEPT 1988

EDITORIAL

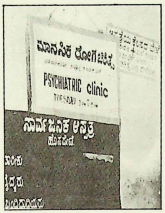
District Mental Health Programme

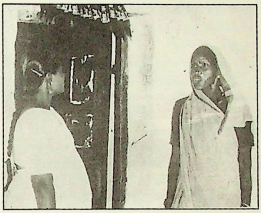
During the last ten years the development of models for mental health care have gradually become more and more sophisticated in terms of methodology. The initial studies related to small groups of 30 to 40 thousand population. These studies illustrated the feasibility of integrating mental health care with general health services with adequate support and supervision from the professionals. But critical examination of these experiences by experts showed that models with these ranges of population would be too limited for wider application and the inputs from mental health professionals were excessive.

Against this background the starting of District Mental Health Programme at Bellary is a major development in the mental health planning in our country. Currently, we not only have plans for an average size district of over 1.5 million population but also have the details of the type service, level of care and the mechanisms for monitoring the programme.

This issue of **Community Mental Health News** brings together the evolution, strategy of action and results of the first three years of the Programme for wider circulation among the mental health professionals and planners.

– Dr. R. SRINIVASA MURTHY
(Editor)





Top left: A sign board of the newly started psychiatric clinic at Hospet Gen. Hospital. *Right:* A female health worker visits a patient's home. *Below:* Dr. Venkatesh Murthy, Med. Officer of Karur PHU, Siruguppa, interviewing a patient and her family members.

In this issue

REACHING THE UNREACHED

ICMR Centre for Advanced Research on Community Mental Health
NIMHANS, Bangalore.

District Mental Health Programme at Bellary

BELLARY AT A GLANCE	
Area	: 9,907 Sq. Kms.
Population	: 14,03,311 (1981 census)
Taluks	: 8
Major Towns	: 2; Bellary (Pop. 2,01,579); Hospet (Pop. 1,40,130)
Places of Historic Importance	: Hampi – the famous Capital of Vijayanagar Empire.
Other places of interest	: Thunga Bhadra Dam.

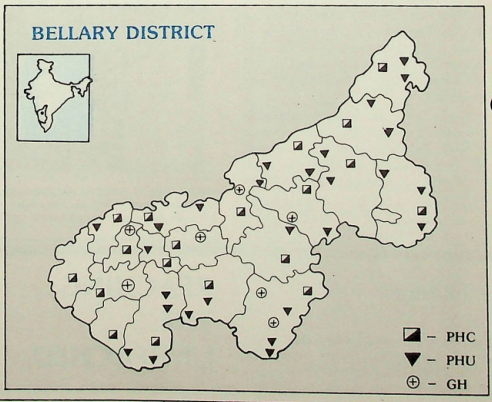
Introduction

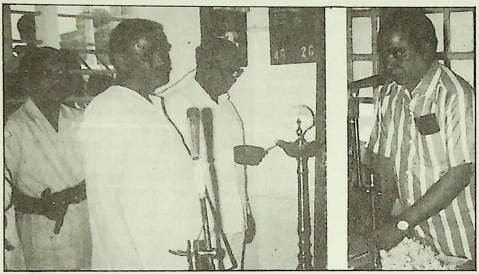
Care of the mentally ill, in most of the developing countries including India, particularly in the rural areas, has been neglected. It is widely believed that mental illnesses are caused by demons, spirits and black magic and that they are cured only by religious, magical and other traditional methods. Health planners, administrators and the medical professionals too are unaware of the wide prevalence and suffering caused by mental disorders. The wide ranging misconceptions and ignorance of the population has resulted in poor demand for modern services. In a broader context, public health services are receiving a low priority in terms of resource allocation and mental health in particular has had the least share of public health expenditure. Most of the limited currently available services are institution based and situated in urban areas — either in large custodial and archaic mental hospitals or in psychiatric units attached to general hospitals.

The past 30 years have witnessed many remarkable developments in the care of the mentally ill in India. *(CMH News*, Issue No 1) The various general population surveys of mental illnesses carried out in different parts of the ountry during 1960's and 1970's, demonstrated that these illnesses are as common in India as it is elsewhere and are equally common in rural as well as urban areas. The surveys indicate that the number of people suffering from serious and incapacitating neuropsychiatric condition needing urgent attention, in the whole country, are in the range of several millions (*CMH News*, Issue No 2). During the same period from the 'Mental Hospital' base, the care of the mentally ill slowly shifted to the general hospital setting. This brought on a new type of care for larger number of mentally ill persons mostly from the urban areas. General hospital psychiatric care meant shorter hospitalization and more active involvement of the family members in the care as against the well known long-term custodial care in the mental hospitals without involvement of the family.

Steadily increasing (though slow) number of trained mental health professionals, improved facilities, especially in the urban areas have assured better care. However, this has been only for those who have access to these available services. Currently, early recognition, management with appropriate psychopharmacological agents and properly organized rehabilitation programmes can control symptoms as well as prevent secondary handicap for most mental disorders. However, unfortunately this 'mental health know-how' has not reached over 90 percent of those who are urgently in need of it due to the highly centralised and professionalised nature of the existing mental health care services as well as the paucity of resources and lack of public awareness.

To bridge the wide gap between the enormous mental health care needs of the country and the meagre resources (trained personnel, beds, finances etc.) available in the country, **integration of mental health with the existing general**





Dr. H.L. Thimme Gowda, Minister for H & FW, inaugurating DMHP at Bellary on 20 July 1985. Others in the Picture are Mr. M. Ramappa, MLA, Bellary and Dr. V.G. Shetty, DHO Bellary. *Right:* **Dr. J.L. Javare Gowda, DHS, speaking on the occasion.**

health care services, was thought of as a feasible and appropriate approach. The growing consensus amongst experts in the field — national and international — is , 'decentralisation and integration of mental health services with the general health services by training the existing general health care personnel to provide basic mental health care'.

An expert committee of the WHO on 'Organisation of Mental Health Service in Developing Countries' which met in 1974 (WHO 1975) urged the member states to recognise mental disorders as a problem of high priority for the individual, for the community and for national development and made several important recommendations. The committee recommended that: **"Countries should, in the first instance carry out one or more pilot programmes to test the practicability of including basic mental health care in an already established programme of health care in a defined rural or urban population".** It further recommended that "training programmes, including a simple manual for the training of health workers should be devised and evaluated".

During 1975-76, major community mental health care experiments were launched at Bangalore and Chandigarh to test the feasibility of shifting the care of the mentally ill from the 'hospital' to the 'community' and from the 'mental health specialist' to the 'primary care physician'.

Community Mental Health Unit at NIMHANS

The Department of Psychiatry at National Institute of Mental Health and Neuro Sciences (NIMHANS) focused its attention on extending mental health services into the community as early as 1975. A specially designated and staffed 'Community Psychiatry Unit' was established. **The main aim of the Unit was to extend mental health services by integrating it with the existing system of primary health care.** For this, the primary health care staff had to be trained in basic mental health care. More specifically, the task of the unit was to develop, carry out and evaluate suitable short-term training programmes in basic mental health care for different categories of health care personnel, so that after training, these personnel could provide mental health care in their respective areas of work.

A rural community mental health and training centre was established at **Sakalawara** (Anekal Taluk) near Bangalore in 1976. Initially a service programme was developed and feasibility exercises were carried out in the villages around Sakalawara. Based on these experiences, simple manuals of instructions and short-term training programmes for medical officers and multipurpose workers of PHCs were developed (*CMH News* Issue No. 1). Pilot training programmes were carried out and evaluated at Primary Health Centres at Malur and Anekal (Kolar and Bangalore Districts, Karnataka State). These pilot programmes helped the unit to crystallize the educational objectives for the mental health training of PHC personnel and meaningfully revise and rewrite the manuals of instructions in basic mental health care.

Since 1982, every month, regular training programmes for medical officers and health workers, working in various PHCs and/or PHUs of Gulbarga and Mysore divisions (Karnataka state) and deputed by the Department of health and family welfare are held at the rural mental health centre at Sakalawara. These are held in small batches of 5-15 persons and are residential. The health workers' training is for a period of 6 days while the medical officers' training is for 12 working days. The training is routinely evaluated by pre and post-training assessments. So far, more than 400 medical officers and 600 health workers have participated in this training.

The regular monthly training programmes and their evaluation facilitated frequent reviews and whenever necessary, revisions of the 'training package', namely, education objectives, methodology of training, time allotment for various activities, manuals of instructions, tools of pre and post-training assessments and simple records for mental health care at PHCs. After several revisions, the rewritten 'Manual of Mental Health for Multipurpose Workers' and 'Manual of Mental Health for Medical Officers' are currently available in printed form for wider use (*CMH News*, Issue No. 1). Similarly, the instruments for evaluation of the training also have been standardized.

Evaluation of work carried out by trained PHC personnel

While it is acceptable that the mental health training can be evaluated in a limited way by pre and post-training

Need for Developing a District Model for delivery of Mental Health Care

1. **Earlier efforts to integrate mental health with PHC involved only population of 40,000 to 60,000 and personnel of one PHC**
2. **Field level evaluation of trained PHC personnel highlighted the need for developing a district model.**
3. **NMHP envisages implementation of the programme atleast in one district of every state in the country, within a specific period of time.**
4. **All health care and welfare programmes are implemented and monitored at a district level.**

assessments which would give an indication of the knowledge gained by the trainees, the ultimate criteria for evaluation will have to be the ability of the primary health care team to recognize and manage the mentally ill in their PHCs thus bring down the overall neuropsychiatric morbidity. In a few 'micro level' pilot research projects carried out in either in part of or a whole PHC involving a limited number of personnel, it had already been shown that mental health care can be provided at the PHC level by trained PHC personnel.

Following the training, when a follow-up visit was made the doctors and health workers in the centres visited had undertaken mental health care activities to varying extent. Some of the centres and personnel had done excellent work while others had done very limited amount of work.

There appeared to be problems because of the small number of health workers trained from each PHC. Population coverage wise, they accounted only for a small percentage of the total population of the PHC. In some PHCs the trained doctors talked to all the health workers to identify, refer and follow-up cases and impart mental health education. Many of the cases presently being managed by the doctors, were identified by themselves from their daily clinics.

None of the health care personnel interviewed felt that their work load had increased because of this programme, while many feared that as the number of cases identified and managed increases, the work load too might increase. It was noticed that the work of the health personnel could have been better if several of their following administrative and supervisory needs were fulfilled: (i) provision of minimum number of essential psychotropic and antiepileptic drugs on a regualr basis, (ii) provision of simple recording and reporting method, (iii) involvement of all the health care personnel, of the PHC/district belonging to various categories, (iv) regular supervision and monitoring of the programme at all levels, namely, PHC, district, division etc., (v) availability of specialist referral facilities, (vi) provision of material for public mental health education, (vii) facilities for continued learning of trained personnel (refresher courses), and (viii) to improve public understanding and acceptance of PHC as places of treating mentally ill and epileptics. **The field level evaluation of trained PHC personnel highlighted the need for planning mental health care at a district level.**

Genesis of the Bellary District Mental Health Programme

By 1983-84 in addition to the ongoing work of the community mental health unit at NIMHANS, few other projects had practically demonstrated that primary health care system can provide mental health care at the community level. Notable amongst these are the "Strategies for Extending Mental Health Care" a WHO multicentre collaborative study with a collaborating centre at Chandigarh and the ICMR-DST (Indian Council of Medical Research - Dept. of Science and Technology) 'Severe Mental Morbidity Project' carried out at 4 centres in the country, namely, Bangalore, Calcutta, Baroda and Patiala. Few other experiments from centres like Vellore, Lucknow, Jaipur and Hyderabad also added to the growing evidence for community based mental health care by general health staff. By then, the 'National Mental Health Programme' (NMHP – 1982) for India was also approved by the Central Council of Health and family welfare for countrywide implementation (*CMH News*, Issue No. 1).

A result of these developments was the increasing realization that further work was needed to consolidate the gains and achievements of the previous few years. The existing know-how of integrating mental health with primary health care had to be operationalized and applied to larger areas and target populations. The already proven methods of training, the PHC personnel, manuals, curricula, training aids of different types and methods of evaluation had to be applied in a wider setting. The district level psychiatric facilities of referral and consultation by the PHC Teams had to be developed. Above all, the National Mental Health Programme, already approved for implementation, envisaged the operationalization of the programme 'in at least one district in every State and Union Territory, and in at least ½ of all the districts in some States within five years'. It is proposed by the NMHP that specialized psychiatric services be made available at the district level. It would be the responsibility of specialist health personnel at the district level to provide training and supervision to the workers at the primary health centre level. So, it was in the light of all these specific issues and as the next logical step in the implementation of the National Mental Health Programme that the 'district mental health programme' was developed by the community mental health unit of NIMHANS.

During the field level evaluation visits in 1983 to several peripheral health care institutions by a team of the community mental health unit of NIMHANS, headed by Director and Senior Officers of Department of Health and Family Welfare, Karnataka, many health workers reported that, while they had identified

and referred many cases of mental illnesses and epilepsy, most of them had not actually come to the PHCs and PHUs for assessment and initiation of treatment. Since the number of neuropsychiatric patients seeking treatment at the peripheral health institutions were low, many PHC doctors including their supervisory officers like the District Health Officer (DHO) had doubts about the actual prevalence of these disorders in the rural community. Therefore, aimed at demonstrating to the rural public that mental illness and epilepsy could be assessed and managed at health institutions close to their villages by trained health personnel and demonstrate to the medical officers and their administrators like the DHO that large number of persons suffer from these conditions in their own PHCs, mental health camps were conducted in one of the districts of Gulbarga division, Bellary.

Information about these camps were given to the public by the health workers and these mental health camps were actually organized and conducted by trained PHC staff with the assistance of resource persons from NIMHANS. Such camps were held at Siruguppa, Hadagally, Harappanahally (Taluk Hq. towns) and Bellary from 18.09.1983 to 01.10.1983 and large number of mentally ill and epileptics (ranging from 135 to 300 at each centre) were examined and treatment initiated. They were advised to visit PHCs/PHUs where trained personnel worked, close to their villages for follow-up. This opportunity was also utilized for public education by group meetings and exhibitions on mental health. A major outcome of these camps was the sensitization and increased awareness of health officials particularly the DHO (Dr. K.B. Makapur) of Bellary District regarding the need for organizing mental health services in the periphery — both at the district headquarters and the peripheral health institutions.

Following the above experience, District Mental Health Programme (DMHP) was developed over a period of several months during 1984-85. The decision to take up Bellary as the district for developing implementing and evaluating DMHP emerged following the evaluation of April 1983 and the mental health camps in several places in the district in Sept-Oct. 1983. Following a series of meetings of NIMHANS team with the district health office team and the Deputy Commissioner of Bellary, it was decided that the DMHP be taken up as a joint project of Dept. of Health and Family Welfare, (Govt. of Karnataka) District Administration, Bellary and NIMHANS. At a meeting, held at Bellary in May 1985 attended by Dr. G.N. Narayana Reddy, Director NIMHANS, Dr. C.Prasanna Kumar, Joint Director (Health Programmes & Planning), Directorate of Health and Family Welfare, Govt. of Karnataka and Mr. Sudhir Kumar, Deputy Commissioner, Bellary and their respective teams, the joint project was formalized.

HEALTH CARE FACILITIES IN BELLARY DISTRICT

Medical College	:	1
Primary Health Centres	:	23
Primary Health Units	:	28
General Hospitals (Taluk)	:	7
Govt. Allopathic Dispensaries	:	18
Urban Family Welfare Centres	:	6
National Leprosy Control Centres	:	4
No. of Medical Officers	:	77
No. of Health Workers (Male – 268; Female – 353).	:	621

It was agreed that NIMHANS will continue to offer technical inputs in terms of training, monitoring and evaluation of the programme, the district administration will ensure the funding for adequate and regular supply of drug requirements (estimated expenditure Rs. 50,000/- per year) and printing of records for health personnel and the Directorate of Health and Family Welfare services will implement the programme through its existing infrastructure and personnel. In addition the directorate also agreed to spare the services of one of its medical officers (Assistant Surgeon) with experience of programme administration to oversee the DMHP at the district level (Programme Officer) and meet his transport needs (Vehicle, driver and POL) to tour the district regularly.

The DMHP was formally inaugurated at Bellary by the then Health Minister of Karnataka Dr. H.L. Thimme Gowda on 20th July 1985. The inaugural function was attended, in addition to a large number of the general public, by members of the legislative assembly from the District, Mr. B.Shivarama Reddy, Mr. M.Ramappa and Mr. C.M. Revana Siddaiah, Dr. J.L. Javare Gowda, Director of Health Services, Dr. G.N. Narayana Reddy and Mr. Sudhir Kumar.

Aims and objectives of the DMHP

The general aim of the District Mental Health Programme is to extend mental

Advantages of planning mental health care at a district level

1. The district is an independent administrative unit with district commissioner as the head.
2. DHO, has powers of planning activities in the district.
3. Monitoring of programmes occur at the district level.
4. Inter-sectoral coordination is possible at the district level.
5. Mobilisation of additional resources is possible.
6. All existing staff can be best utilised by involving the total district for care programme.
7. A district, not a PHC, is the planning and implementation unit for most other health and welfare programmes.

health services to the severely mentally ill persons in the district through the existing health care personnel and institutions. The more specific **objectives** of the Programme are:-

1) **To develop and implement a decentralized training programme in mental health for all categories of health personnel, appropriate to their levels of functioning with least disruption to the ongoing general health care activities.**

2) **To provide a minimum range of essential drugs for treatment of severely mentally ill persons at all peripheral health care institutions.**

3) **To develop a system of simple recording and reporting of care by health care personnel.**

4) **To monitor the effect of the service programme in terms of treatment utilization and outcome with treatment.**

5) **To develop mechanisms of community participation in the mental health care programme through planned activities.**

6) **To study the cost-effectiveness of the programme.**

Towards achieving these objectives the DMHP has several components, namely, (i) Training of personnel, (ii) Provision of Drugs, (iii) Simple recording system, (iv) District level programme officer & his team (v) District Mental Health Clinic, (vi) Review cum training as part of visits to the periphery, (vii) Weekly mental health clinics in the periphery, (viii) Monthly reporting, monitoring and feedback, (ix) Community participation, and (x) Field Training for MH professionals.

Training of Health Personnel

Services for the mentally ill can become an integral part of the general health services, only if all categories of personnel are trained to carry out routinely, the mental health care tasks assigned to them.

It would not be possible to effectively and meaningfully launch a mental health programme, if most of the personnel in the district are not trained within a reasonable period of time. Deputation of large numbers of these personnel to Bangalore can cause disruption of their routine ongoing work. The 2-week training module has no planned facility for refresher inputs to the trainees to clarify their doubts which arise after their using the knowledge gained through the initial training. Continuous 'on-the-job' inputs though of short duration can be very beneficial to trained personnel. Therefore, a 'decentralized training' strategy was developed.

The training was to be carried out for different categories of personnel separately and wherever the numbers were high, in batches of manageable numbers. The broad approach of training was to impart to the trainees not only new knowledge about mental illnesses but also the ability to identify and manage all the mentally ill in their community. The educational objectives of the training were to teach the personnel to carry out various tasks already identified. The training was to be decentralized and carried out at the district headquarters and taluk headquarters towns. It was to be divided into 3 different sessions of 1 to 3, each held at intervals of few months. This would enable the trainees to bring back difficulties in implementation of the programme, so that they could be discussed and clarified. Manuals of instructions (for doctors and health workers) already developed for this purpose, would be made use of for the training.

Thus, the training for PHC personnel at a district level was as follows:

a) ***Medical officers:*** Total trianing days - 9, in 3 sessions of 3 + 3 + 3 days with an interval between sessions of not less than 3 months, and in batches of not more than 25.

b) ***Multipurpose workers:*** Total training days 4 - in 3 sessions of 1 + 2 + 1 day with an interval between sessions of not less than 3 months. One batch could consist of all the health workers in a PHC and venue of the training may preferably be the PHC itself.

c) ***Health supervisors*** (health inspectors and lady health visitors): Total training days - 4, in 2 sessions of 2 + 2 days with an interval period between sessions of not less than 3 months. The training can be either at district headquarters or one or two taluk headquarters. In addition, the supervisors would be expected to attend the training for multipurpose workers.

d) ***Community health volunteers:*** Two days of training preferably during their initial 3 months training period. The CHVs should be called for a 2 day training at the PHC level to be carried out by trained medical officers, and health supervisors.

e) ***Block health educators:*** The block health educators of each PHC (generally, one in each PHC) could join the programme of health supervisors i.e., 4 days in 2 sessions of 2 + 2 days.

In addition to the above mentioned formal training for larger groups of personnel, informal 'on the job' training inputs will continue for personnel of PHC by a district mental health team visiting PHCs regularly once in two or three months, preferably on a fixed day of the week which could be designated as the weekly 'Mental Health clinic' day when most of the old and new patients of the PHU/ PHC could visit the centre for their follow-up consultation.

While training in mental health for medical officers, multipurpose workers and other functionaries is important for identification and management of the needy population, the programme would be successful only if it is regularly supervised and monitored at the district and sub-divisional levels by the DHO and ADHOs. Therefore, even the supervisory officers at the district level were appropriately oriented and sensitized to the mental health needs of the population.

Training for Medical Officers

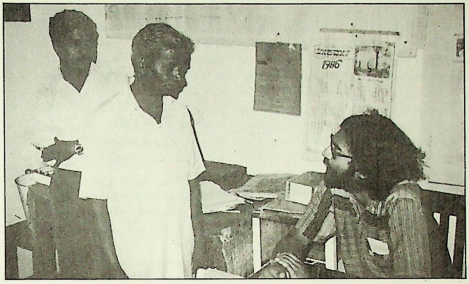
The total number of medical officers practising the allopathic system, working in various health institutions of the district and coming under the administrative con-

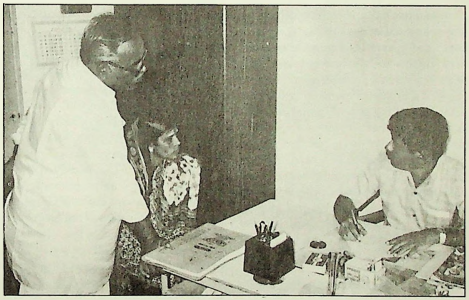
trol of district health officer in Bellary in 1984-85 is around 75. The doctors were trained in 3 batches for 3 consecutive days at Bellary. The training was carried out by a faculty of two psychiatrists from the community mental health unit, NIMHANS.

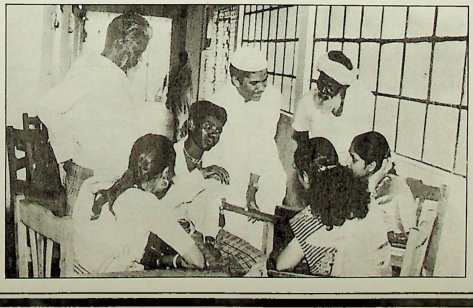
The primary objective of the training was to sufficiently sensitize the medical officers to mental health problems in the community and demystify the management of common psychiatric problems. They were told about the extent of mental health problems in the community, need and strategy of integrating mental health with primary health care and their role in its implementation. Of the three training days available, the first day's morning was spent for these topics. In addition, a pre-training assessment of their present mental health knowledge was also carried out during the 1st day morning. They were shown short video recorded interviews of the patients suffering from different psychiatric conditions and were asked the diagnosis, management and prognosis.

During the afternoon session of the first day, the basis of normal human behaviour was discussed, reviewing the structure and functions of the brain and the factors contributing to the understanding of behaviour — biological, psychological and sociocultural. In the light of this understanding of normal human behaviour, the various abnormalities that can take place to produce mental illnesses of different types, were then discussed. The various features, types, causes and treatment of mental disorders in general was also covered.

The whole of second day was utilised for teaching 'psychosis'. After discussing their (the trainees) general reactions to a severely mentally ill patient, the approach







Top: Dr. Sekar Seshadri, Lecturer in Psychiatry, NIMHANS, reviewing the diagnoses of a patient at Mariammanahally PHC. Dr. Krishna Murthy, MOH, is also seen.

Middle: Dr. Muralidhar, Former Programme Officer, DMHP, examining a patient at District Clinic at Bellary.

Below: Three Lady Medical Officers taking the history of a patient during a training session at Bellary.

to a psychotic patient — history taking and examination — was discussed, followed by clinical features, types and practical management of psychosis. The emphasis was mainly on giving the doctors to diagnose and satisfactorily manage psychotic conditions, and hence the practical work of interviewing and diagnosing as many actual cases as possible was given the maximum priority in the allotment of training of the second day. Carefully prepared video recordings of interviews with psychosis patients highlighting the symptomatology, and clinical presentations were also demonstrated and discussed.

On third day, the morning session was spent for discussion on epilepsy. The doctors' basic pre-training knowledge regarding epilepsy seemed to be much better than their knowledge of mental illness and hence there were large number of questions, doubts and clarifications. Although neurosis, mental retardation and other childhood problems are to be covered in detail during the second phase of training, are also briefly touched upon. The afternoon is mainly made use of for discussion on the problems which are likely to come up in the implementation of the mental health care programme all over the district. There is no post-training assessment. The doctors were assured about the availability of drugs at the PHCs and PHUs.

Following the initial training, all the medical officers were to identify and manage cases from their clinics as well as cases referred by the health workers from the community. They were also required to maintain simple records, follow-up the cases regularly and refer cases which they could not manage to the District headquarters. Essential drugs were made available at all peripheral institutions. The progress of the mental health care programme was reviewed every month during the monthly conference of medical officers.

The second phase of the training was carried out after a few months. This 3-days training begin with an assessment of the doctors' knowledge of mental health care. The assessment was carried out to ascertain how much of mental health care knowledge the doctors had retained, after the initial phase of trainIng and accordingly develop the curriculum and methodology for the second phase of training. The doctors had difficulty in differentiating schizophrenia, reactive psychosis and depression. While they knew the common drugs and their dosage, they were unsure of dosages and duration of treatment for specific conditions.

To facilitate development of diagnostic and management skills, most of the time during the 3 days was used for practical demonstration of cases and discussion of cases worked up by each of the trainees. Emphasis is also laid on nonpharmacological management of non-psychotic psychiatric disorders.

Provision of Drugs

Earlier efforts at integrating mental health with primary health care had shown that availability of five basic psychotropic drugs (Tab. Chlorpromazine 50 mg./100 mg., Tab. Imipramine 25 mg., Tab. Trihexyphenidyl 2 mg. Inj. Fluphenazine and Tab. and Tab. Phenobarbitone 60 mg.) at the primary health centre/unit was very essential for the successful implementation of the programme following the training of the health care personnel. All these drugs are routinely not available in the PHCs and these drugs are generally not included in the supplies to the periphery from the state level general medical stores. Therefore specific efforts were made to generate the necessary funds to supply minimum amounts of essential drugs during the first one or two years of the programme to every peripheral health care institution, in Bellary district.

This crucial assistance for the starting of the district programme — initially Rs. 20,000 and later Rs. 50,000 annually came from the district administration from the district development funds, and was sanctioned in 1984-85 by the then Deputy Commissioner of Bellary district Shri Sudhir Kumar. The availability of these funds helped in the launching of the programme all over the district. Subse-

Community Awareness and Participation Activities

For any effective community oriented programme we need to look into the 4 Ps: Political or Planners' commitment, Professional commitment, Progress in the mental health know-how, and Participation of the community (Srinivasa Murthy, 1985). Community participation, according to NIPCCD Manual (1984) is a coglomeration of activities which enable the community to: (a) be aware of its needs and problems, (b) enrich the knowledge about services and facilities in operation, (c) get conviction about the efficacy and usefulness of those services, (d) develop an understanding about its participation and contribution, and (e) involve consciously and actively in the implementation of new strategies for practice.

Considering its value and importance, all efforts have been taken from the very inception of Bellary District Mental Health Programme to ensure community awareness and strengthen its participation in a wide range of activities related to mental health care.

Mental Health Camps: The mental health camps organised at Sirugutppa, Hadagally, Harappanahally and Bellary in the year 1983 had sown the seeds of public awareness about mental health problems and services. Large numbers of mentally ill, ranging from 135 to 300 were examined and teatment initiated. The overall effect of these camps was the increased awareness of the public about mental health problems in their community, and the facilities for treatment available near their homes. It also sensitized the health officials regarding the need for organising mental health services beyond the District Headquarters setting.

District Mental Health Committee: A District Mental Health Committee was formed as part of the District Health and Family Welfare Committee. This committee headed by the Deputy Commissioner having the representatives from different departments like Education, Social Welfare and Development enhanced the process of

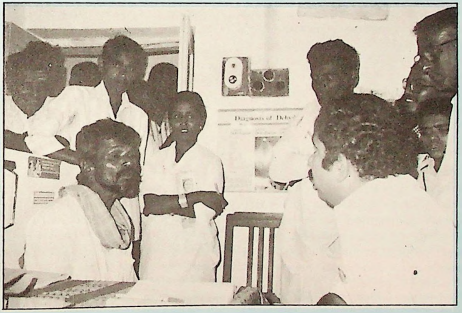
communication and interaction between health and other departments which in turn represents the intersectoral cooperation at higher levels of administration.

Orientation to Media Personnel: It is important that personnel involved with mass media activities — Newspapers, magazines, A.I.R., News agencies, State and Central wings of Publicity are oriented towards the facts of mental health problems as well as newly introduced services in the district. Accordingly, one day programme was organised for the representatives of the mass media personnel. they were adequately helped to incorporate the mental health matters into their day-to-day media activities. As a result of such efforts, the mass media personnel gained scientific awareness about mental health problems and transmitted the same to the public through their respective media.

Interaction with Social Welfare Personnel: Social welfare personnel like superintendents, teachers, case workers, supervisors, wardens and others working in the Remand Home, Junior/Senior Certified schools, and other institutions were met and group discussions were held. During such sessions, the focus was made on issues related to mental health risks of delinquents, orphans, deserted individuals, destitute women and physically handicapped. Later, the welfare personnel were met periodically to strengthen the impact of orientation programmes conducted initially.

Contact with Voluntary Agencies: In order to enlist the support from the Voluntary agencies for mental health programmes, professionals' participation in the meetings of Rotary Club, Lions Club, Croftons (Ladies) Club, Youth Clubs, Mahila Mandals and other allied agencies was proved to be fruitful. Initially, these collaborative activities with voluntary agencies would seem to be challenging, but in due course of time with the continuous and consistent efforts of the professionals, they became rewarding and enriching experience.

Orientation to Zilla Parishad Members: Initial efforts were taken to discuss with the Chief Secretary and the Deputy Commissioner and later with the President of Bellary Zilla Parishad regarding the issues related to mental health services in the district. Their positive responses and support, in fact gave a fillip to the programme. Subsequently, a brief orientation programme was arranged to other members of the Zilla Parishad. The details pertaining to the beneficiaries, the nature of help, the importance of public involvement and related issues were briefed to the august gathering of the MLAs, MPs, Zilla Parishad members, VIPs of the Bellary District, Mass Media personnel and the public in the monthly meeting of the Zilla Parishad. As a result of such interactions, the Zilla Parishad members felt that these orientation programmes need to be held at Mandal Panchayat level so that local involvement could be intensified.



Dr. R. Parthasarathy, Asst. Prof. of PSW, NIMHANS, demonstrating symptoms of a patient to a group of HWs at Hollalu.

Booklets: Specific booklets both in Kannada (6,000 copies) and in English (1,000 copies) on District Mental Health Programme were printed for the communication to the Youth Clubs, voluntary agency members, staff of Welfare institutions, teachers, Mandal and Zilla Parishad members, MLAs, and MPs and others interested in the programme. This method helped them to understand the details of the programme and the scope of their participation.

Films: The District Health Education Wing continued to screen NIMHANS' films on mental health in the villages along with other films on family planning, health activities etc. It has been observed that the movies on 'Child and its mind' and 'Towards Light' became popular among the rural folks in the district. The villagers started realising the value of modern treatment for mental ailments and their increased convictions led to increased utilisation of the services.

Cinema Slides: Cinema slides were prepared with the help of local agencies like Lions Club, Rotary Clubs and Union Bank of India. These were shown in the theatres to create awareness about the features of mental illnesses, mental retardation and Epilepsy and the available services in the Government Hospitals, PHCs and PHUs.

Educating the Educators: Considering the fact that not less than 40 percent of the beneficiaries of the mental health services offered by the PHC system being children and adolescents, the discussion was later focussed on the modalities of the involvement of th eight Assistant Educational Officers and of the District. Documents like *Mental Health perspectives of the new system, Mental Health problems of students, play activities: pathways to an integrated personality, Learning Difficulties: Causes Remedies and How to get along with people* were sent to them. They served as background material for discussions and interactions resulting in the active collaboration with Schools and teachers in Bellary District.

Satisfied Consumers: Effors have been made to offer systematic education to the family members of the patients. The patients who dropped out were followed-up. Home visits were made, reminder letters were written emphasising the regular follow-up. This was given much emphasis and importance with the understanding that the satisfied beneficiary would be the best agent of education and community participation. □

Dr. R. PARTHASARATHY
Asst. Professor of Psychiatric Social Work,
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quently during the first annual review, when the programme was reviewed by the Director of Health Services along with the Deputy Commissioner of Bellary and Director of NIMHANS, it was decided that for the routine running of the programme, part of the drugs would be supplied from the General Medical Stores and the remaining could be purchased locally by the District Health Officer from the discretionary funds available to him for purchase of drugs. Currently, all the essential psychotropic drugs are made available in every peripheral health care institution of Bellary district. The amount of drugs available in each institution is related to the number of cases being managed and the indenting and regular supply of drugs all over the district is monitored by the programme officer.

Recording and Reporting System

A simple recording and reporting system is designed to be maintained at various levels.

Health worker's records

Patient identification cards: As soon as the health worker identifies a patient with psychiatric illness, he issues a card to the patient or to the family members which has to be presented to the doctor in the hospital.

Record book: A record book is maintained by the health workers. This record consists of minimum details of the patients and their symptoms on one side and columns to record the follow-up details on the other side of the sheet. This record is checked by the supervisory staff at regular intervals regarding completion and appropriateness of the information.

Doctor's records

Four different proformas are designed for the doctors to collect information about patients with psychoses, neuroses, mental retardation and epilepsy. The follow-up details are recorded in the cards.

A separate monthly report form was to be filled up by the doctor in which he gives minimum details of the new cases identified in that month, the drug position and the number of drop-outs etc.

Essential Drugs for Primary Health Institutions

Tab. Chlorpromazine	50 mg.
Tab. Imipramine	25 mg.
Tab. Phenobarbitone	60 mg.
Tab. Trichexyphenidyl	2 mg.
Inj. Fluphenazine	25 mg.

Records of Research Team

The research team will keep a record of all the cases registered in every peripheral institution of the district, at the district head-quarters. This will be essentially an extract of the case cards maintained by the medical officers in various institutions. These will be obtained during regular visits to the periphery by the research team after scrutiny and review with the medical officer and his staff at each of the institution. The research team will also keep a note of the overall quality of mental health care delivered in each of the institutions with special mention of any lacunae observed.

Records of DHO and DHS

Monthly statistics of all types of case identification, case holding and case cure, drug consumption, and list of mentally disabled people who are certified for dispensation of social benefits etc. is maintained properly at the DHO and DHS level.

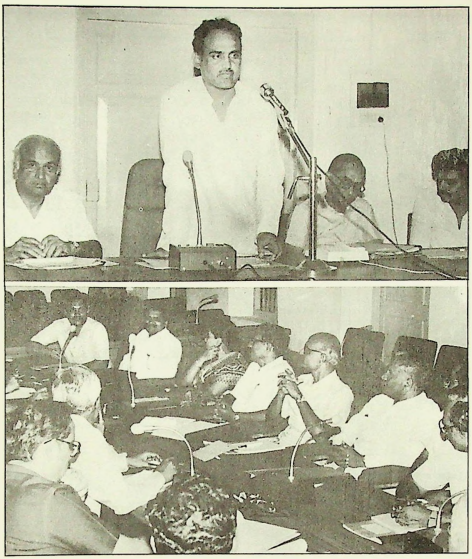
Programme Officer and the District Team

The various national health care programmes like Family Welfare Programme, National Malaria Eradication Programme, (NMEP) Tuberculosis Control Programme, Leprosy Control Programme etc., are monitored and supported at the district headquarters level by programme officers who work under the DHO. These personnel are often medical officers who have several years of service and administrative experience or those who have specialised in this area. During the initial planning of the DMHP, it was agreed by the Directorate of Health and Family Welfare that a programme officer for the DMHP would be appointed from 'leave cum deputation reserve' pool. Hence one of the assistant surgeons with many years of experience in various capacities in the district and with interest in mental health was appointed as the programme officer. He was deputed to NIMHANS for a 6-week training to gain proficiency in clinical psychiatry and thus be able to monitor and supervise the other PHC doctors and health workers. During this period, he worked like a resident both in outpatient and inpatient settings and participated in all the teaching programmes at NIMHANS. Following the successful completion of the training he returned to Bellary to run a regular mental health clinic at the district health and family welfare office campus (District TB Centre) in addition to organising the DMHP.

The office of DMHP was also opened at the District TB centre, Bellary. In addition, a health assistant (MPW) was also deputed to assist the work of the programme officer.

One of the assistant surgeons of the district (Medical Officer of PHC,Ittigi) got interested in psychiatry after attending the initial pilot decentralised training in mental health held in Bellary. He pursued this interest to seek admission for a two year post-graduate diploma in psychiatry at NIMHANS and later successfully completed the course (1984-86) and returned to Bellary. He assisted the DMHP as a trained psychiatrist at the district headquarters and later took over as programme officer, when the services of the first programme officer was withdrawn.

The programme officer is assisted by district level research team consisting of 3 assistant research officers — one each in psychology, Social Work and statistics. This team is appointed by NIMHANS and funded by NIMHANS research grants. Although DMHP was formally inaugurated in 1985, the first staff joined in September 1986, and full team of 3 persons was available only from October 1988. The team assists the programme officer in running the district clinic, monitoring the programme by regular field visits, routine data collection from the periphery and its analysis. The psychologists, in addition, certifies the mentally retarded individuals and assist in their management and the



Mr. Bhavi Bettappa, President ZP, Bellary speaking during the Second Annual Review Meeting of DMHP at Bellary. Others in the picture are Dr. G.N.N. Reddy, Dr. Prasanna Kumar and Mr. Nattakarlappa. *Bottom:* **Annual Review Meeting in progress.**

social worker initiates community participation activities in the district.

Reporting, Monitoring and Feedback

Medical officers of all the peripheral institutions are expected to send the monthly reporting forms giving the details about the number of cases on hand, cases newly identified during the month, and cases attending follow-up during the month. The monthly reporting form gives various details of all the new cases identified during the month (name, age, sex etc.) and also details about the drugs position. The DMHP is reviewed along with all other progammes during the monthly meeting at the PHCs and also during the monthly meeting of medical officers held at the district headquarters by DHO. The medical officers are given a feed back on their work based on their monthly reporting forms. Monitoring and supervision are also carried out by the programme officer and his team by regular field visits to the peripheral institutions.

District Mental Health Clinic at Bellary

The programme officer and his team run an outpatient mental health clinic at Bellary. During the initial period (first one and half year) this was a daily clinic, but later it was reduced to three days a week to facilitate the team to tour the periphery on the other days. This clinic caters largely to people from Bellary and villages nearby including, people from adjoining Andhra Padesh. When patients belonging to other PHCs register here, they are assessed and referred to the trained medical officer closest to their villages. The simple records for psychosis, epilepsy, mental retardation and neurosis are maintained for all registered patients.

The efforts are going on to develop the district mental health clinic as a model for the peripheral institutions. It partly fulfills the need for a referral centre at the district headquarters for the peripheral doctors.

Field Visits by the District Team

While the district clinic is an important constitutent of the DMHP, the success of the district programme will be determined by the work of peripheral institutions and personnel working there. In addition to monthly reporting of work by each centre and the review at the monthly medical officers meeting at the district level the crucial factor which enhances the quality of work at peripheral health care institutions is the regular field visits by the district team, on many occasions, also accompanied by persons from NIMHANS. These visits facilitate cross checking the diagnosis and management of a certain number of cases on treatment at the PHCs and PHUs, understanding the problems which doctors and health workers face in managing cases, maintaining records etc., and assisting the health personnel to promote comunity participation. The lack of availability of an independent vehicle for the DMHP during the initial two years hampered to some extent, achieving of the targets of field visits set initially.

Community Participation in DMHP

From the very inception of the DMHP, it was recognised that community par-, ticipation should be developed to form the backbone of the programme. Various activities have been undertaken towards achieving this during the past three years and a summary report is given elsewhere in this issue. *(See p. 8 & 9)*

Training for Mental Health Personnel

NIMHANS has a 4-week 'Training of Trainers of PHC personnel in Mental Health Care' programme for mental health professionals desirous of initiating community based programmes. These programmes are conducted a few times a year and many mental health professionals from different parts of the country as well as other developing countries attend the programmes. Field visits to Bellary and some of the health institutions in the district lasting 3-4 days, and discussions with various persons connected with the programme like PHC personnel, the DC, DHO and programme officer have now become an integral component of the 'Training of Trainers' programme.

This visit has been rated as one of the 'most useful' activities of the programme by many participants. Many such visits were carried out several times during the last 3 years. The participants of these programmes include senior professionals like superintendents of mental hospitals, professors and assistant professors of psychiatry. During the past three years, participants have come from almost all the states and union territories of the country as well as from other developing countries in the region like Bangladesh. These visits have been found to be very useful by the participants as they acquire a first hand experiential understanding of the DMHP as the field level realities and constraints.

Results and discussion

Table 1 to 8 and the bar diagrams show certain aspects of the Bellary District Mental Health Programme particularly the utilisation pattern and outcome of treatment in an illustrative manner.

The data presented in these Tables refer to the period from the beginning of the programme till 31st July 1988. It specifically refers to **5852** cases identified and registered at the district clinic as well as all the peripheral health care institutions of the district, and reviewed by the district team.

The number of all categories of patients being identified managed has been con-

TABLE – 1 : Talukwise total case detection per 10,000 population *(Bellary District)*

Taluk	Population	Cases detected			Rate per 10,000 population		
		1985-86	1986-87	1987-88	1985-86	1986-87	1987-88
Bellary	3,85,714	737	1,545	2,257	19.10	40.05	58.51
Sandur	1,26,658	154	277	429	12.15	21.86	33.87
Siruguppa	1,48,929	225	357	499	15.10	23.97	33.50
H.B. Halli	98,814	173	220	280	17.50	22.26	28.33
Harapanahalli	1,57,627	333	494	716	21.12	31.33	45.42
Kudligi	1,65,679	331	438	601	19.97	26.43	36.27
Hospet	2,29,290	272	460	613	11.86	20.06	26.73
Hadahalli	90,600	262	325	457	28.91	35.87	50.44
	14,03,311	2,487	4,116	5,852	17.72	29.33	41.70

TABLE – 2 : Talukwise detection of cases from 1983 to July 1988

Taluk	Doctor in position	Epilepsy	Psychosis	M.R.	Neurosis	Total	%
Bellary	13	886	664	201	506	2,257	38.56
Sandur	4	322	48	17	42	429	7.33
Siruguppa	9	301	119	15	64	499	8.52
Hospet	12	463	100	26	24	613	10.47
H.B. Halli	6	229	34	12	05	280	4.78
Kudligi	11	496	71	21	17	605	10.33
Harapanahalli	12	547	85	63	21	716	12.23
Hadahalli	10	280	81	28	64	453	7.74
Total	77	3,524	1,202	383	743	5,852	100

TABLE – 3 : Mode of referral of cases

Model of referral	Epilepsy %	Psychosis %	M.R. %	Neurosis %
MPW & other health staff	454 (12.88)	145 (12.06)	96 (25.06)	63 (8.47)
Doctors (Govt., G.P., Dist. Hosp.)	306 (8.68)	267 (22.21)	13 (3.39)	225 (30.26)
Other patients	240 (6.81)	124 (10.32)	36 (9.39)	74 (9.95)
Identified in the clinic	178 (5.05)	58 (4.82)	10 (2.61)	34 (4.57)
Self (Patient or his family)	1,220 (34.62)	284 (23.62)	85 (22.19)	191 (25.70)
Others (Camp, village leaders)	144 (4.08)	147 (12.22)	106 (27.67)	99 (13.22)
No clear information about referral	982 (27.86)	177 (14.72)	37 (9.66)	57 (7.67)
Total	3,524 (100)	1,202 (100)	383 (100)	743 (100)

Figures in paranthesis show percentage

TABLE – 4 : Distance from Institutions

Distance from the Institution	Epilepsy No.	Psychosis No.	Neurosis No.
Within 5 km.	2,516 (71.39)	694 (57.74)	451 (60.60)
6 - 10 km.	505 (14.33)	127 (10.56)	48 (6.46)
11 - 30 km.	353 (10.01)	109 (9.08)	61 (8.20)
More than 30 km.	150 (4.24)	272 (22.61)	183 (24.50)
Total	3,524 (100)	1,202 (100)	743 (100)

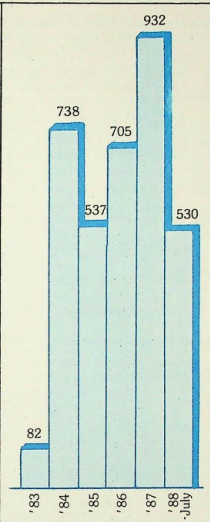
TABLE – 5 : Duration of illness

Duration of illness	Epilepsy No.	Psychosis No.	Neurosis No.
Within 1 month	65 (1.84)	253 (21.05)	109 (14.66)
1-6 months	792 (22.46)	287 (23.95)	179 (24.08)
7 months to 1 year	356 (10.10)	75 (6.24)	59 (7.94)
1 to 3 years	814 (23.09)	218 (18.13)	224 (30.12)
More than 3 years	901 (25.56)	266 (22.13)	106 (14.26)
No definite information	596 (16.91)	103 (8.57)	66 (8.88)
Total	3,524 (100)	1,202 (100)	743 (100)

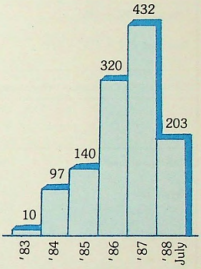
TABLE – 6 : Regularity and outcome of treatment

Regularity & outcome	Epilepsy No.	Psychosis No.
Regular Symptom - free or symptoms reduced with regular medication.	1,899 (53.88)	507 (42.18)
Irregular (Prolonged.irregularity or dropout).	1,590 (45.12)	558 (46.49)
Stopped medications on advice	13 (0.36)	118 (9.81)
Died	22 (0.62)	18 (1.48)
Total	3,524 (100)	1,202 (100)

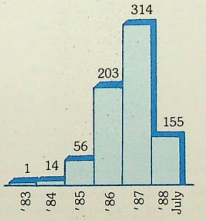
DIAGRAMS OF DIFFERENT DIAGNOSTICS CATEGORIES OF CASES IDENTIFIED
(YEAR-WISE)



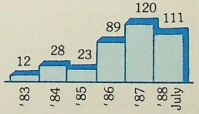
EPILEPSY



PSYCHOSIS



NEUROSIS



MENTAL RETARDATION

stantly increasing, all over the district. During the initial period, the number of epileptics identified and managed outnumbered other types of cases, but recently, the number of persons with psychosis, neurosis and mental retardation has been steadily increasing. It is found that most people who utilize the mental health care facilities reside within a short distance of the institution from where they receive care. Only a small percentage of patients or their families reported that they were actually referred by the health workers. Most of the patients who utilize the services, come either on their own or through referral by other patients who regularly make use of the mental health care facilities. 42 percent of

TABLE – 7 : Comparison between various types of institutions 1983 to July 1988 (PSYCHOSES)

	Dist. clinic No. of cases	G.Hs. No. of cases	PHCs No. of cases	PHU + GGAD No. of cases	Total No. of cases
Total number of cases	632	180	284	106	1,202
	(52.58)	(14.97)	(23.62)	(8.82)	(100)
Regular and maintaining improvement	338	71	65	33	507
	(53.48)	(39.44)	(22.89)	(31.13)	(42.18)
Stopped drug on advice	64	17	18	19	118
	(10.12)	(9.44)	(6.34)	(17.92)	(9.82)
Irregular and dropout	216	90	194	54	554
	(34.18)	(50.10)	(68.30)	(50.94)	(46.09)
Cases with duration of illness less than 1 week	38	15	16	15	84
	(6.01)	(8.33)	(5.63)	(14.15)	(6.99)
Drug used CPZ + THP	212	70	38	26	346
	(33.54)	(38.89)	(13.38)	(24.53)	(28.78)
Drug used CPZ + FPZ + TPH	266	33	30	28	357
	(42.08)	(18.33)	(10.56)	(26.41)	(29.70)

TABLE – 8 : Comparison between various types of institutions 1983 to July 1988 (EPILEPSY)

	Clinic (N = 1) Cases	G.Hs (N = 7) Cases	PHCs (N = 23) Cases	PHU & GAD (N = 27) Cases	Total (N = 58) Cases
Total No. of cases	609	957	1,509	449	3,524
	(17.28)	(27.15)	(42.82)	(12.74)	(100)
Regular cases*	400	458	781	260	1,899
	(21.06/ 65.68)	(24.11/ 47.85)	(41.12/ 51.76)	(13.69/ 57.90)	(100/ 53.88)
Irregular cases	200	490	717	183	1,590
	(12.58)	(30.82)	(45.09)	(11.51)	(100)
Regular - controlled	334	399	674	223	1,630
	(54.84)	(41.69)	(44.66)	(49.66)	(46.25)
Uncontrolled cases	66	59	107	37	269
	(10.84)	(6.16)	(7.09)	(8.24)	(7.63)
Drugs used - phenobarb only	337	907	1,455	420	3,119
	(55.34)	(94.77)	(96.42)	(93.54)	(88.50)
Drugs used - phenobarb + DPH	147	34	35	24	237
	(24.13)	(3.55)	(2.32)	(5.34)	(6.72)
Fit free - 1 yr.	131	201	316	101	749
	(21.51)	(21.00)	(20.94)	(22.49)	(21.25)
Controlled within 6 months	183	268	431	130	1012
	(54.79)	(67.16)	(63.95)	(58.29)	(62.08)

* % of regular cases within the district and % of regular within institutions.

the psychotics and 53 percent of the epileptics have been utilizing the services quite regularly and have reported improvement and reduction or disappearance of initial symptoms.

The decentralised training strategy in phases, adopted for the DMHP is a feasible method for training large number of primary health care personnel within a resonable period of time and without major disruption in their routine work. The training, in phases, allows the trainee doctors and health workers to bring back their practical experiences, doubts and difficulties for discussion during a formal training session. The continued 'on-the-job training' carried out during the field visits by the district team and/or NIMHANS team, was found to be invaluable. The frequent mobility of health personnel within the district and out of the district due to transfers, leaves, proceedings for post-graduation, promotions etc., posed a problem as the new staff had to quickly be given the mental health training.

The recording and reporting system for the DMHP were designed based on the previous experiences of the investigators as well as the patterns of certain other national programmes. Though simple, these are found to be complicated and difficult to handle four separate case cards for four separate diagnosis. The record keeping by the health workers and their supervisors was found to be not satisfactory. The monthly reporting form too requires several modifications. The quality of the case records varied from institution to institution and according to the diagnosis. Epilepsy records tended to have more information at most of the centres. The personal details of the patient along with diagnosis and drugs prescribed were available in most records. All details of clinical condition and follow-up details were lacking in many centres.

During the field visits the district team, 'on the job training' was given by examining difficult cases and discussing them with the health personnel. Doubts about management, filling-up of case records and monthly return forms etc., were also classified. While all institutions had neuropsychiatric cases registered, the numbers varied widely from about 20 to more than 200. From the records, discussions with the doctors and examining some of the cases on treatment, the broad diagnostic categorisation and lines of management followed by the trained doctors in regard to typical cases appeared to be adequate. But most of the doctors had problem cases of various types. In some, the problems arose because adequate doses of medications were not started eg., in managing acute psychotics (manics) to control their excitement, or in certain epileptics who needed higher doses or combinations of anti-epileptics to reach a fit free status. In others, the difficulty was in determining the types of fit especially when cases were typical, eg., combination of genuine epilepsy with hysterical attacks, and convulsions other than grandmal. In few cases, doctors had difficulty in suc-

cessfully managing side-effects of phenothiazines. This was complicated on rare occasions by patients developing uncommon side-effects like tardive dyskinesia, rabbit syndrome etc. Several doctors had successfully managed status epilepsy.

In one centre, the medical officer marshalled support from the local community and started rehabilitation of two mentally retarded at his own primary health unit. In many institutions, the team came across patients who had improved considerably or recovered as a result of the treatment.

One general difficulty expressed by all the doctors was that, while their health wokers know about one or more cases in their respective catchment areas, they were unable to successfully persuade them to come to the PHCs. Of the registered cases, about 30 - 40 percent were reportedly irregular and health workers were unable to carry out any follow-up with these patients. The dropouts were more with psychosis patients. Lot of patients went to the PHCs because they had seen other patients improving. It was not possible for the review team to interview many health workers other than the headquarters workers during these periods. From discussions with doctors, it was apparent that the identification, referral, follow-up role given to the health worker was not very effective in most PHCs. Many patients mentioned that they were sent to the PHC/PHU by the health worker of their area. It would be necessary to attend monthly meetings of PHCs to see all the health workes together to review the programme.

All institutions visited had designated a certain day of the week for the mental health clinic. In many institutions, boards displayed the day and time of mental health clinics. While patients were seen on all days, the effort was to see old patients coming for follow-up on a particular day and time.

The review visits to the peripheral institutions highlighted the need for such visits by the District team/NIMHANS team on a regular basis to monitor the programme. These can contribute to the development of confidence and skills of doctors and act as the much needed 'continued on the job training'. The visits will ensure better quality recording which is essential for satisfactory monitoring. The most striking point was the steady increase in the numbers of cases on treatment, the quality of care, the availability of records and a format for reporting of the work to the district headquarters.

The range of drugs available at the institutions depended on the numbers and types of cases on treatment. Phenobarbitone and chlorpromazine were available at all the institutions. Antidepressants and depot phenothiazines were not available at some of the institutions in the district.

The visit by mental health professionals from other states to Bellary district has facilitated their starting similar programmes in their respective states. Currently, a programme similar to the Bellary DMHP is being implemented at Nagpur District in Maharashtra.

Future of the DMHP

The DMHP has completed three years and is presently in its fourth year of implementation. Till the launching of this programme, the experience available in the country as well as elsewhere, of integrating mental health with primary health care, was only from a limited population and health personnel involving either part of or a whole PHC. But the DMHP involving a population of 1.5 million and hundreds of health personnel has substantially increased the mental health professionals' understanding of the general health care services and operational and managerial problems of implementing a new health programme.

It has also been a unique example of collaboration between a district level administrative set up, the state department of health and family welfare and a national institute to develop, implement and evaluate a health service programme. The district health personnel under the

PERSONS INVOLVED IN DMHP AT BELLARY

(Present & past)

DIRECTORATE OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF KARNATAKA

Present:

1. Dr. J.L. Javare Gowda, Director of H & FW Services
2. Dr. C. Prasanna Kumar, Jt. Director & State level programme officer for Mental Health
3. Dr. C.R. Krishna Murthy, Divisional Jt. Director, Gulbagra
4. Dr. T. Nizamuddin, District Health & FW Officer, Bellary.
5. Dr. Karur Badri Vishal, Programme Officer, DMHP, Bellary.

Past

1. Dr. A. Narayana Rao, Director of H & FW Services (Retd).
2. Dr. K.B. Makapur, Jt. Director (Formerly DHO, Bellary).
3. Dr. V.G. Shetty, DHO, Chitradurga (Formerly DHO, Bellary).
4. Dr. N. Muralidhar, Asst. Surgeon, (Formerly Programme officer, DMHP).

ZILLA PARISHAD, DISTRICT ADMINISTRATION, BELLARY

Present

1. Mr. Bhavi Bettappa, President, ZP.
2. Mr. Nattakattappa, Vice President, ZP.
3. Mr. B. Lakshminarayan Shetty, Chairman, Health Committee, ZP.
4. Mr. S. A. Patil, IAS, Chief Secretary, ZP.

Past

1. Mr. Sudhir Kumar, IAS, Deputy Secretary, Ministry of Eco. Affairs, Govt. of India (Formerly Dy. Commissioner)
2. Mr. C.S. Surajana, IAS, Formerly Chief Secretary, ZP, Bellary.

NIMHANS

Present

1. Dr. G.N. Narayana Reddy, Director.
2. Dr. S.M. Channabasavanna, Dean & Prof. of Psychiatry.
3. Dr. R. Srinivasa Murthy, Prof. & Head, Deptt. of Psychiatry,
4. Dr. G.G. Prabhu, Prof. & Head, Deptt. of Clinical Psychology.
5. Dr. I.A. Sheriff, Prof. & Head, Deptt. of Psychiatric Social Work,
6. Mrs. Reddamma Raju, Assoc. Prof. & Head, Deptt. of Nursing,
7. Dr. Mohan K. Isaac, Assoc. Prof. of Psychiatry (Co-ordinator, DMHP, Bellary).
8. Dr. C.R. Chandrashekhar, Asst. Prof. of Psychiatry.
9. Dr. R. Parthasarathy, Asst. Prof. of PSW,
10. Mrs. Ahalya Raghuram, Lecturer in Clinical Psychology.
11. Dr. T.G. Sriram, Lecturer in Psychiatry,
12. Mr. Mohan Krishna, Tutor in Psychiatric Nursing.

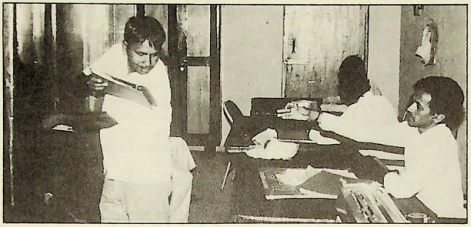
Past

1. Mr. Nagarajaiah, Tutor in Psychiatric Nursing
2. Ms. Nomitha Varma, Formerly Lecturer in Clinical Psychology.
3. Dr. Shekhar Seshadri, Lecturer in Psychiatry.

RESEARCH STAFF AT BELLARY

1. Mr. Arun Naik, ARO Social Work,
2. Ms. Smitha Sanju. ARO Clinical Psychology.
3. Mr. Jayasimha, Statistical Assistant.

ADDRESS: **Programme Officer, District Mental Health Programme, DHO's Office, Bellary, KARNATAKA.**

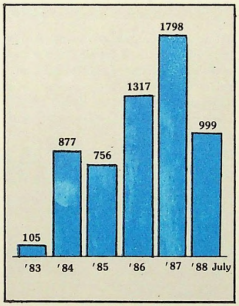


A patient under medication *(Left)* **doing his routine office work in a government office, Bellary**

supervision of the NIMHANS team of investigators have been carrying out the training, monitoring and field level evaluation of the programme. In addition, a district mental health clinic is also being run at the district headquarters. The data generated so far gives certain indications of the nature of utilization, extent of coverage and the outcome of intervention. While this kind of data will continue to be generated during the fourth year of DMHP, it is proposed that various other aspects of the programme also be studied.

Till July 1988, there are more than 1200 psychotics, 3525 epileptics, 750 neurotics and 380 mentally retarded who are registered and on management at different institutions in the district. It is proposed to assess the quality of care being offered to these persons through the DMHP by examining a random number of psychotics/epileptics in detail. This detailed assessment would be carried out by consultants of NIMHANS, who are not associated with DMHP.

Amongst the registered patients, only about 40-50 percent come regularly for follow-up as advised by the medical officers/health workers. It is proposed to carry out a comparison of those persons who are regular to follow-up with those who are irregular and to study factors influencing regularity of follow-up. Similarly, there are noticeable differences in the performance and quality of work of health personnel. Comparing good perfomers versus poor performers amongst these personnel is likely to give insights about



TOTAL CASES IDENTIFIED (YEAR-WISE)

overall performance of primary health care personnel in health care programmes. The already achieved care identification and registration rate (of about 4 per 1000) in the district is lower than what can be expected (about 15 to 20 per 1000) based on published psychiatric epidemiological data. It would mean that there are still large numbers of persons with psychosis, mental retardation and epilepsy in the district, who are not yet identified.

It is proposed to survey certain areas of the district and identify and assess such persons who have so far not made use of the existing mental health facilities. It is also proposed to study the 'pathways' which mentally ill patients take before reaching the health care institutions as well as the time taken from the onset of the illness till consultation at any of the centres.

Conclusion

The NMHP envisages operationalisation of the programme at least in one district of every state in the country within reasonable period of time. Bellary District Mental Health Programme is likely to develop the necessary operational expertise for organising mental health care through the existing PHC set up at a district level and thus usher wider implementation of NMHP all over the country. □

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COMMUNITY MENTAL HEALTH NEWS
Issue Nos. 11 & 12, April-Sept. 1988

The **Community Mental Health News** is published by the ICMR Centre for Advanced Research on Community Mental Health, to keep the professionals, planners, administrators and the interested public informed about the development of community mental health care programmes.

Copies of **Community Mental Health News** are mailed free on request by interested professionals and institutions.

We are interested in exchanging a few copies of this journal, on reciprocal basis, with other medico-health publications. We would like to obtain information on projects/research findings/field work reports relating community mental health programmes in our country.

Letters, comments and communications should be addressed to: **The Editor, Community Mental Health News, ICMR Centre for Advanced Research on Community Mental Health, NIMHANS, Bangalore – 560 029, (India).**

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A BI-MONTHLY BULLETIN ON PRIMARY HEALTH CARE IN COMMUNITY HEALTH

Issue 18th June 1991

PREVENTING PROBLEMS OF THE MIND

Diseases of the mind, mental or emotional, are serious problems to our communities. Probably more work time is lost by mental problems than by any other disease. About 29% of all people have permanent mental handicaps and since they should have all the rights and privileges that other people enjoy, programmes of rehabilitation, meaningful work and the security of an understanding and affectionate home should be provided for them.

Another 89% of all people, at one time or the other are not able to function fully for various periods of time due to various degrees of serious emotional anxiety.

Because people always feel the need for meaning and purpose for their lives in their relationships with others, which gives a sense of personal worth, any threat to these feelings can cause anxiety (disease).

There are many causes of anxiety. Some of these causes are: loss of job opportunities; financial losses; job transfers; sickness; unwanted pregnancy; the approaching delivery date; menopause symptoms; an insult; separation or loss of family members and friends or a divorce and many other forms of threats that cause stress.

Normal reactions to anxiety caused by stress or threats to our well being are like those of "fight" or "flight". These can be: rapid heart beat; rapid breathing; trembling; tight muscles; perspiration; feelings of weakness and nausea; diarrhoea; urinary frequency, dry mouth or feeling of sadness (reactive depression). Those who are feeling sad may try to commit suicide without really intending to die. This is their silent cry for help. However, they may die because their plans are accidently successful!

These being normal reactions, they are prevented by:

(1) Understanding the cause of threats.

(2) Deciding proper ways to deal with them.

(3) Being involved productively in social and community activities.

Beyond these relatively normal reactions to anxiety there are **neurotic** reactions characterized by a loss of emotional control. People with these problems are usually still acceptable to society, often trying to get sympathy or pity by exaggerating their problems and demanding help in one way or the other.

Signs of neurotic reactions are:

1. Unexplainable and unusual temporary sensations in different parts of the body which are usually worse in tense circumstances.
2. Abnormal fear of disease with complaints of chest pain, awareness of the heart beating, or headache without evident physical cause.
3. Going from doctor to doctor because medicines don't really cure the problem.
4. Excessive hand washing, fingernail biting, nightmares, and difficulty in going to sleep.
5. Sudden loss of a certain body function (voice, use of arm or leg, sensations, even eyesight) excessively deep sighing or severe vomiting (these are called hysteria).

These problems can be cared for best by:

1. Showing genuine personal concern and respect for the patient and expecting respect in return.
2. Encouraging talking about the patient's feelings so that they begin to understand the reasons for them.
3. Giving a snack or warm drink to divert attention from the patient's sense of suffering.
4. Giving relistic firm reassurance that, if the patient is willing, the problem can be cared for effectively.
5. Helping the patient rediscover the joy of giving as well as receiving.

Even small children have neurotic reactions such as breath holding, finger sucking beyond infancy, hair pulling, stammering, stuttering, finger nail biting, abnormal eating patterns, stealing and lying. These are mostly attention and comfort seeking habits usually found in children wanting and needing more love without over protection and security without over-restriction.

Alcoholics and drug addicts are also neurotics who have sought ways to escape from their feelings with dependency developing drugs. They need specialized help.

There are other types of mental diseases requiring treatment by specialists. These are the **psychoses.**

I .Schizophrenics who have signs such as:

1. They are not easily accepted by society because they make others feel uncomfortable.
2. They do not realise that they have any problem and therefore are difficult to help.

   They don't want sympathy or help.
4. They escape from the real world with its problems into their own world, with which they often interact (as when they walk around naked or talk as if to some unseen person-hallucinations), and feel that those who don't understand them are trying to harm or even kill them (delusions). These patients can therefore be dangerous to others. There are now very helpful medicines given by specialists which may have to be taken permanently to help schizophrenic people feel more comfortable interacting with the real world so that many of them can be rehabilitated to not only care for themselves, but also perform productive tasks.

II. Physiologic Depression (morbid melancholy) of which the symptoms often are: inability to sleep, often waking up very early in the morning; constant tiredness; lack of ability to concentrate; withdrawal from other people and suicidal thoughts. This can be very serious as 1/7 of all severely depressed people actually commit suicide. As psychotics, they also want to withdraw from this world.

The first step in caring for a depressed person is to have a proper physical examination. The next step is to have a fully qualified physician or psychiatrist give proper medicine which may be needed only temporarily. These medicines are helpful in lightening the mood of the depressed patient, often restoring them to useful activity.

For both neurotic reactive depression or psychotic physiologic depression whether taking medicines or not, certain routines can be very helpful such as:

1. Do something constructive.

   Write a daily plan from the time one gets out of bed until it is time to sleep.
   (List everything in manageable steps).

   Don't wait until you feel like doing something to do it. ("Prime the pump") by getting started with even a small step).

2. Lend a helping hand to someone. Think "since I can do things I am not worthless" (human contact itself helps in healing—creates incentives for volunteering).

3. Schedule enjoyment with friends; doing enjoyable and manageable projects; mastering a new skill; dining out or going to cinemas; smiling as much as possible because behaviour shapes emotions; walking briskly; sitting upright (the actions that go with being happy can make one feel happy).

4. Exercise regularly by walking, jogging, swimming, bicycling etc. (Exercise boosts self confidence and the increased energy output later produces relaxation with reduced tension and anxiety.

5. Brighten the environment with bright lights and furnishings.

6. Read helpful books about depression.

Sometimes in addition to medicines, a machine giving electro convulsive therapy (E.C.T.) is useful for severe depression but this must be given only in well equipped centres by well trained specialists.

However, the best of modern machines are not capable of listening, caring, sharing with sympathy and loving kindness. This "third dimension" of healing recognises that it is our relationship to our neighbours, our environment, ourselves and the God we believe in that gives meaning and purpose to life.

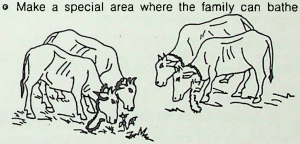
Probably the most meaningful or relationships and most powerful healing force in life is love.

Fiona Plus Focus

How to keep your neighbourhood clean

Action for the household to take

- Put all animal and human excreta into the latrine, and teach children to use the latrine. If there is no latrine, bury or burn excreta
- Keep the latrine clean at all times
- Put all food scraps into a special container which is covered and kept out of reach of children and animals
- Food scraps can be fed to domestic animals
- If animals are kept, keep them penned or fenced in
- Put all garbage in a container in a safe place away from children; keep it covered to keep out flies and rats. When it is full, take it to a special pit or dump, where it can be composted buried or burnt.
- If the community does not have a communal pit, dig a pit for the family, away from the water source, and fence it off. Each time rubbish is put in the pit, cover it with a layer of earth
- Fill in holes in the floor, in the street, and close to the home
- Dig drains to cary away water
- Keep the area around the home clean and free from garbage
- Make a special area where the family can bathe

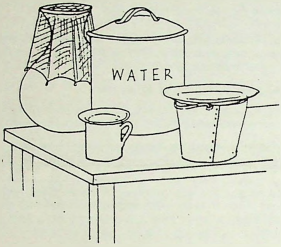


Action for each community to take

- Have a communal rubbish dump
- Put a fence around the rubbish dump
- Keep streets and children's play areas clean and free from dangerous objects and garbage
- Fill in holes in the streets and children's play areas
- Make sure that the well or standpipe is clean, and that spilt water can drain away
- Dig drains to carry away waste water and rainwater from each household or communal area

How to keep drinking water clean

- Keep drinking water in a clean container, such as a bucket, in a clean place
- Keep the contaier off the ground, away from children and animals



- Keep the container against a wall, away windows and the cooking area
- Always keep a clean cover over the container, even when it is empty
- Make sure that the container has no leaks or cracks, and that the lid completely covers the mouth of the container
- Clean the cover every day, with boiling water if possible
- Rinse the bucket or other container for drinking water inside and outside each time it is empty
- Always use the same container, such as a mug, to take water out of the bucket. Do not use this container for any other household tasks
- Pour the water from this container into a clean cup (or clean hands) for drinking
- Never put hands or fingers into the drinking water bucket
- Do not put hands or fingers into the cup; hold it on the outside or by the handle if it has one
- Keep the mug upside down on top of the cover

Handwashing

You should wash your hands with soap and water:

- after using the latrine/defaecating;
- before cooking;
- before eating, or feeding children;
- before breastfeeding;
- after touching animals and poultry or anything dirty;
- after eating.

Keep a special cloth for drying hands; do not use clothes, which may be dirty.

Text of "How to keep your neighbourhood clean", "How to keep drinking water clean" and "Handwashing" has be extracted from 'Dialogue on Diarrhoea' AHRTAG, 1 London Bridge Street, London SE1 9SG.

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No method in the madness

IT is a matter of great sorrow that we Indians are showing an increasing tendency to adopt anti-social and violent means to get what we want. The phenomenon seems to have achieved epidemic proportions; no day passes without newspaper reports of destruction of property and murderous frenzy erupting in some part of the country. What has happened in Ayodhya epitomises the virulence of a disease which threatens the very life of the nation.

The situation is frighteningly complex. No one can underestimate the pain caused by economic disparities, religious bigotry and caste hierarchies. No one denies the role of political forces both within and outside the country which exploit the people, especially our youth, in the name of injustice. But how does one explain the senselessness of violence that has been unleashed on the families of Punjab policemen or is seen during the Bihar pogroms?

WHAT makes the current situation in the country so frighteningly complex is the irrationality of the recent violence. Making a psychiatric diagnosis of the aggression, R.L. KAPUR feels a deeper understanding of militant enthusiasm is necessary before a cure is found.

At times, the violence is a part of some ideology, as for example, behind the Naxalite movement in West Bengal. But how does one account for the aggression that erupts when students are not allowed to copy in examinations or when tickets to a coveted cinema show are sold out?

The irrationality of such aggression strikes one even more when it is self-directed as in the case of the self-immolations which followed the move to implement the Mandal Commission report.

Most of the children who doused themselves with kerosene were too young to be emotionally involved in the complex philosophical issues behind the Mandal Commission controversy. Finally, what defence could be offered for the happenings in Ayodhya? If pride in Hindu culture was the aim, the destruction of the mosque was the best way of ensuring the opposite. What seems to be common to all the cases mentioned above is an incendiary fury which is ready to ignite at the slightest frustration, the causes of which must be examined not only in terms of political, economic and social factors but at a much deeper — psychological — level.

LET us first look at the psychobiological roots of violence. It has to be admitted that violence is a part of nature. One lives by eating other life forms and this is possible only through violence. Violence against members of one's own species is also prevalent in the animal kingdom. Ethologists tell us that it is the intraspecific violence which helps in distribution of populations (thus, leading to more equitable availability of food). It also helps in selection of the strongest genes and the formation of hierarchies. This kind of violence must have played much part in the formation of primitive human groups but there are certain checking mechanisms against aggression which are also a part of our biological makeup, without which, the intraspecific violence would have led to the annihilation of species.

One such checking mechanism is a desire not to hurt another being. This desire is based on a cognitive understanding of similarity with the other and the related emotion of empathy which arouses a sense of pain when the other is suffering.

It is this empathic ability which is then elaborated by culture into mutual obligations, group values and group symbols which ensure strong ties between people. It would not be an exaggeration to say that while the history of humanity has been largely written in terms of wars, all major civilisations have links with and much of human progress has origins in this nascent sense of empathy which first makes its appearance at the age of two.

Children learn through a process of identification — that is by modelling themselves on others: fathers, mothers, teachers, friends and even mythological heroes.

Healthy societies nurture empathy by the way of strong cultural traditions, operating through adult figures one can trust and who therefore qualify as suitable.

In time, this kind of learning helps the child to grow up with an insight that others are as important as oneself and one's objectives are, in fact, better served through a mutual give and take.

So strong is the need for identification, especially during adolescence, that when cultural values are confusing and the role models inconsistent, there is a tremendous feeling of helplessness and despair.

As a result, some just opt out of adulthood, preferring to lead a dependent, escapist existence. Some allow the aggressive instinct — always lurking in the background — to take over and lash out desperately at the slightest frustration. Others are driven to follow small men with limited vision just because they appear to be clear and consistent.

These observations are relevant to present day India. There is no clear-cut understanding of one's

Continued on Page II

No method in the madness

Continued from Page I

rights and responsibilities as a member of a nation. Those who brought the nation into being are gone and those currently claiming power as national leaders are poor role models. No wonder, the people of India, especially the youth, are showing the kind of reactions mentioned above.

THERE is one more psychological insight pertinent to the phenomenon of violence which I would like to highlight. Lorenz talks of Militant Enthusiasm, a particular kind of communal aggression which has a psycho-biological basis.

In this state "... a shiver runs down the back and ... the outside of both arms. One soars elated above all ties of everyday life. One is ready to abandon all for what ... seems to be a sacred duty ... instinctive inhibitions against hurting and killing one's fellows, lose much of their power. Men enjoy the feeling of absolute righteousness even while they are committing atrocities.."

Lorenz says that a similar response is also shown by chimpanzees when defending their respective groups. While in our primitive ancestors this kind of aggression emerged to defend a group of concrete individuals, now, through a process of cultural conditioning, the same response occurs when one believes that the customs, rites and symbols of one's immediate group are being challenged.

Lorenz goes on to examine the trigger mechanisms for such a response. These are, among others, an inspiring leader figure and the presence of others who are emotionally charged in the same fashion.

WHEN I read about the communal riots in India, Lorenz's description jumps to my mind.

What can a psychiatrist offer as a solution to the crisis faced by the nation. One is, of course, a little deeper understanding of the phenomenon. If the above account, brief as it is, makes possible this understanding, I would be happy. However, there are a few other things which come to mind.

There is a pressing need for a crash programme on universal education. Education brings information and the more informed people are, the less inclined they will be to be led by small men. There is a need to resurrect value education which seems to have disappeared from the school curricula, but value education is at its best when the young are exposed to the realities of life.

I am strongly in favour of a moratorium on formal education for 1-2 years after school, so that the young go and work with the voluntary service organisations.

Finally, there is a crying need for new leadership. As mentioned above, the young are thirsty for good role models but they are also good judges of hypocrisy. Those who believe in broader values and aspire for leadership will have to demonstrate these by personal example. Gandhiji was no freak phenomenon.

(Dr R.L. Kapur is Professor of Psychiatry and Deputy Director, National Institute of Advanced Studies, Bangalore).

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Round the World

From our Correspondents

Pakistan

REVOLUTION IN MENTAL HEALTH CARE

In most parts of the developing world, services for mental illness barely exist outside the major centres of population. Several million people with epilepsy, schizophrenia, or severe depression either receive no treatment at all or get treatment which is harmful or ineffective. Mentally handicapped children face a variety of experiences ranging from neglect, confinement, or victimisation to the expenditure of their parents' resources on spurious cures. Psychiatrists have tended to preside over largely custodial mental institutions which are the legacy of the colonial past, and otherwise tend to provide outpatient care for those able to travel to see them.

The integration of provisions for the mentally ill into primary care was encouraged by the World Health Organisation and pioneered in India about ten years ago.[1] It has now been developed a step further in Pakistan. In this model, psychiatrists find themselves doing three things they have not done before: providing training courses to enable primary-care physicians and multipurpose health workers to carry out the additional clinical work; engaging in extensive health-education activities with community and religious leaders; and providing a backup service on a sessional basis in the primary-care clinics.

The new service in Pakistan has been started in a rural area with a population of 400 000 near Rawalpindi. Attention has so far been focused on five conditions: psychosis, epilepsy, depression, mental handicap, and drug dependence. The multipurpose health workers routinely visit each house in the villages to check on immunisation, tuberculosis, and sanitation and to distribute oral rehydration salt for children with diarrhoea. They have now taken to showing the villagers five coloured cards. Each card has a picture of a person with an illness together with basic facts about the illness; and villagers are asked to say whether they know of anyone with the condition. The campaign has led not only to a staggering increase in the number of patients coming to treatment for the five illnesses but it has also caused the villagers to start using the clinics for general health care to a greater extent.

A flow chart has been drawn up for each of the five illnesses, showing what symptoms raise suspicions of the condition, which additional symptoms confirm it, and how the illness is managed.

1 Wig N, Murphy S, Hedberg T. A model for rural psychiatric services. *Indian J Psychiatry* 1965; 2: 275–80.

The primary-care physicians have the most complete form of these charts on the walls of their offices and they are used to instruct the multipurpose health workers. A simplified version of these charts is displayed in the waiting rooms of the primary health clinics.

The most exciting recent development has been the work in the schools, since children are the eyes and ears of a village. Teachers set aside five minutes each day for health education, and they have been extensively briefed by the visiting psychiatrists. The campaign has components of prevention, treatment, and rehabilitation and it has been introduced with three slogans: "smoking is injurious to health", "mental illnesses are not caused by *jins* (spirits), they respond to treatments like physical illnesses"; and "it is a grievous sin to laugh at someone with a mental or a physical disability". This campaign has caused a striking additional increase in referral rates to the primary health clinics for epilepsy and mental handicap, as well as increases in referrals for the other three conditions.

One 11-year-old burst into tears after his teacher described the symptoms of psychosis: "Sir, we had thought my father was possessed by spirits. I now know him to be mentally ill." The boy's father had been confined to the house for four years with violent behaviour related to hallucinations: the story has a happy ending.

The service was set up without additional resources, other than the preparedness of psychiatrists and primary-care physicians to allocate their time differently, and the costs of travel and the printing of cards and charts. The staff of the primary-care clinics is the same as it was, and the cost of psychotropic drugs has been met by savings on expensive tonics and placebos. Most important of all, the community leaders are enthusiastic, as they see the achievements of the primary-care workers. Now that the new service is well into its second year, it is possible to begin to get a clearer idea of the resource implications. One of the primary-care physicians who has had special additional training in psychiatry spends his time travelling between the basic health units giving advice on the more difficult cases, and each unit is visited once weekly by an academic psychiatrist from the university department. The larger basic health units serve approximately 60 000 people and have a small number of beds for severely ill patients: some of these beds are now used for mental illness, and there are two small wards in the Tehsil General Hospital, which serves the entire area. Academic psychiatrists visiting the rural centres now come accompanied by their medical students, who assist by taking histories from patients and their relatives. It seems likely that when these students become primary-care physicians themselves, they will have a very much clearer idea about the way in which mental illness presents in general medical settings than will students trained entirely within the walls of the hospital.

attached – (photo-copy)

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مرکز برائے ذہنی امراض

آپ سے درخواست ہے کہ مریض کو دیہی مرکزِ صحت/بنیادی
مرکزِ صحت _____ میں علاج کیلئے لائیں۔

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مجلة الخدمات الصحية لإقليم شرق البحر المتوسط

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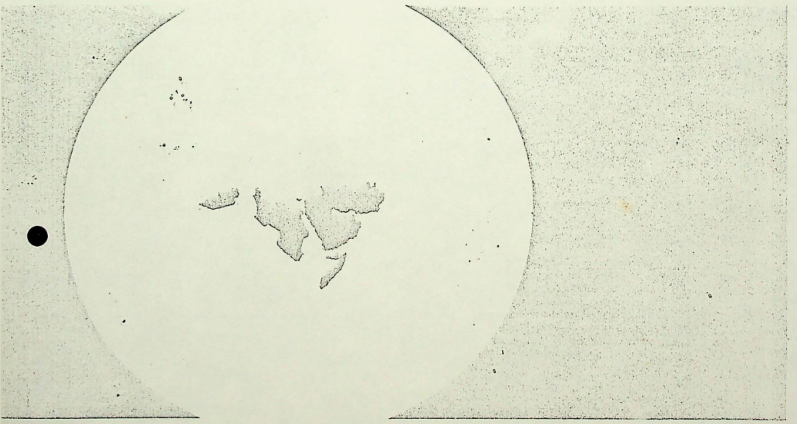

منظمة الصحة العالمية
المكتب الإقليمي لشرق البحر المتوسط

WORLD HEALTH ORGANIZATION
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COMMUNITY-BASED RURAL MENTAL HEALTH CARE PROGRAMME
Report of an experiment in Pakistan

M.H. Mubbasher[A] Shakeel J. Malik[A], Javed Rasool Zar[AA], N.N. Wig[AAA]

ABSTRACT

Mental well-being is an integral part of WHO's definition of health. The existing institutionally-based mental health services in the developing countries are grossly inadequate owing to shortage of specialist manpower and limited economic resources. An alternative approach is to decentralize mental health services through integration with general health services at primary health care level. In a WHO supported project carried out in rural parts of a sub-district in Pakistan during 1985-1986, 117 medical officers, 75 medical assistants and 617 multipurpose health workers were given short training courses in mental health with the help of specially prepared manuals. Following this training, four existing rural health centres started providing mental health services to the local community. Within a period of about a year, over 1700 cases of various types of common mental illness were seen. These included cases of depression, psychosis, neurosis, epilepsy, mental retardation, organic syndromes and drug dependence. Supervision and referral facilities were provided by the visiting team from the department of psychiatry of the neighbouring medical college. The essential neuropsychiatric drugs, limited to three or four medicines, were provided by the local health department. The community response was very supportive of these mental health services. The experience suggests that it is both feasible and practical to deliver mental health services integrated with general health services at primary health care level in developing countries. However, in order to ensure the success of these programmes adequate supervision and referral facilities along with continuous supply of essential neuropsychiatric drugs are considered necessary.

RESUME

La santé mentale fait partie de la santé telle que définie par l'OMS. Les institutions pour les services de santé mentale existantes dans les pays en voie de développement sont généralement inadequates, en raison du manque de spécialistes et des ressources économiques limitées. Une approche possible est de décentraliser les services de santé mentale en les intégrant avec les services généraux de santé au niveau des soins de santé primaires. Au cour d'un projet aidé par l'OMS, dans une zone rurale au Pakistan durant 1985-1986, 117 médecins généralistes, 75 assistants médicaux et 617 auxilliaires de santé ont reçu une courte formation en santé mentale utilisant des manuels specialement préparés. A la suite de cette formation quatre centres de santé ruraux ont commencé à offrir des services de santé mentale à la communauté locale. En l'espace d' une année environ plus de 1700 cas de maladies mentales, comunes de types variés, ont été reçus dans ces centres. Ils comprennent des cas de dépression, de psychose, de nevrose, d'épilépsie, de retard mental, des syndromes organiques et de dependence médicamenteuse. La supervision a été assurée par des équipes venant du département de psychiatrie, de la faculté de medecine voisine. Les médicaments essentiels de neuropsychiatrie limités à deux ou trois ont été fournis par le centre de santé local. La réponse de la communauté à ces services de santé mentale a été très favorable. L'experience suggère qu'il est à la fois possible et pratique de fournir des services de santé mentale intégrés avec les services généraux de santé au niveau des soins de santé primaires dans les pays en voie de développement. Cependant afin d'assurer le succès de ce programmes une supervision adéquate, un système de référence et l'approvisionnement continu en médicaments essentiels sont considérés comme nécéssaires.

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INTRODUCTION

Mental well being is an essential element of health and the goal of Health for All by the Year 2000 cannot be achieved unless mental health is given appropriate attention. Accordingly, prevention and control of mental, neurological and psychosocial problems should be given higher priority in national programmes than is now the case in many countries. At a recent inter-country meeting in Damascus [1] it was noted that some 300 million people in the world suffer from one or other of the various types of problem in this area. Of these, some 40 million suffer from psychoses and related conditions while an estimated 25 million suffer from epilepsy. Alcohol and drug dependence are now ravaging younger age groups [2,3].

Existing health care, including mental health care, has so far failed to provide for the needs of most of the world's population. The existing systems are, for the most part, centralized, hospital-based, specialist-focused and disease-oriented; health care is delivered by medical personnel via a one-to-one doctor/patient relationship. In developing countries in particular, these systems have produced a form of care inconsistent with the principle of social equity.

A WHO study group [2] reviewed the mental health services in developing countries and concluded that:

(a) the need for mental health services is as great in rural as in urban areas;

(b) decentralized mental health services could be operated at the primary health care level in rural and urban areas in developing countries; the methods of treatment provided are effective and seem acceptable to the community;

(c) mental health care could be provided by general physicians and by auxiliaries, including community health workers, after they have undergone limited psychiatric training; this approach has been adopted in many centres, which have produced training manuals in local languages;

(d) some mental health skills should be taught to all medical staff, not just to enable them to help the mentally disturbed but also to improve their delivery of all forms of medical care.

In many developing countries, where specialist manpower and material resources are limited, extension of mental health services through the existing infrastructure of the health systems might be one way through which mental health care could be provided to the millions of cases in the vast rural areas who are currently not receiving any kind of modern mental health service [4,5]. The present report describes the experiences which have resulted from a WHO-supported project in Pakistan, the aim of which is to extend mental health services to rural areas.

OBJECTIVES OF THE PROJECT

Generally,

- to develop a model for the extension of mental health services to rural areas through the existing infrastructure of primary health care.

Specifically,

- to develop a set of priority disorders in mental health for inclusion in primary health care services;
- to provide an effective basic training in mental health care to primary health care personnel;
- to organize a system of referral for mental health cases from the primary health care facility to the referral facility;
- to develop an effective follow-up service;
- to stimulate community effort in mental health care.

The project, with the above-mentioned objectives, was started in Tehsil* Gujar Khan in 1985, covering an area and population of the entire tehsil.

*Sub-district

A social and demographic profile of the field practice area is given below:

SOCIAL AND DEMOGRAPHIC PROFILE

Tehsil Gujar Khan District Rawalpindi

Situation	north-east of Rawalpindi, Pakistan
Total area	962 square miles
Distance from Rawalpindi	50 miles
No. of villages	380
Total population	417 000
Rural population	378 000
Density of population per square mile	742
Ratio male:female	1052:1000
No. of cinemas	2
No. of police stations	3
Major crops	wheat, bajra
Total no. of mosques	1020
Total no. of commercial banks	20
Total no. of cooperative societies	147
Total number of post offices	76
Literacy rate	
(a) male	25%
(b) female	7%
No. of primary schools	216
No. of middle schools	54
No. of colleges	1

PHASING OF THE PROGRAMME

The project had four distinct phases.

Phase I

The first phase involved collection of background information on the social and other characteristics of the project area, the existing health facilities and the current health problems. In addition, interviews with health personnel were arranged in order to assess current mental health knowledge, the extent of mental health care provided and their willingness to take up mental health work. The extent of the community's perception of mental disorders was also elicited. During this phase a weekly psychiatric clinic was set up in the area.

Phase II

The second phase involved the training of primary health care personnel in a task-oriented manner. This training was carried out at the tehsil hospital and at the Department of Psychiatry, Rawalpindi Medical College.

Phase III

The third phase involved monitoring of the mental health care personnel. Data was maintained regarding case identification, patient care, treatment provided, referral and outcome.

Phase IV

The fourth phase dealt primarily with analysis of the results and an in-depth study of the attitudes of the health staff and of the community towards mental health.

DESCRIPTION OF THE PROJECT

The planning of the project was done in close collaboration with the Deputy Director of Health Services and the staff at the rural health centres and basic health units. Cooperation was also obtained from the union council, district council and the local community leaders. The project coordinator visited the area extensively over a number of weeks and addressed many prayer meetings in mosques.

For provision of services, four rural mental health centres with an integrated rural health complexes at Mandra, Daultala, Qazian and the Civil Hospital in Gujar Khan. Each of these rural health complexes coordinate further with between six and eight basic health units.

A team from the Department of Psychiatry, Rawalpindi Medical College visited the rural health centres, the basic health centres, the union councils and the district council in order to create a climate of better understanding and motivation in the community and amongst the health care personnel. The visits were also helpful in assessing the prevailing attitudes, both in the community and amongst the health workers to mental health care. One of the most important objectives was to determine why health care facilities remain unutilized even when they are available. The record-keeping system envisaged by the programme was also pre-tested.

TRAINING OF HEALTH STAFF

The training of health staff had the following objectives:

(a) to provide basic knowledge about the importance of human behaviour in health and disease;

(b) to make health personnel familiar with the wide prevalence of mental, neurological and psychosocial disorders in primary health care;

(c) to enable recognition and management of the following priority disorders: severe depression, neurosis, psychosis, epilepsy, mental retardation, drug dependence.

Training of primary health care physicians

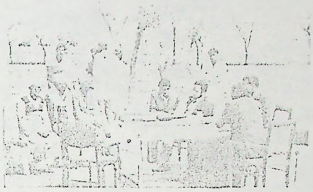
This training was carried out at the Department of Psychiatry, Rawalpindi Medical College, and the rural health centre in Daultata. The training consisted of lectures, case discussions, field work and visits to rural mental health centres. The medical officers were encouraged to start mental health clinics on a pilot basis. The difficulties they encountered were reviewed by the visiting teams from the Department of Psychiatry.

Training of multipurpose health workers

With a view to decentralization the multipurpose health workers were each trained in their own region. They were given lectures followed by case discussions and exercises to practice the knowledge acquired. A manual, written especially for them, was also provided, its aims being to train them to identify patients suffering from acute-psychosis, epilepsy, depression, drug abuse and mental retardation. The manual, lectures, discussions and exercises were all in the local language, Urdu. The multipurpose health workers were also trained to educate people about the dangers of heroin, charas and other drugs, to care for and treat patients with convulsions, and to refer patients to hospitals for expert management if and when required.

COMMUNITY ORIENTATION

A massive community-orientation programme was launched, aimed at reaching as many of the public as possible. To this end teams from the Department of Psychiatry, Rawalpindi Medical College, addressed prayer congregations, especially Juma (Friday prayer) congregations. The community was also reached through the school system, the local health facility and through the village headman, "numberdar" or "punchiayet". Pamphlets, handouts and other literature on the subject were extensively distributed and health committees were formed in each basic health unit. The members of these health committees included religious leaders, teachers, councillors and other influential people of the community.



Weekly rural psychiatric clinic given by the Dept. of Psychiatry, Rawalpindi Medical College.

PROVISION OF ESSENTIAL DRUGS

As part of the project, essential drugs have been provided at the different levels of the health care delivery system. The multipurpose workers have been provided with phenobarbitone and chlorpromazine; medical assistants with phenobarbitone, chlorpromazine and imipramine; and the medical officers at basic health units with phenobarbitone, chlorpromazine, imipramine and injection fluphenazine decanoate. The medical officers at the rural health centres have diazepam in addition to the above drugs.

DEVELOPMENT OF REFERRAL SYSTEM

The trained mental health care personnel are expected to identify the

TABLE I. PRE- AND POST-TEST ASSESSMENT OF PERFORMANCE OF HEALTH PERSONNEL

Tier of health personnel	Assessment score: Pre-training test				Post-training test			
	Grade*				Grade*			
	A	B	C	D	A	B	C	D
Medical officers	3	10	33	74	46	58	13	Nil
Medical assistants	Nil	Nil	3	72	13	29	33	Nil
Multipurpose health workers	Nil	Nil	7	664	109	335	59	04

*A - Above 70% C - 40-59%
B - 60-69% D - below 40%

mentally ill during visits to the villages and to work in close collaboration with the health care delivery system. Special referral cards were introduced to enable quick referral from the periphery to the centre and back. A community mental health care centre was established in the Department of Psychiatry, Rawalpindi Medical College, to coordinate the activities.

RESULTS

Phase I: Study of the attitudes of the health staff and the community

Total no. of people interviewed	317
Medical officers	57
Multipurpose health workers	79
Community leaders (numberdars, patwaris, masjid imams)	53
Patients	128

Analysis of knowledge/attitudes

Health personnel

The main constraint experienced by the various tiers of health personnel was inadequate training and skills in detection and management of psychiatric disorder. Even if a disorder was diagnosed there were no suitable facilities for drugs and referral.

Community

The community's approach towards mental health care was punctuated with scores of taboos and myths based on ignorance, lack of mental health care facilities and exploitation by non-qualified healers. The prevailing attitude was that mental disorders are inflicted as punishment from God and are untreatable, and that if treatment is possible at all it is extremely expensive.

Phase II: Results of training

Total no. of persons trained	853
Medical officers	117
Medical assistants	75
Multipurpose health workers	671

Analysis

The health personnel were evaluated in a pre-test assessment which took the form of a written test during their training workshops/classes. In addition to continuous monitoring during the courses all the participants underwent a post-test assessment. Performance ability and knowledge were counted on a scale of grades, A, B, C and D, roughly equivalent to 70+%, 60-69%, 40-59%, and less than 40%, respectively. The majority of personnel showed marked improvement between pre- and post-test assessments, as shown in Table I.

Phases III and IV

Following monitoring of mental health care personnel and through the data collected, the response of the

TABLE II. NUMBER OF PATIENTS SEEN, FOLLOWED UP AND REFERRED AT MENTAL HEALTH CENTRES

	Total patients		Follow-up		Referral	
	1985	1986*	1985	1986*	1985	1986*
Mandra	7	537	Nil	170	Nil	17
Daultala	32	469	5	138	Nil	29
Qazian	13	230	Nil	37	Nil	19
Gujar Khan	43	487	17	155	Nil	45

*Data relates to the period January-June 1986 only.

TABLE III. DIAGNOSTIC BREAKDOWN OF PSYCHIATRIC ILLNESS IN VARIOUS MENTAL HEALTH CENTRES

Mental disorder*	Total no. of patients	Mandra Total M	F	Daultala Total M	F	Gujar Khan Total M	F	Qazian Total M	F
Depression	592	207 77	130	140 47	101	148 43	105	89 59	30
Neurosis	432	152 48	104	108 51	57	96 44	52	76 40	36
Psychosis	180	55 20	35	45 20	25	44 17	27	36 26	10
Epilepsy	168	60 30	30	42 20	22	45 25	20	21 10	9
Mental retardation	274	95 55	40	68 37	31	65 37	28	46 42	4
Organic syndrome	24	10 6	64	5 3	2	7 4	3	2	2
Drug dependence	68	28 26	2	15 13	2	17 16	1	8 7	1

*Diagnostic classification as used in the training manual "Rahnuma-i-tarbiat".

community in bringing mentally ill patients to the rural centres was shown to be positive. This is reflected in Table II. A diagnostic breakdown of cases is shown in Table III.

The impression received after one year indicates quite strongly that there is widespread community acceptance of delivery of mental health services at the primary health care level. In the past the mentally ill patient from rural areas had to be taken to the Department of Psychiatry at Rawalpindi (20–50 km) or to the mental hospital in Lahore (about 200 km). As a result of the new service, many mental patients who had been ill for a number of years received adequate psychiatric treatment for the first time. Another significant change noticed by health staff was that, as a result of the introduction of mental health training, health staff started spending more time in talking to patients and families. This led to an increase in the total attendance at the rural clinics and, consequently, better overall utilization of services. The cooperation of health staff at primary health care centres was generally very good and they seemed to like their new role as providers of mental health services. However, for the success of the project, adequate supervision, quick referral facilities and continuous supply of essential drugs were considered essential.

CONCLUSIONS

(1) A significant proportion of patients attending general health clinics in the developing countries have psychiatric problems which go undetected.

(2) The existing primary health care staff working in such countries can, with only limited training, recognize the majority of these disorders, and can intervene effectively by providing treatment and follow-up.

(3) Specified treatment leading to reduced disability in defined neuropsychiatric disorders can be provided through the health service structure existing in the developing countries.

(4) The social functioning of individuals who are seriously disabled due to neuropsychiatric disorders can be improved by stimulating community action through education.

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MENTAL HEALTH AND MANPOWER: THE COST OF MENTAL ILLNESS AND THE EFFECT OF APPROACHES TO VOCATIONAL REHABILITATION

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I. Introduction

I want to thank all of you, members of the Tamil Nadu Branch of the Indian Association of Occupational Health, for the opportunity given to me to participate in this meeting. I want particularly to express my sincere thanks to Dr. S. Nagraj, Hon. Secretary, for his kind invitation requesting me to give a talk at this important occasion.

The subject for my talk is: Mental Health and Manpower - The Cost of Mental Illness and the Effect of Vocational Rehabilitation. In this paper, I would attempt to deal with the following issues: (a) Who are the mentally healthy employees? Their characteristics? (b) Cost of Mental Illness (c) and the Effect of approaches to vocational rehabilitation. In this context, I shall particularly like to discuss the role of industrial medical officers in promoting mental health in industry.

II. Mentally Healthy and Mentally unhealthy Employees

Mentally healthy, productive, growth-oriented and successful organizations differ from the sick, unproductive, short-term profit oriented and stagnant organizations. The difference lies in the goals of the organization, nature of human resources, the philosophy of management toward human resource utilization and the infrastructure availability for effective human resource utilization. The difference in the two types of organizations is primarily due to the mental health of the

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Talk given at the Indian Association of Occupational Health Meeting, Tamil Nadu Branch, March 11, 1979.

employees. Question arises what are the characteristics of mentally healthy employees? How far are they different from the mentally not healthy employees? The mentally healthy individuals have the following characteristics (Jahoela, 1958).

1. The mentally healthy person is able to get along with others. He adjusts himself to the group and the prevailing norms. In other words, success comes with the ability to work with associates, not against them.

2. The mentally healthy person acts to solve problems as they arise. He faces up to him problems and then does something about them.

3. The mentally healthy person enjoys work. He gets satisfaction out of doing a job and this contributes to his on-going state of mental health. In other words, those who have a zest for working, may be said to be mentally healthy.

4. The mentally healthy person controls his emotions and/or directs them into harmless outlets.

5. The mentally healthy person plans ahead without fear of the future.

6. The mentally healthy person establishes goals for himself that are within the limits of his capacities to reach and then he strives to his utmost to achieve these goals.

7. The mentally healthy person accepts himself the way he is -- physically, mentally and socially.

8. The mentally healthy persons are highly motivated and goal-directed. They integrate their goals with the goals of the society and channel their creative energies toward betterment of the society.

9. The mentally healthy persons have the ability to control their frsutrations and emotions and channel these emotions toward constructive ends.

10. The mentally healthy persons are able to relate with the world, accept each persons the way he/she is and show genuine concern toward the welfare of other human beings.

On the other hand, mentally unhealthy or mentally sick persons do not have clear goals; their motivational orientations are directed toward satisfaction of animalistic needs; they live in the past or in the future rather than in the present; they have excessive anxieties, fears and show neurotic and psychotic behaviours; they are not aware of their abilities and potentialities; rather than being engaged in productive-constructive behaviours, they tend to show high grievance behaviour, sickness, accident proneness, frequent visits to the medical doctors and hospitals, and are passive destructive in their behaviours.

III. Cost of Mental Illness

No clear survey in India has been made as to the degree of mental illness in industry. Be it in the form of effects of indecisiveness, alcoholism, drug addiction, psychopathic and psychotic behaviours, and other emotional disorders. Newspaper reports and other surveys, however, clearly indicate the degree of job dissatisfaction among employees at various levels of the organizations, both in public and private sectors; low productivity and profitability of organizations; high degree of absenteeism and escapism from work; investments made of employees through Employee State Insurance schemes and other welfare schemes, strikes, lock-outs and other delays and bottlenecks experienced in the process of achieving the organizational goals. These people-problems are almost common in all types of organizations -- a factory, store, laboratory, hospital, office, major private or public sector organization.

For the purpose of this paper, I would like to illustrate the cost of one type of mental illness, ie. absenteeism from work which is an escapism from dissatisfying job and organizational climate.

According to the latest available statistics (1974), there are approximately 22 million people working in the organised sector of Indian economy. This includes approximately 13 million in the public sector and 9 million in the private sector. The absenteeism rate reported ranges from 8% to as high as 30%. If we take one per cent of the employment force as being absent from work due to sickness, we will have approximately 220 thousand people being absent on a single day. Let us assume the average compensation per employee is Rs.20/- per day. At the rate of five full working days a week (in most of the industries it is 5½ days working week), we would have a loss of Rs.114.40 crores during a year. If we include absenteeism from work on other grounds -- there are possibly hundred other different reasons -- the figure will have to be multiplied by at least 20 times.

As managers, administrators and supervisors, you are certainly concerned with what are the causal factors of this absenteeism. Many administrators, however, feel that some degree of absenteeism is normal, just like many individuals feel that getting sick once in a while is normal.

As a health professional, it is possible to have good health and not get sick. There are enough examples all round that in spite of serious sicknesses, persons have been very productive. However, several attempts have been made to study the causation of absenteeism. For example, Newton (1950) in a study of absenteeism, compared machine shop employees who tended to have more absenteeism over a two-year period with those who tended to be relatively absence-free. The two groups were matched as far as possible on age, length of service, and other variables. He found that the high-absence employees were less emotionally stable than the ones with low-absence rates.

Another study of absenteeism among female employees in a telephone company was conducted by Plummer and Hinkle(1952). They compared 20-year service employees who had the highest absence records with 20-year service employees who had the lowest absence records in terms of medical case histories. It was found very definitely that the high-absence group had a much greater number of emotional disorders and other kinds of disorders which had an underlying emotional basis.

I conducted a comprehensive study of approximately 400 professional managers, engineers and scientists in several industries and studied the personality factors related to absenteeism. In the last 12 years, I have also maintained statistics on graduate and under-graduate students with regard to their absenteeism. In both these studies, I have found that the absenteeism group tends to be high in their lying, neurosis, tend to be emotionally less stable, are less willing to assume responsibility, live in either past or the future,and have low ego strength.

IV. Preventive and Rehabilitative Programmes

A. Management Responsibilities

The question which the organizational leaders and the managers are likely to ask is: What can the management do to minimise sickness behaviours in their organizations? As indicated in the beginning of this paper, almost every social system has inherent potentials for stress and sickness. However, some of the following measures could be initiated in an organization for prevention of sickness situations in the organization.

1. The organizational leaders should have clear objective for the organization and the various members of the top management must whole-heartedly accept those objectives and commit themselves to achieving those objectives. This will minimise the climate of ambiguity at the top which usually filters down the organization in the form of neurosis.

2. In the light of the above objective, the organization must clearly and sincerely establish policies and practices for the effectiveness of the organization. The effectiveness of the organization is not only the result of achievement of its goals but basically the result of effective utilization of its human resources. The organization must be sincerely committed to the development and utilization of its human resources.

3. Keeping in view its objectives of maximum utilization of human resources, the organization must create meaningful jobs for its employees on a continuing basis. This requires that the organization must have an organizational development department seperate from the personnel administration department. The organizational development department's responsibilities are to create meaningful and enriching jobs for its employees and ensure that there is a maximum match between the jobs and the job holders.

4. The organization must be adaptable to the changing social, economical, political and technological developments. Thus the organizational structure must be flexible so as to accommodate internal and external resources as well as constraints. Flexible and adaptable organizational structure brings innovation, creativity and involvement of the people toward achievement of the goals and objectives.

5. The organization must select employees who are growth-oriented and later provide conditions and opportunities for continuing growth and development of its employees at various levels. Besides organizational responsibility, however, the individuals must take sincere efforts toward their personal and professional development.

6. To promote a mentally healthy organization, the employees at various levels must have a positive attitude toward themselves as well as others in the organization. Favourable inter-personal relationships, commitment and goal-directed behaviours will result in creation of a healthy environment in the organization.

B. Responsibilities of Industrial Medical Officers

The responsibilities of industrial medical officers and/or health institutes in an industrial setting can briefly be classified into four categories:

1. Humane care of the sick person (both physical and mental)
2. Early diagnosis, treatment and rehabilitation of the sick person.
3. Prevention of sickness (both physical and mental).
4. Promotion of positive health (both physical and mental) in industry.

1. Humane care of the sick person -- both physical and mental

The progress in medical and behavioural sciences has shown us that all problems, both physical and mental, are caused and thus can be treated. Until recently, some of the physical and mental problems, particularly the mental problems, such as alcoholism, drug addiction, psychotic behaviours, particularly paranoia, schizophrenia, psychosis, and sociopathic behaviours were considered to be the result of demonic or satanic origin of man and as a result were not treatable. Individuals suffering from such symptoms were institutionalised, like criminals, isolated from the community and the loved ones and made to suffer until death. Since 1961, the medical, psychiatric and psychological associations around the world have clearly stated that all such problems or 'sicknesses', like any other sickness, are treatable. It is thus the responsibility of the industrial medical officers to not only cure but provide care. Care is more than cure. Care is not only practicing the art of medicine, but also treating the individual as a human being with love, affection, and understanding. The industrial medical officers have, no doubt, to take care of a great number of patients and provide minimum care including cure and as a result cannot provide the best attention and care required. But at the same time it is the responsibility of the industrial medical officers to provide the best humane care possible.

2. Early diagnosis, treatment and rehabilitation of the sick person

The industrial medical officers interact with the employees at three levels: (a) at the time of medical examination, (b) when the employee visits the hospital or the medical officer visits the employee at home or at the work setting, and (c) interaction with the members of the family of the sick person.

A good physician who has perceptual ability and cognitive flexibility will be able to identify the individuals

at the time of medical examination who are prone to sicknesses and are likely to experience strains due to stresses in the organization. This the physician can only do if they educate themselves and are aware of the organizational dynamics and the environments in which the employees have to work. It is well documented in research that employees who have high degree of absenteeism rate and accident proneness visit more time the hospitals and come up with grievances, have emotional problems, particularly low level of emotional stability, low degree of frustration tolerance and have high degree of worries and anxieties in life. At the time of the employees' visit to the hospital, the physician, in the process of diagnosis and prognosis, must become human to interact with the patient, show interest in the employin the employee's work and needs, interests and home situations. Similarly, in those situations where the physician has the opportunity to work with the members of the family of the employee, the physician should be perceptive enough to study the family environment and gather information which might have bearing on the employee's work behaviour.

Keeping in view the work environment and the family environment, the physician should provide the cure and the care. He is expected to deal with simple facts of stress such as anxiety, frustrations, dejections and mild depressions. Like the family physician, if the resulting symptoms become very disabling or of grave nature he should refer the patient to specialists for consultation and treatment. This required that he should, to some extent, be effective in psychological and psychotherapeutic techniques as he is in the medical techniques. In simple language, he must understand the patient as a human being, understand his needs, his conflicts and defenses and know how to help him solve the problems. The art of medicine requires that the industrial medical officers should be

able to recognise the relation between the stress of circumstances and the patient's health and should develop the abilities to handle successfully the emotional and personality factors in illness. The more severe cases should be referred to the experts and, if necessary, the patient be admitted for medical and psychiatric help.

3. Prevention of sickness - both physical and mental

Each organization is a miniature, authoritarian, social, political and economic in nature. As a result, it influences the health and particularly the public health aspects of the organization. Your role as industrial medical officer is not only to provide medical care but also to promote public health in the organization. Your role, however, is certainly advisory rather than legislative. Most of the medical officers have no direct authority either in medical or related policies affecting the health of the employees. Still, however, as a medical officer, you are professionally responsible to work with the top management in developing and promoting public health policies in the organization such as clean drinking water, hygienic bathrooms and lavatories, clean and hygienic kitchen and canteen services, and minimal smoke, dust and noise in the industry. Such preventive measures will not only minimise physical sicknesses but also create a physical working environment condusive for better morale and job satisfaction.

Most of the mental sickness problems are due to stresses in the organization and the resultant strains experienced by the individuals. All of you, however, know that the degree of stressers experienced by the individuals are affected by the perceptual systems of the employees. The industrial medical officers thus have to serve as counsellors to the employees and help them alleviate the anxieties and strains. Major stressers are uncertainty of jobs, relationship with colleagues, inequitable

policies of the organization, the attitude of the supervisors toward the employees, lack of role clarity, quantum of work, high standards of performance required, and the demands from the personal life of the employee.

4. Promotion of positive health in industry

As all of you know, the positive health is different from absence of sickness. Positive health is the result of not only having a sickness free body and mind but also a continuing programme of maintaining healthy body and having positive attitudes, goals, carefully chosen occupations and continuing opportunities for fulfilment from the work. If such conditions exist in any industry, the employees are likely to experience minimal stresses and strains. The industrial medical officers should advise the management in promoting health education, family health, work orientations and social adjustment programmes in industry aimed at total well-being of the employees. The industrial medical officers should work with the departmental heads and the top management in suggesting jobs which provide the best opportunities to the employees for utilization of their knowledge and skills and continuing fulfilment from the work. The industrial medical officers can help create an environment of trust, openess, creativity, sharing and a sense of belonging. Such an environment will result in maximum creativity and goal achievement for the organization and maximum health and happiness for the employees.

To perform the above roles and responsibilities, the industrial medical officers should be truly professional so as to provide the best health service to all irrespective of their race, religion, sex and creed; should have the orientations of continually learning not only from books but learning from interactions with the patients; should have the ability to communicate effectively with all kinds of employees at various levels of the

organization; should have the positive attitudes and confidence so that they can project the image of a healthy human being to those with whom they interact; should be highly motivated and missionary in nature so that the quantum of work and the infrastructure in which they work do not easily frustrate them to perform their challenging roles; and should have the highest self-esteem and self-image which comes from commitment and dedication to the chosen profession.

The industrial medical officers should work with the top management and in fact should be on the Board of the management of the company to help develop organizational and personnel policies which will minimise mental health problems at work. My observations, based on my interactions with the medical officers who have participated in my various training programmes in the last two-and-half years, is that most of the medical officers are treated like employees and not even given the adequate recognition and importance as professionals which they deserve. It is my hope that the Indian Medical Association, Indian Association of Occupational Health and other professional bodies will strive toward a situation when the management will give the respect and acceptability to the medical officers and the medical officers of the industries will serve on the Board of the management of the companies.

I wish you, one and all, a great success and best wishes for your challenging role as a health professional in your organizations. Thanks again for the opportunity given to me to share my thoughts on the subject with you.

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reaching the unreached

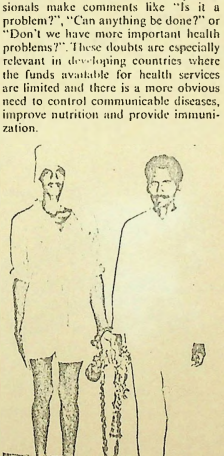
by R. Srinivasa Murthy

In the last two decades there has been a major shift in the organization of health services all over the world. There have been efforts to "deprofessionalize" many health activities, to decentralize services and to 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 individual health care. In this context, the present article attempts to highlight possible ways of providing mental health care in peripheral health centres of developing countries, and in particular of India.

Traditionally, mental disorders have been considered as a problem of the affluent countries. The organization of services is thought to be too complex and expensive for developing countries. Thus it is not surprising that there is, at present, very little recognition of mental health needs within general health services.

The reasons behind this relative neglect of mental health needs are not difficult to understand. Firstly, until about a decade ago there was very little reliable epidemiological data relating to the distribution and prevalence of mental disorders in the population. Secondly, in the past the major effort in planning the services was directed towards establishing mental hospitals and clinics. These mental hospitals were more often custodial than therapeutic. Thirdly, there has been a severe shortage of trained professionals, and few of those available have been working in urban centres. Fourthly, the general public often view mental disorders from religious, superstitious and magical standpoints. This has limited the effective utilization of even the available services. Fifthly, there have been no meaningful models for the provision of services suited to rural societies; the research efforts of the professionals have only recently been directed towards this field. Lastly, the supply of psychotropic drugs is limited and very few welfare agencies exist to undertake rehabilitative work.

It is not unusual to hear health planners, administrators and medical professionals make comments like "Is it a problem?", "Can anything be done?" or "Don't we have more important health problems?". These doubts are especially relevant in developing countries where the funds available for health services are limited and there is a more obvious need to control communicable diseases, improve nutrition and provide immunization.



Above: *Even today, acutely ill patients in some countries are managed by being restrained in chains rather than by drugs and hospitalization.*

(Photo WHO/R. S. Murthy)

Right: *Too much emphasis in the past was placed on large central mental hospitals, more often custodial than therapeutic.*

(Photo WHO/E. Schwab)

At this point a brief consideration of the magnitude and the public health importance of mental health will illustrate the need as well as the scope for organizing services. Epidemiological studies from different parts of India during the last decade have shown that different forms of mental disorders are prevalent in all cultures and communities. The prevalence of different forms of psychoses is about one per cent, and if mental retardation and epilepsy are included it is about two per cent. This figure represents the severely ill, requiring care.

What about their "community effect"? It is estimated that about one-fifth of all the disability in a community is due to mental disorders, and these cause a still greater degree of social disruption. For example, the frequency of marriage-related problems in schizophrenia were shown in a Chandigarh study to be about ten times that for the comparable general population. A significant number of students with schizophrenia do not complete their studies. The effect on the family members is another aspect of the problem; nearly half of them resented a schizophrenic living in the family. The effects of psychotic depression in terms of individual suffering, loss of production and the risk of suicide illustrate the importance of treating acute psychoses.

But mental health care is not just the care of psychotics. Health services are burdened in their routine work with a significant proportion of patients with emotional disorders. Studies carried out at a big referral hospital at Vellore, South India, and in the peripheral health centres of the Raipur Rani Block, in North India, have shown that nearly 30 per cent of general out-patients have mainly emotional problems. These cases are most often mis-diagnosed, leading to costly and time-consuming investigations and treatments. This mal-utilization of the limited health services can be avoided if primary physicians and health workers are trained in mental health care.

In addition to the above traditional problems, there are others. Some examples are the growing problem of drug abuse and dependence, adverse effects resulting from the break-up of the joint family system, and the ill-effects of industrialization and urbanization. In a developing country like India, social upheaval is inevitable as a result of attempts to increase the rate of development and modernization. If adequate plans are not made, there is every likelihood that these problems will soon become the chief burden of the welfare services. Planning ahead and prevention are the two most important needs in this area.

There are other sources of avoidable mental health problems in developing countries. A good example is the problem of mental retardation. There is growing evidence to show that malnutrition and anaemia in the pregnant mother, as well as poor nutrition in the first two years of life, contribute significantly to the incidence of mental retardation. Professor Sethi's study of rural families near Lucknow suggests that a majority (72 per cent) of the retarded in the community were of the mild retardation group. It was further noted that this could arise mostly from environmental factors, especially from "nutritional deficiencies". Similarly the high rate of first cousin marriages (as much as 40 per cent) in some communities of South India may contribute towards certain forms of mental retardation. There is scope for preventing the above groups of problems through public education, legislation and the provision of adequate maternal and child health services. This preventive approach is also relevant for implementing such mass health activities as immunization and family planning.

Against this background of needs, the available services and the awareness of mental health problems in the peripheral health centres are very meagre. There are fewer than one psychiatrist per million population, about one-third of the medical colleges in India do not have departments of psychiatry, and the mental health training of basic health workers is negligible. Thus even today most acutely ill individuals are managed by being restrained in chains rather than by drugs and hospitalization.

Fortunately, in the last 30 years, there has been a significant increase in trained personnel and training facilities in India. What has been lacking is a coherent national policy and a commitment to provide basic mental health services to a majority of the population in the quickest time possible with the minimum of expenditure. This is the challenge facing mental health professionals in developing countries.

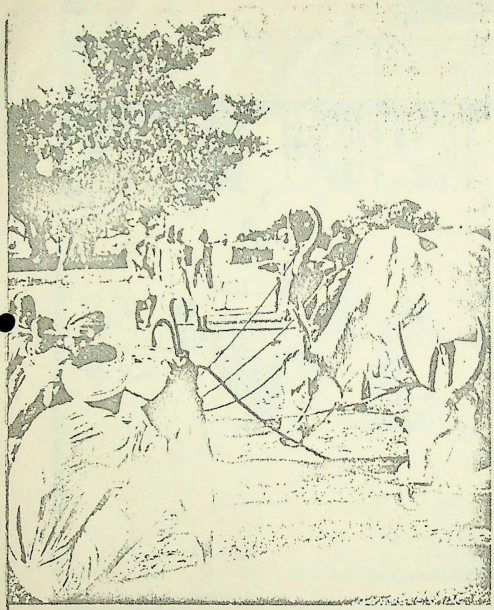
A wide network of health facilities exists in the rural and urban areas of India. The basic unit is the primary health centre (PHC) catering to about 100-120 villages with a population of about 100,000. There are two to three medical officers in each PHC along with other additional health staff. In-patient facilities for eight to twelve patients are available. The PHC is connected to the peripherally situated subcentres (six to ten per PHC) manned by auxiliary health staff—health supervisors, multipurpose workers and dais (nurse-midwives). Thus there are provisions for the rural population to get medical services through a network of subcentres and PHCs. In addition, the multipurpose workers visit each household periodically to collect vital statistics, provide care for minor illnesses and give health education.

More than 5,300 PHCs and 33,000 subcentres distributed all over the country have been unable to provide effective health care for a number of reasons, the chief of these being the lack of supplies, supervision and support. The drug budget of the PHC is Rs 6,000 (8.70 rupees = US$1) and that of the subcentres Rs 2,000 per year. The average per capita expenditure on drugs works out at less than one rupee per year, out of the ten rupees spent on health services. This drug scarcity imposes an important limitation on the effectiveness of the existing health staff to provide curative services.

The problem of drugs becomes very clear if the following example is considered. Out of the population catered for by the PHC about 900 epileptics requiring drugs can be expected. The treatment of these 900 with phenobarbitone, the cheapest drug, would cost more than the total drug budget of the PHC! At present health workers have no sedatives or psychotropic drugs with them and even at

A happy scene of village children dancing. Nevertheless, a variety of mental disorders are prevalent in all cultures and communities. Indeed about one-fifth of the disability in a community is due to mental disorders, which in turn cause a great deal of social disruption.

(Photo WHO/E. Schwab)



Left: *Recent evidence shows that rural life itself may be beneficial in preventing chronic mental illness. Studies also show how important it is to avoid the dangers of social isolation which result from moving mental patients to hospitals away from their communities.*

(Photo WHO/E. Schwab)

Right: *In the grounds of an Indian psychiatric hospital. Today's emphasis is on integrating mental health care with general health services, and on placing responsibility for primary care upon those health workers who are closest to the community, leaving more complex problems to be dealt with by more intensively trained staff.* *(Photo WHO/S. Lochar)*

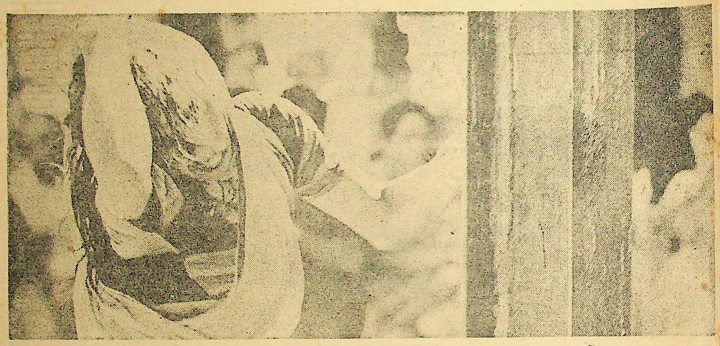
the PHC the availability of the basic psycho-pharmacological agents is quite inadequate.

Other limitations are the lack of mobility of health workers and medical officers which prevents proper supervision and support. The same problem hinders the functioning of a proper referral system from the subcentres to the specialized institutions. These are inherent problems of the rural areas and are as relevant to mental health care as to general health care. Existing personnel can, however, be used to advantage by stepping up training, support and supplies, and this should result in quick benefits. The existence of large numbers of traditional healers and practitioners of indigenous systems of medicine is another source for providing care to the rural populations.

What attempts have been made in the past to provide services? Efforts were mainly 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. Any hope of having enough trained professionals and facilities is unlikely to be realized in the near future, nor is there 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. Indeed recent evidence shows that rural life may be beneficial in preventing chronic mental illness. A more important reason for abandoning or lessening the emphasis on imported professional models is the lack of funds available for fresh programmes which require massive inputs in training, building and rehabilitative services.

The alternatives, for the present, appear to lie in decentralization, increasing community participation and deploying available health workers and staff in the periphery. The aim should be to provide care for "priority conditions" in the shortest possible time. The choice of priorities should be based on community concern, prevalence, disability caused and amenability to treatment. Acute psychoses, severe depression, epilepsy, chronic psychoses and mental retardation can be chosen on the basis of above criteria. Next, the emphasis should be on integrating mental health care with the general health services. An essential part of this approach would be the strengthening of medical personnel and facilities by increased support from the psychiatrists. The emphasis is not on the psychiatrist nor on the health worker as such, but rather on a change in their roles and their mode of work, so as to place responsibility for primary care upon those closest to the community,

Sunday Standard Magazine



"Hair in wild disarray she writhes, snakes, sings, chants and screams"

The possessed

During every aarti in the temple at Ganagapur in Karnataka a transformation takes place in the behaviour of some of the devotees: they suddenly writhe and twist on the ground in a "self-punishing frenzy", contorting into almost impossible postures, their speech hurried and distorted. This state is commonly known as possession. NRUPEN MADHVANI recently visited Ganagapur and provides some answers to this strange phenomenon.

THE small clinic just outside the Ganagapur temple precincts in Karnataka is run by a qualified doctor. Though an outsider, he's been here for several years. Initially, he was sceptical about the goings on at the temple. His attitude now is that he cannot complacently shrug off the phenomenon. If he did, he would be closing his mind on the subject of spiritual "possession" for the sole reason that it isn't discussed comprehensively in medical books.

He introduces a young man, a BA, who is at the clinic to get some bruises treated. But for more serious complaints the young man visits the next-door temple of Datta Guru. There complaints range from headaches to constriction of the chest and severe cramps in the stomach. Several doctors had been consulted, but all of them were unable to diagnose his malady and finally in desperation he had decided to visit this temple that so many friends and relatives had expressed such faith in. Once in the temple he noticed that his various illnesses seemed to fade away. But, during the time when aartis are held, a transformation in him takes place. He writhes on the ground in a self-punishing frenzy. He loudly chants the name of Datta, and even climbs, quite easily, the thirty-foot girder that supports the corrugated roof over the temple quadrangle. After the aarti, he has little or no recall of what he has done. He does not comprehend what is happening to him, only that he feels better after having come to Ganagapur. A little apprehensively, he expresses the fear that a spell has been cast on him by someone wishing to do him harm. The doctor admits that it is possible. Occult practices seem to flourish in rural areas. The victims or subjects are, by and large, female. It seems that women are highly susceptible, virgins more so.

Below but in middle-aged. She has a fairly physique and is very active when 'possessed' during the aartis. Her movements are rapid and it's almost like she's all over the place at one time. Hair in wild disarray, she writhes, shakes, swings, chants, and screams. She climbs, disappearing noisily above the metal roof, at least twice during each aarti, and with

A possessed devotee: a contest between good and evil

This unity can be seen in some manifestations but identical behaviour patterns. For instance, unlike the mainstream of devotees who move around freely in the temple, not one of the 'possessed' minority venture beyond the last enclosure fencing in the inner enclosure that houses the idol of Datta Guru. This is strange since nobody restrains them, either physically or verbally, from going beyond this invisible boundary. Whatever be the status quo, it is apparently unspoken and understood.

Photos by the author

Also, though one cannot imagine them as being gymnastically inclined, they perform headstands on cold concrete, their bodies contract and flex in postures of all kinds, the most common being the foetal position. Their speech is hurried and distorted, but they have the ability to speak clearly and sometimes even give answers to questions put to them by onlookers. They have been known to converse in a language alien or alien to them, but this appears to be a rarity. Another trait shared universally is their almost continuous recitation of the name of Datta and, invariably, with the completion of each aarti, the trance-like state ends.

A clear cut explanation is not available of this strange and bizarre phenomenon at Ganagapur, there are a variety of theories. One of them is that these people are possessed by an alien spirit through the use of the occult. The spirit becomes active during the ritual of the aarti, performed to awaken the slumbering deity. A contact is thereby established between the two and consequently there is a contest of the aroused forces of good (represented by Datta) and evil (the alien spirit). The cure is achieved by the ejection of this spirit from the body it has wrongly occupied. Ultimately, this depends, to a great extent, on the will and strength of the individual.

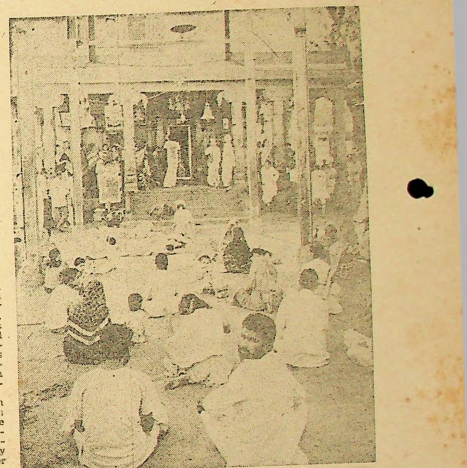
It is also believed that antidotes exist in Tantric and Mantric texts. There is, however, little likelihood of encountering a genuine Tantric, though there are the usual manipulators residing in the hands-ful of dharmashalas in the village who claim to know the required antidotes. But their abilities are devoted more to mercenary than spiritual ends.

A more down to earth theory is that the people who come here are not really possessed. What they're doing is merely "letting their hair down". In Ganagapur, frustrations and energy. Their otherwise strange behaviour is perfectly acceptable here. The implication here is that their condition arises from suppression, stress, and related psychological reasons.

With so much speculation, it is not possible to unequivocally state that any one particular theory is correct. It is obvious that a vital piece is missing from the puzzle that is Ganagapur.

Through all this muddle of theories, one fact remains unalterable: the devotees' belief in Datta Guru. To them, he is the all-pervading force. He is the embodiment of the gods Brahma, Vishnu, Mahesh, and is identifiable by his three heads. The legend dates back approximately five hundred years, and begins about two miles away from the village, at the confluence of the Bhima and Amar Jha rivers, called Sangam. An atmosphere of tranquility surrounds this area. Devotees take a dip in the sacred river and pray for salvation. It is believed that the second avatar of Datta Guru meditated here. He was called Shri Narasimha Saraswati. He was an ascetic and stories abound about his miraculous powers, among them his ability to heal the sick. It is believed that he did not die like an ordinary mortal, but that he bodily disappeared from the earth.

The legend still lives strong in people's minds. At any given time of the year, there are more than a thousand visitors at Ganagapur, i.e., a fifth of the population of the village. They mainly consist of rural devotees. Over the years there's been an increasing influx of the more curious urban dweller, as the word gradually spread. And that word is Datta.



The Ganagapur temple: waiting for Datta Guru, the "all-pervading force."

after the release of "pent up frustration and energy"

THE HYPNOTIST

Jose Faria, a priest from Goa, was the first hypnotist to liberate hypnotism from "esoteric and useless theories". But despite his achievements, he died in disgrace, ridiculed by the public.

ON an unrecorded date in 1781, exactly two centuries ago, Jose Custodio Faria, a 33-year-old, dark-skinned Indian priest from Goa, climbed to the pulpit of the royal chapel in Lisbon, Portugal, to preach the Sunday homily to the then reigning monarch, Dona Maria I, and her Court.

As he gazed at his expectant audience, the young preacher — who had just returned from Rome where he had earned a doctorate in theology — lost his nerve. Cold sweat trickled down his back, his throat felt dry, and his mind went blank. Just then he heard his teachers, who stood directly below the pulpit, whisper to him in his native Konkani: "Cator re bajil" (shoo off these vegetables). The result was immediate and dramatic. For no apparent reason a wave of relief flooded his frame. The nervousness vanished. He cleared his throat and preached eloquently.

The statue of Jose Faria in Panjim, Goa

Faria never forgot his father's words and their astonishing impact on him. The episode threw up a question which worried him: how could just a few words have such a profound psychological effect on the listener? He found his clue over a decade later in France.

By this time Faria's father, a punishment figure in the Portuguese Court, had fallen under suspicion of instigating a revolt in Goa against the Portuguese. And the suspicion now threatened to engulf the son as well: so he fled to France and lost no time in getting drawn into the French Revolution. He even led a battalion against the French Convention. In the thick of hostilities, the priest, now known as Abbe Faria, befriended a Marquis Cassiend de Puysegur, who had been a disciple of Anton Mesmer, the Austrian 'magnetist' who claimed to cure all kinds of ailments with the help of convulsions occasioned by a 'magnetic fluid' from the planets. A French royal committee assigned to investigate Mesmer's claims had concluded that "imagination, without magnetism causes convulsions; magnetism without imagination causes nothing."

Mesmer had been banished from France, and Puysegur had proceeded with his master's cures without alluding convulsions from his patients, and without resorting to theories of magnetic fluids. His cures were usually accomplished simply by soothing talk.

Talking to Puysegur, Abbe Faria found in the Marquis' procedure an echo of his father's powerful injunction: "Cator re bajil". So he theorised that suggestions, skilfully implanted, could cause psychological and physiological changes in people. He opened a school where he explored and demonstrated the power of suggestion. By merely ordering his subjects imperiously to "Sleep!," he would throw them into a trance, which would later be known as the hypnotic trance, but which Faria himself termed "lucid sleep."

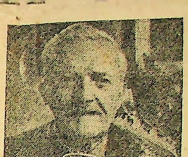
Dr. Egas Moniz, the Portuguese Nobel Prize winner in medicine, and also a biographer of Abbe Faria, credits the latter with astonishing advances in hypnotic techniques: "It was Faria who discovered the importance of practice in hypnosis. We all know that it is much easier to hypnotise people after they have been repeatedly hypnotised. Faria also considered the focusing of attention as the immediate cause of lucid sleep. He could provoke in deeply hypnotised subjects all the muscular deaths later demonstrated by Charcot. By suggestion he would paralyse an arm or leg, muscles of the eyes and tongue and so on. He could make his subjects shiver with cold, or sweat with heat; often the sensations would be confined to just one part of the body. Post-hypnotic suggestions (that is, suggestions to be acted upon after being aroused from a trance) did not escape Faria, and he was the first to discover the importance of deep hypnosis in surgical operations."

Dr. Bernheim, the famous French hypnotist, a contemporary of Freud and the latter's teacher, concurred with Dr. Moniz: "It is not to James Braid that the discovery of hypnosis is due; only the name...To Faria belongs the undoubtable credit of having established for the first time the theory and technique of hypnosis by suggestion, and of having neatly liberated it from esoteric and useless theories that hid the truth about it."

But Faria died in disgrace, ridiculed in public and banished to serve as a chaplain in a remote chapel. He planned a treatise on the subject, expanding to four volumes, but only one came to light. It was called *De La Cause Du Sommeil Lucide* (On the Cause of Lucid Sleep).

After Faria, hypnosis continued to suffer from disrepute, from which it was rescued by James Braid, a British medical man who gave the phenomenon the name of hypnosis. But it was only after World War II that systematic exploration and exploitation of hypnosis began. During the War, shell-shocked and wounded soldiers were effectively cured by using hypnosis as an anaesthetic.

In the three and half decades since, great strides have been made in the understanding of hypnosis, both in its theory and in its applications. It is today believed to be a peculiar state of mind in which the unconscious is open to suggestions from the outside, without interference or interception from the conscious mind. This state of consciousness is achieved through at least two processes. The first consists in relaxing the conscious mind to an extent which forces it to drop its guard sufficiently to enable the suggestions to penetrate the unconscious. This is usually done by telling the subject, in a monotonous fashion, to relax and relax and relax, until he is asleep. At the end of it, it is only the conscious mind that is asleep, but the unconscious mind is alert and obeys suggestions to stop feeling pain, to paralyse an arm, to hallucinate, to remember long forgotten events.



Dr. Milton Erickson: persuading the unconscious

Hypnosis merely actualises the potentialities of human beings by getting the unconscious mind to supply the necessary motivation that the conscious mind may lack.

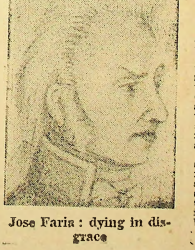
The other technique of inducing hypnosis is to shock the conscious mind and paralyze it with fear or some other strong emotion so that its reasoning and responding faculties are temporarily suspended and the unconscious mind can be penetrated. When Abbe Faria suffered his celebrated stage-fright, his conscious mind was struck totally inoperative, and the unconscious responded immediately to the symbolic injunction of his father to discount the intelligence of the audience Faria was addressing.

Suggestions need not be verbal to be effective. Dr. Milton Erickson, one of the most accomplished hypnotists of our time, who died last year, describes how he used to paralyse a subject's hand in the act of shaking it in greeting. "I shake hands normally", he said. "The 'hypnotic touch' begins when I let loose. The handshake becomes transformed from a firm grip into a gentle touch by the thumb, a lingering drawing away of the little finger — just vague enough sensation to attract attention. As the subject gives attention to the little finger — I shift to a touch with your little finger. I sever contact so gently that the subject does not notice exactly when — and the subject's hand is left going neither up nor down, but — begin".

Erickson was born colour blind, tone deaf and, at the age of 17, was paralyzed by polio and able only to move his eyes. But by learning self-hypnosis he slowly persuaded his unconscious to restore the use of his muscles.

Hypnosis is now in widespread use as an anaesthetic in obstetrics and dentistry; it has been used to enhance creativity by reducing the time needed to perform a work of art and by eliminating writers' blocks. It has no match as a cure for psychosomatic ailments, like ulcers, migraine and stuttering.

Stage hypnotists gave hypnosis a bad name from which it has not yet fully recovered; but they also maintained it in the limelight at a time when scientists tended to ignore it. Today it has again retained a modicum of respectability.



Jose Faria : dying in disgrace

Luis S. R. Vas

Behaviour

The right way to solve problems

Each individual reacts to events in life in his own way. This behaviour pattern is determined early in childhood. With this background how can a mature person deal with problems? This article, the second in the series on "The way to a stress-free life" deals with understanding our feelings and analysing them to tackle life situations.

OUR feelings are generated by thinking and beliefs. We have four major feelings Glad (Happiness) Mad (Anger) Sad (Sorrow) and Scared (fear, anxiety).

Other feelings like guilt, jealously, resentment, self-blame are variations or combinations of these major feelings.

We may look at the same incident but each one of us may have different feelings depending on what we tell ourselves.

If four of us are walking along and see two people fighting with glass bottles and see a heap of stones nearby each one can get the following feelings.

Scared because I might get injured. Sad because I tell myself. "Why can't two people live peacefully?". Angry because I tell myself. "It is a puny fellow (or a friend) who is getting beaten up and I get angry and go to his rescue. Happy because the fellow who is getting beaten up refused me a favour or belongs to a different social class whom I hate and guilty because I cannot go to his help.

These feelings are learned or we decide upon them early in our life. They depend on certain beliefs which are unconscious. Bringing these early incidents and beliefs to our conscious awareness helps us examine them on the basis of current realities and change them.

Our beliefs and expectations (irrational, impossible and disproportionate) about ourselves, others and quality of life and the world around us cause stress, frustrations, anxieties and sadness and are responsible for negative emotions and diseases.

We learn the different feelings from our parental figures in our early childhood. They label the experience and the feelings. Instead if they ask us what feelings we experience, they give us permission to experience appropriate feelings.

How do unsolved problems cause disease? If problems are not solved and are swept under the carpet they lead to diseases. Being aware of them, confronting them, solving them in a pragmatic way, leads to health. When a person is in a fix and faced with a problem which he is not able to solve and feels overwhelmed, conversion reactions take place causing the following type of diseases: (1) Temporary paralysis, speech disability; (2) Temporary blindness, deafness and (3) Skin reactions and diseases. When a solution is found for his internal conflicts these diseases slowly disappear.

Sickness is an escape mechanism unconsciously used to avoid facing problems and solving them. This is especially common among children, women and weak-minded people.

What is the right way to solve problems? We have values, ideals and beliefs which govern our behaviour and actions. We have our feelings, the emotional side of ourselves. We have wishes and goals. We have to face the realities of the world. Taking into account all these factors, if we arrive at a pragmatic solution and implement it, it will lead to a healthy self. This process touches all parts of our personality.

In this way, the decisions we arrive at are done after due deliberations. If the results are not positive, we do not condemn ourselves or feel depressed, since we cannot succeed in all our endeavours. We take disappointments with equanimity.

The Bhagvad Gita is a form of psychotherapy which Krishna used to help Arjuna resolve his inner conflict.

Our present way of dealing with feelings and problems is learnt when we were young or by our reactions to early incidents. They operate from out of our awareness. They were appropriate when we were young. They may not be so now. The beliefs and values which we learnt and which govern our behaviour can be brought to our awareness and dealt with in the light of current reality. Our reactions and behaviour can then be changed appropriately. By relaxing (self hypnosis) and regressing we get in touch with the earliest incidents when we set up the pattern of coping with feelings and problems, or through neurolingistics we can learn successful patterns of tackling troublesome situations (anchoring).

Improving our self-esteem and self-confidence helps in taking care of our emotional needs.

Excessive competition leads to stress and anxiety which are the major causes of all diseases. Relaxation, inner calm, being aware of our strength and using and developing our potential are far more important than comparing ourselves with others. Motivation should come from within for achievement rather than competition and comparison with others. Such inner motivation does not cause anxiety and stress.

We are under stress when we work. It is good to balance it with relaxation every day. Many confuse recreation with relaxation. During recreation many compete leading to stress. Playing a game for the fun of it leads to relaxation. Even holidays are sometimes stressful since they are overplanned and rushed through.

Progressive muscular relaxation, removes muscle tension and improves blood circulation, calms the body and the mind. Self-hypnosis adds to tranquility of the mind.

Visualisation will help improve self-image, self-confidence, coping with problems and feelings. It can lead to a detached view of problems and help find better solutions.

Stress and anxiety cause most of our diseases. Keeping track of our stress and problems and feelings help us in isolating the causes.

Maintaining a diary on the following lines helps: Stressful incidents prior to illness. Self-talk — what do you tell yourself about the incident? Feelings — what feelings are evoked by the incident? Action taken. Any problems unsolved/solved—what was the process of problem-solving?

Cancer is a result of stress build-up from six to eighteen months before the attack. Most of us have stresses in life, but how we deal with them is the crux of the problem.

Is a psychological approach a substitute for medical aid? It is not a substitute for medical treatment. It is a booster enabling the patient to recover quickly. The psychological approach is preventive and prophylactic, enabling a normally healthy person (present standards) to attain "Arogyam" (Tamil word for high level of health) a very high level of physical, emotional, mental and spiritual wellbeing.

The psychological approaches to cure personal illness are: (1) Take charge of yourself, accepting yourself with all your faults, and strengths, make mistakes and not feel unduly guilty. Take calculated risks and find your hidden potential, become aware of your strength, developing it and enjoy using it.

(2) Own your feelings — treating the mind and body as one; deal with them appropriately.

(3) Take care of your needs for affection recognise and support them. Also build your self-esteem.

(4) Love people (not manipulating them) and use things instead of loving them. Gifts are only a substitute for real love.

(5) Develop your whole personality/parent, (your value system) taking care of your child, (emotional part) having joy, fun and laughter, being creative and developing your adult (logical part) to deal with your problems adequately.

(6) Take over the responsibility for your health by paying attention to nutrition, physical fitness, stress management and environment by being in communion with nature, be aware of stressful events and adequately handle them.

(7) Develop a sense of identity, choose a good model to pattern your behaviour and life and have a purpose and a will to live.

(8) Deal adequately with stress caused by self-image, interpersonal relationships, life styles and life transitions (stages)-having a mentor, wise sage or God in whom you have faith, to whom you can unburden your problems or at whose feet you can lay them and free yourself and

(9) Keep a close watch on what you are telling yourself.

R. Rathnam

(To be continued)

Dennis the menace

Behaviour

Family relationship key to wellbeing

TENSIONS are the basic cause of illness. Relationship problems cause tensions which further aggravate them leading to quarrels, and later physical and mental illness. Family health depends on whether the family allows its members to express their feelings appropriately — listens to their feelings allows them to participate in solving family problems that affect them — using a proper process — recognise their problems and deals with them adequately improves the self-image and self-confidence of each member, gives them adequate support and allows them to grow according to their skills, aspirations and dreams, accepting them unconditionally with all their faults and strengths, provides them a good model for them to pattern their behaviour and life, gives each person the time, space and opportunity for developing his total personality, his values and ideals, his joy and dreams, his contract with his reality and his goals.

These are crucial for personal health and family health.

Strife and quarrels and tension between parents, cause stress and anxieties in children and they may develop asthma, short sight etc. Nagging may cause and reinforce alcholism in the spouse. Husband's behaviour may cause mental illness of the wife. Over-anxiety of parents may make children rebel and undue pressure on them to study, excel and conform makes them ill.

Family wellbeing depends on the kind of relationship that exists among the members. The key is consensus after due delliberation with everyone's involvement in tackling a problem.

Neck, shoulder, back and joint pains are symptoms of suppression of anger towards someone. A healthy family which is bound by love, where open expression of feelings and opinions and needs are allowed.

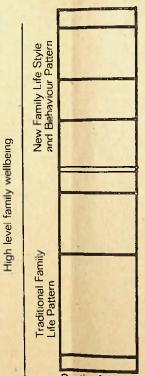
Sometimes parents in their anxiety try to provide for children what they had missed in their own lives. These messages may often be non-verbal, not spoken. It may spoil children or if children are compelled to do something it may interfere with their growth e.g. college education for a child whose father did not have one. Very often parents seek to complete their unfulfilled lives through their children.

The non-verbal messages, which are generally beyond our consciousness, are very powerful. Their impact makes or mars a family and its relationships.

If your child is anxious or scared, acknowledge it, relax yourself and touch the child for a few minutes passing on relaxation messages and say you would take care of it. After a few days, the child will be able to hook its adult (logical part) and watch how you deal with the scaring situation and be emboldened to deal with it in a similar way.

Anger is an emotion which people are scared of expressing. Some think that expressing anger breaks relationships. Appropriate expressions improves relationship.

What are the feelings which are



Family Welfare Ladder

Self-actualisation	Harmony, peace,creativity and realisation of full potential of the individual and family.
Growth	Awareness, diagnosis, confrontation and family therapy.
Education	Individual and family counselling, training family discussions.
Neutral point No discernible illness or wellbeing	
Signs	Control through guilt, anger, sadness, fear, etc. (power dynamics) discounting others, their feelings and their problems.
Symptoms	Frequent illness of family member, cold relationships, runaway children, lack of unified goals and united approachtoproblems—everyone pursuing their separate goals, excessive drinking, smoking, drug addiction.
Disease disability	Broken family, separation, divorce.

Sources of Tensions and their causes and cures

LEVELS	CAUSES	CURES
Social relationship	Peer pressures, peer expectations, social pressures, poor social support, poor models for emulation.	Awareness, providing healthy atmosphere and activities; allowing each person and family to grow, adequate social support.
Family relationship	Undue expectations, secret wishes of parents for the children—trying to realise their unfulfilled desires through their children, over control, over anxiety, putting down.	Awareness, allowing each person to grow according to his abilities and wishes, support and love.
Personal level (Inner conflict)	Unexpressed feelings, unresolved problems, poor self image, lack of identity, purpose in life insecurity, lack of love.	Self awareness, taking charge of one's own life, self esteem, relaxation, coping with feelings and problems, taking care of own psychological needs.

Personal Health

Feelings like food, should be processed through the body and whatever is not wanted should be eliminated.

Power dynamics or power play and flow in a family cause many emotional problems. Possessive love causes guilt in another person and he is made to do things out of guilt. Some people use tantrums (anger) fear or sadness as a means of getting what they want, or exercising their power. If love and concern

Give them positive attention, they are well.

If in a family each person expresses his feelings and voices his opinions and a pragmatic solution is arrived at, taking into account the realities of the world, it tends to be an emotionally, mentally and physically, a healthy one.

The key is consensus after due deliberations with everyone's involvement and willingness.

We communicate with each other in the following patterns: (1) Communicating values, opinions, limits, ideals; (2) exchanging information, facts, examining probabilities our goals; (3) exchanging feelings sharing love, joy, having fun and laughter and joking, sharing our dreams. (4) expressing concern, love, appreciating and encouraging and (5) requesting help.

When we analyse communications in a family, if this pattern is not present, something is missing in relationship.

R. Rathnam

What makes an organisation sick or sound?

What holds good for personal and family wellbeing applies to organisations and society. Promotion of self-esteem of the employees, provision of proper outlets for suppressed feelings and a consensus approach to settlement of problem contribute to the healthy working of an organisation.

UNEXPRESSED feelings, unresolved problems, low selfesteem and sense of insecurity are factors that affect the health of any organisation.

Most of the problems in institutions arise from the way employees are treated devoid of feeling. This neglect of feelings interfere with the normal relationship making problemsolving difficult. Relaxation rooms, humour clubs, soothing music and guided exercise are some well known methods of promoting healthy feelings and getting the best out of the workers. As tensions build up appropriate outlets have to be provided. Helping them develop values and having fun in life help total development of personality. When feelings like anger do not find an outlet, the person or group is emotionally disturbed and not in a position to deal with situations in a mature way. An outlet restores their ability to solve problems and the organisation is restored to health.

Problems which are not tackled quickly cause ill-health. Instead of discounting them, dealing with them openly, listening to the feelings and opinions of everyone and arriving at a pragmatic consensus lead to the healthy functioning of the organisation.

The Western type of democratic approach by majority vote is a cause of social ill-health. The losers are unwilling partners and create social tensions. Consensus based on the Indian democratic tradition is the best process for social organisational, family and personal health.

Putting down a person or a group lowers his or its selfesteem. Anything done to boost self-confidence helps people bring out the best out of their lives. This improves the problem-solving process in an organisation and at the same time helps the person and the group to take care of the emotional needs.

Stress, which is the cause of diseases and strife is a result of the interaction of a poor self-image and poor interpersonal relationships. Insecurity leads to fear which is converted later into anger leading to violence, strikes and riots. A sense of security contributes to emotional balance.

Just as oxygen is essential for a healthy body, persons and groups feel the need for attention either positive or negative. An organisation paying positive attention to the staff and motivating them reaps good health. Negative attention like threats and punishments can also help it function, but not in a healthy manner. Sometimes violence and riots will break out caused by resentment and suppressed feelings. This is comparable to inadequate breathing and oxygen supply when a person is emotionally disturbed.

An organisation under tension

Communication, similar to blood circulation in a body, is essential for an organisation to function healthily. When emotions are put down the muscles become rigid interfering with the blood supply. Similarly groups in an organisation when emotionally disturbed build up insulation around them and it would be difficult to communicate with them. The same can be extended to society where social groups function healthily or unhealthily. Social health can also be improved by following the above principles.

When a group is emotionally unbalanced, it is liable to be influenced by external negative forces and ideas which lead to malfunctioning of the group and the organisation. Their capacity for resistance to unhealthy ideas is lowered.

The Personnel Department (like the doctor) brings the organisation only upto the neutral point in the organisational ladder of wellbeing. By educating the worker to deal with his feeling and problems and providing outlets for feelings and opinions of work groups, the Personnel Department can take the organisational health to a higher level.

What is the present behaviour of Workers and Trade Unions? Most of them are operating from the negative aspect of their critical parent ego state and rebellious child ego state. They need inputs to develop the positive aspects.

Many sick and malfunctioning units have been nursed back to health by the following approaches. Listening to the feelings and problems of individuals and groups and responding to them positively helping them get their emotional needs fulfilled — giving vent to their frustration through humour, laughter and exercise giving them and the organisation a sense and unity of purpose and a will to live and survive, by implicit trust in the employees and in the general goodness of human beings and expecting them to behave in a responsible and mature manner.

Mature workers have good attendance, productivity and safety records. To help workers become mature, Quality of Life programmes have been run to improve the organisational climate at the most crucial interface nearest to the production line, where real action takes place. These run for six days of six hours, have enabled the participants to become aware of themselves, aware of others, improve relationships, reduce tensions, cope better with feelings and problems, become more mature, improve their happiness, their family's happiness and thus their health and their family's health. These programmes are non-residential and participants go back to their homes every day and tryout these skills at home.

The improved relationships makes them and their families participate eagerly in these programmes. Skills learned at home are transferred to the workspot and social life. These programmes are intended to improve themselves by managing themselves well, improve their family by managing their work well and improve the community.

The aim of organisational development is to get maximum results out of the organisation. Results are produced at the lowest level by the workers.

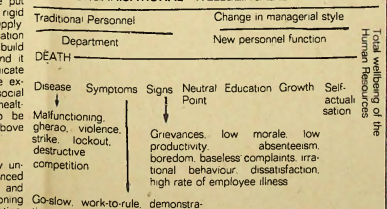
To cite two instances. A c (250 workers) where the thieving, gambling, gro discipline and violence wa into a successful self-d organisation within three w

A multinational compar workers in three factories city) was able to help tw and three groups merge a single company-ied un a seven-day programm Union leaders and he look at things in a mature way. Even violent leade mature leaders.

R. Ra

To be continu

ORGANISATIONAL WELLBEING LADDER



Sanctified suicides

KIYOO Ishikawa, a liquor store owner, came home to find his two young sons strangled to death, their bodies placed symbolically between the mattresses on which he and his wife had slept.

On a mirror, written in lipstick, was the message: "Thank you for caring for me for a long time. I am taking the children with me. Sayonara. Sayonara."

But Sueko Ishikawa, her wrists slashed, was still alive. She was arrested and charged with homicide in the deaths of the two boys, one aged five and the other nine months.

An average of one child, 13 or younger, is killed by a parent every day in Japan — more than a quarter of all the country's homicide victims. In most cases, the murderer is the mother, and frequently she is intent upon committing suicide.

Typically it is an urban housewife, aged 25 to 34 with marital troubles or an illness in the family, further burdened by raising a child or two with little or no help from either her husband or his parents.

What Sueko had attempted is what Japanese call "oyako-shinju," parent-child suicide.

Japan's suicide rate ranks 10th in the world, according to the Demographic Year book for 1978, yet suicides in Japan appear to be a bigger factor in murder than in other countries because of the propensity toward oyako-shinju. Many scholars here view the phenomenon as the radical tip of an iceberg of troubles.

Japanese police keep no statistics limiting suicides or attempted suicides to specific homicides, but a 1977 Welfare Ministry survey indicated that about 17 per cent of all homicide victims in Japan were children killed by a parent who committed or attempted suicide. Why?

Scholars cite a weakening of the family as society's main pillar and the stress that women suffer as a result of the continuing limitations placed on their role in Japanese society.

For suicide general, as well as for fathers who take the lead in the family suicides, motives are linked to their position in society, said Tadayoshi Shimamura, associate professor of the Japan Red Cross Women's Junior College. Dr. Katato Momose, who formerly worked for the Tokyo Medical examiner's office, called it simply "face."

But for suicidal women, the reasons almost always are personal ones, Shimamura said.

Changes in family life — and resultant new pressures upon a mother — rank high among them, professor Kinji Tamura of Toyo University said.

Scholars such as Hiroshi Inamura, a Tsukuba University psychopathologist, believe that family suicide—at least among Japanese — and mother-child shinju did not develop until sometime in the early decades of the 20th century, and were chiefly the result of poverty.

Since the end of World War II, however, mother-child shinju committed for reasons of poverty has all but disappeared. Family customary has taken over as the chief cause, Tamura said.

Spurred by Japan's postwar economic boom, population shifts from rural to urban areas have brought the nuclear family to the fore, Tamura said, and the modern-day housewife finds herself without the help and advice that her predecessor used to get from their husband's parents living together in the old three-generation households. She also gets precious little help from the husband who devotes most of his time to his job.

Indeed, some husbands pay so little attention to their families that in most cases of mother-child shinju the father was unaware of his wife's concern, Shimamura said.

Opportunities for women to work have grown, and mothers who do have a job almost never commit shinju, Shimamura said. Job opportunities, however, remain limited in terms of personal gratification and many Japanese housewives lack skills for rewarding jobs.

But why do mothers kill their children?

Partly, it is because the country has provided few institutions to care for orphans, Tamura said. Reluctance to impose a financial burden upon relatives is another factor.

Most of all, however, mothers kill their children because they do not consider the act to be murder.

"In Japan, the unit of society is the family, not the individual," Inamura said. "The family provides all kinds of help to an individual even after the individual becomes an adult. But if something goes wrong, shinju can occur. It's a bad part of a good social system."

In essence, the murder of a child by a suicidal parent, — particularly a mother — is regarded as an inseparable part of the parent's own suicide, Tamura said.

The great strength that makes Japan's society such a stable one — its homogenity of values — also can make it a fearful society for the small minority who fall out of step with the mainstream.

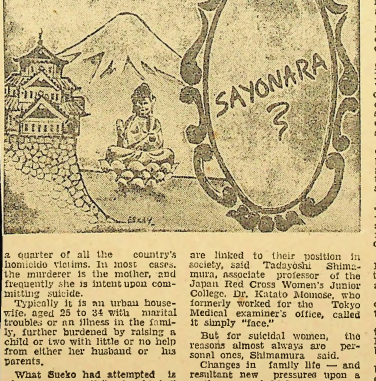
Tamura cited another factor: Buddhist teachings which hold that all who die become saints and achieve bliss.

Among other factors, this creates a public sympathy for those who commit shinju.

If sympathy is widespread for the person who commits suicide, however, it is not for those left behind.

Momose said that every member of a family in which suicide occurs is branded with a social stigma — a presumption that there is "something wrong" with him too. Other relatives also suffer, he added.

Sam Jameson



Methods Against Madness

MENTAL illnesses have an incidence higher than that of leprosy but there is as yet no national programme for their relief. Studies conducted in India show 30 to 40 million suffer from psychiatric problems. To serve these people, there are less than 2,000 mental health professionals in the country, all concentrated in urban areas.

If Western-style mental health care is adopted as a model for India, its extraordinary high cost will only ensure that mentally deranged people remain without succour, for probably a century to come.

For instance, if the nine hundred epileptics found in a population of 1,00,000 usually covered by a Primary Health Centre, were to be treated with phenobarbitone, the cheapest drug available, the entire drug budget of the centre would not be adequate.

Responding to this situation, the National Institute of Mental Health and Neurosciences (NIMHANS) here, has developed a low cost strategy using the staff of Primary Health Centres as surrogate psychiatrists.

No additional facilities or staff are called for. The strategy is based on early detection and management of basic mental illnesses such as epilepsy and psychosis by giving short training courses to the doctors, nurses and multipurpose workers running Primary Health Centres and subcentres in rural areas.

A one-and-half-year evaluation of the NIMHANS' strategy in 120 villages in Bangalore District has shown that the cost of treatment using the approach averages to only Rs. 20 for each epileptic patient and Rs. 50 for each psychotic patient.

Dr. Ravi Kapur, head, psychiatry department at NIMHANS is extremely proud of the simple techniques his institute has developed to train PHC health workers and he believes the country can now launch a rural mental health programme.

One to two per cent of India's 700 million people suffer from mental illness: the majority live with their plight, as Western-style mental health services are beyond their reach. RITA MUKOPADHYAY describes a simple and cheap strategy adopted by NIMHANS to treat these unfortunate ones.

Mental health care has been partly neglected in developing countries because of the erroneous belief that the incidence of mental illness in these countries is less than that in the developed countries, where the fast pace of life creates greater stress. But more recent surveys have shown that the incidence of mental illness is almost the same in both types of societies. In other words, each society has its own quota and nature of stress. Extremes of both poverty and affluence tend to aggravate mental stress.

There is also little difference between the urban and rural areas of India, according to a recent study conducted in Chandigarh by Dr. N. N. Wig, head of the department of psychiatry at the All-India Institute of Medical Sciences in New Delhi. Dr. Wig found 27 new cases of serious mental illness each year for every 1,00,000 urban people and 34 new cases per 1,00,000 rural people.

Many such cases go untreated. NIMHANS found, in the villages outside Bangalore, that all psychotics had been ill for more than two years and one-third of them ill for more than 10 years. The majority of the epileptics were ill for more than three years. Over four-fifths of the affected were disabled because of their illness.

The popular belief among mental health specialists that villagers are not sophisticated enough to seek help for mental disorders has also been found to be wrong by NIMHANS. Over half of those with psychiatric symptoms do actually consult a therapist — usually a traditional healer — and virtually everyone with illnesses normally considered serious by trained psychiatrists (like epilepsy and psychosis) consult a therapist.

NIMHANS is training the PHC staff for treating only epilepsy and psychosis because these two conditions affect as much as one to two per cent of the population and cause a great amount of stress and social dysfunctioning. Moreover, they can be treated with simple drugs as compared to neuroses, which are more difficult to diagnose.

The NIMHANS training programmes are of short duration varying between 15 days to one month. The doctors in the health centres are trained to diagnose and treat psychosis while multi-purpose workers are trained to recognise these conditions and follow-up the patients being treated. The nurses are trained to educate the relatives and neighbours of the mentally ill. It has been found that the best way of giving health education is to demonstrate a recovered patient.

The NIMHANS team seeks active community participation. Cured patients from the same village are often asked to accompany the team of psychiatrists and social workers on their regular visits. Community members are also involved in detection of psychiatric cases.

To identify mental cases within a village, Drs. Kapur and Mohan Isaac find it costs one-tenth to ask just one member, aged 25 or over, from each family in the village about mental symptoms in others, instead of interviewing every adult in the village. All the psychosis and epilepsy cases can be discovered in this way. The more detailed survey only helped to identify cases of neurosis.

The NIMHANS experiment has worked extremely well, with the majority of people treated having improved considerably. About 75 per cent of the patients fully followed through with their treatment, which is vital for good mental care.

But some observers doubt the success of the NIMHANS strategy when applied all over the country, as it is based on the efficiency and dedication of the staff of the Primary Health Centres, attributes for which they are not well known. Dr. Kapur, however, argues that if the PHC staff were to work with even 50 per cent efficiency, it will be a major step forward for mental health care, given its bleak future at the moment. — **CSE.**

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SCHIZOPHRENIA RESEARCH

Gender differences in disability: a comparison of married patients with schizophrenia

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Abstract

Gender differences in disability constitute a fertile area of research, as disabilities need to be measured and evaluated in the social context which defines role expectations and consequently the role performance. This paper reports on the differences in disability in married patients with schizophrenia, as marital status is an important determinant of role expectation. The study sample constituted 30 married patients, of both sexes, who satisfied DSM-III criteria for schizophrenia, and were living with their spouse at the time of assessment. Disability was evaluated using the DAS (modified version). The findings indicated that women were more disabled than men on many of the evaluation parameters ($p < 0.05$); there was also a strong correlation between negative symptoms and disability variables in both the sexes. While a correlation between PSE syndromes and disability variables was seen in the case of males, the relationship was not seen in females. Stepwise regression also revealed that negative symptoms predominated among the factors associated with global disability in both sexes. Most of the reports in the literature reveal that women are less disabled than men. The findings of this study, that women are more disabled than men, is discussed in the context of the social conditions prevailing in India.

Keywords: Gender difference; Marriage; (Schizophrenia)

1. Introduction

The last two decades have witnessed an increasing interest in conceptualising, defining and measuring disability consequent to mental illness. The impetus to develop a sound conceptual base and refine the measurement of disability has been prompted by several concerns. The first stems from the recognition that disability merits independent attention as an outcome parameter in the longitudinal study of illnesses such as schizophrenia. Second, understanding the constituents of disability is fundamental to the development of programmes towards disability amelioration and psychosocial rehabilitation. Lastly, a sound definition of disability is crucial for framing legislation to determine eligibility for social welfare benefits.

Anthony (1972) has suggested that an understanding of psychiatric disability should be derived from the deficits that influence the living, learning and working environments of an individual. DeJong et al. (1985) have stressed the need to study social disabilities in the context of a matrix of expectations which society has towards the individual. Liberman (1987) has also emphasised that disabilities should be measured and evaluated in a social context, and that such an approach would help to formulate the appropriate skill acquisition paradigms. Although the phenomenon

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of disability is closely linked to role expectation and role performance, there are very few reports that have studied disability from a gender based perspective. Bachrach (1988) has described social disablements to be more severe in women as compared to men, and has advocated a system of care which is sensitive to the special needs of chronic mentally ill women.

The literature has reported a favourable trend for females on most of the course and outcome parameters that have been the focus of research (Leff et al., 1992; Watt et al., 1983). These measures have included time spent in psychosis, pattern of course of illness, and social adjustment. The later onset of illness in the female sex has been one of the explanations offered for the better outcome in women, as it allows for women to develop those social skills that can mitigate the disability arising out of the illness.

Gender-based comparison of disability is likely to be compounded where the role expectations of women are linked to their marital status, as in a traditional society like India, where unmarried women stay in their parental home and have no clear cut role definition. This paper compares disability in married individuals of both sexes who have received a DSM-III diagnosis of schizophrenia. It is important to study this group of patients for the following reasons.

1. Little is known about the lives of married patients with schizophrenia, as the marriage rates in this population are low, (Haverkamp et al., 1982)

2. A relatively homogenous group (for example a group of married patients) with clear cut role expectations may inform on the gender differences in disability consequent to a schizophrenic illness.

2. Materials and methods

The study was conducted at the Schizophrenia Research Foundation Madras, India, a non governmental organisation that offers an active out-patient and day care programme for patients with schizophrenia.

2.1. The sample

60 consecutive married patients (of both sexes) registered between 1989–1991, (and satisfying DSM-III criteria for schizophrenia at the time of their inception into the centre) were included in the study. The patients had been residing with their spouses continuously for a minimum period of one year prior to entry into the study. The sample was essentially urban, from the city of Madras and its suburbs. While the sampling procedure made no conscious attempt to match the sexes on duration of illness or age, both variables (by coincidence), were highly comparable between the males and females who constituted our study sample. The mean age of the males ($n=30$) was 38.60 years (SD 8.431) and that of the females ($n=30$) was 38.433 years (SD 8.250). The mean duration of illness for males was 12.467 years (SD 6.146) and for females was 11.033 years (SD 5.756) thereby resulting in a very homogenous study group.

2.2. Method

Cross-sectional assessments were done by two trained psychiatrists (RS and SK) on patients who fulfilled the inclusion criteria. The instruments administered were the Present State Examination (Wing 1974), Schedule For Assesment of Negative Symptoms (Andreasen, 1982) and the Disability Assesment Schedule (World Health Organisation, 1988). The DAS (modified version) contains three sections: Section one deals with overall behavior; Section two measures social role performance in the context of a multiplicity of roles (household activities, marriage, care of children, occupation etc.); Section three deals with factors that have the potential to modify disability, (these include assets like supportive relationships and abilities that are above average). Specific liabilities are also rated in this section. The DAS also includes a global clinical rating on the overall level of disability. All ratings are on a six point ordinal scale with 0 indicating no dysfunction and five indicative of maximum dysfunction.

The DAS and SANS were administered using the spouse as the informant. The Present State

Examination and SANS interviews were conducted independent of the DAS interview. Disability assessments were performed by the psychiatrist who had not rated the patient on the PSE and SANS. Interrater reliability exercises performed at the beginning of the study and on every tenth case was 90%. Several clinical and sociodemographic variables were studied. These included age, age at marriage, socioeconomic level, employment at the time of marriage, current employment status, number of children, all PSE syndromes and ratings on the SANS. Disability was computed for each domain separately, the time frame for assesment being set as the level of functioning in the preceding one month. In addition, global disability was also analysed independently.

Analysis was done using the SPSS-PC; Chi-square or *t*-tests were used to compare the variables. Correlation analysis was performed between global disability and the PSE syndromes as well as between global disability and the SANS items for both sexes independently. Similarly, a stepwise regression was performed to determine the factors associated with global disability.

3. Results

3.1. Gender differences in sociodemographic and clinical variables

As mentioned earlier, there were no differences between the sexes either on mean age or duration of illness. 30% of the males had a college level education as compared to 6% of the females, a difference that was statistically significant ($p<0.05$). However, 60% of the patients in both sexes had a school level education. At the time of assessment, 18 of the males were employed and only 3 of the females were employed. ($p<0.001$) (the three employed women held clerical positions in government undertakings, while 9 (50%) of the men had white collar jobs); 22 men were holding jobs at the time of marriage as compared to five women ($p<0.001$). Socioeconomic status (80% of the sample belonged to the low and middle income groups)and family structure (65% nuclear families) were comparable between the two groups. 23 of the males and only nine of the females had received a diagnosis of schizophrenia prior to marriage ($p<0.01$). The mean age at marriage for males who had been ill before marriage was 30.17 years. The males who had fallen ill after their marriage were married at a mean age of 25.28. This difference was not significant, however.

The mean age at marriage for the 21 females who had fallen ill after marriage was 22.04. In the case of the nine females who were ill before marriage, the mean age at marriage was 23.77, a difference which was not significant (Table 1).

All 60 patients had traditional marriages, arranged by the families and in most of the cases, the spouse had either not been informed about the illness or had been told that their partner had suffered from a minor nervous problem and needed to take some sort of medication. Consanguinous marital unions were equally represented in both the sexes and only 28% had married a first or second degree relative. Eight female patients had no children as compared to 10 males who were childless. However, 10 of the females (33%) and only 2 of the male patients had three or more children ($p<0.01$).

Table 1
Gender differences in socio demographic and clinical variables

Variable	Male $n=30$	Female $n=30$	χ^2/t	Significance
Currently employed	18	3	16.48352	$p<0.001$
Age at marriage (in years)	29.03	22.56	4.48	$p<0.001$
Employment status at marriage				
Unemployed	6	25	24.99299	$p<0.001$
Temporary job	4	0		
Permanent job	18	5		
Had a job not attending	2	0		
No. of Children				
0	8	6	6.67787	$p<0.01$
1–2	20	14		
3+	2	10		
Residual syndrome				
Present	0	4	4.28571	$p<0.05$
Absent	30	26		
Global scores attention	1.667	2.333	−2.16	$p<0.05$

A comparison of the PSE syndromes between the two sexes revealed no differences except for residual syndrome, which was more common in women ($p<0.05$). There were also no differences in any of the SANS items except for inattention during mental testing, for which women had a higher score ($p<0.05$).

3.2. Comparison of disability scores

Women had higher scores on all the disability items except on parental role where men had more deficits than women. The differences in disability scores reached statistical significance for the following items: slowness ($p<0.01$), participation in household activities ($p<0.05$), social contact friction outside the household ($p<0.05$)and information seeking behaviour ($p<0.01$). Women had higher Global disability (mean 3.033) as compared to men (mean 2.5333 $p<0.05$). Global disability was dichotomised into low disability and high disability with global disability scores of 0, 1, 2 representing the low disability group and scores of 3, 4, 5 falling in the high disability group. 17 men (56.6%) and only nine women (30%) had low disability scores ($p<0.05$) (Table 2).

3.3. Correlation between disability and PSE syndromes and SANS variables

Correlation analysis was performed for global disability between the PSE syndromes for both sexes independently. The relationship between global disability and the SANS variables was also analysed in a similar fashion.

In the case of female patients there were no correlations between any of the PSE syndromes and global disability; in males, the analysis revealed that the syndromes of depressive delusions, general anxiety, delusions of reference, and self neglect were all positively correlated with global disability ($p<0.01$). However, global scores on avolition apathy, anhedonia asociality and attention were strongly correlated with global disability ($p<0.001$) in both sexes.

3.4. Factors affecting disability

Factors which influenced global disability (sociodemographic, PSE and SANS variables) were independently determined in the two sexes using a stepwise multiple regression analysis (Tables 3 and 4). In males, 6 variables contributed significantly to the global disability ($r=0.87$). Important variables included depression, attention, intimacy and avolition apathy. In females, seven variables were found to influence global disability. These included age at marriage, employment at marriage, hypomania and grandiose and religious delusions. ($r=0.86$). As in the case of the males, Intimacy

Table 2
Gender differences in disability variables

Variable	Male	Female	t-value	Significance
Slowness	1.4333	2.1667	−2.90	<0.01
Participation in household activities	1.6333	2.667	−2.08	<0.05
Social contact friction	0.3000	0.9333	−2.20	<0.05
Information seeking behaviour	1.633	2.5667	−3.43	<0.01
Global disability	2.533	3.033	−2.16	<0.05
High disability	$n=13$	$n=21$	4.34389	<0.05
Low disability	$n=17$	$n=9$		

Table 3
Regression coefficient of the effect of sociodemographic and clinical variables on global disability in men

Variable	B	SE B	t	Sig. t
Global attention	0.184445	0.055172	3.343	0.0029
Ability to feel intimacy	0.384943	0.081496	4.723	0.0001
Other signs of depression	0.951491	0.263716	3.608	0.0016
Social unease	−0.382518	0.189781	−2.016	0.0562
Recreational interest and activities	−0.302873	0.076715	−3.948	0.0007
Global rating of avolition apathy	0.144395	0.639787	3.629	0.0015
Constant	0.686036	0.375536	1.827	0.0813

Multiple $r=0.9359$, $r^2=0.8758$, $f=25.864$, $p<0.05$.

Table 4
Regression coefficient of the effect of sociodemographic and clinical variables on global disability in women

Variable	B	SE B	t	Sig. t
Impersistence at work	0.250182	0.072854	3.434	0.0024
Ability to feel intimacy	0.245409	0.089565	2.740	0.0120
Age at marriage	0.088734	0.019024	4.664	0.0001
Hypomania	1.506143	0.391817	3.844	0.0009
Grandiose and religious delusions	1.003098	0.292310	3.432	0.0024
Global rating attention	0.270906	0.94347	2.871	0.0089
Employment status at marriage	−0.274768	0.116871	−2.351	0.0281
Constant	−2.938832	0.706296	−4.161	0.0004

Multiple $r=0.9305$, $r^2=0.8659$, $f=20.298$, $p<0.05$.

and attentional deficits were among the variables that influenced global outcome in the females.

4. Discussion

As the profiles of age as well as duration of illness were comparable, the study could effectively assess gender differences in disability in chronic schizophrenia. As can be seen from tables one and two, differences in occupational functioning are significant between the males and females who constituted the study cohort. A higher percentage of males were employed not only at the time of the assessments, but also at the time of marriage. In urban areas, only 9.17% of the female population is involved in income generating activity as compared to 48.94% of the male population. (Census of India, 1991). Therefore, the differences in occupational functioning between the sexes in our study sample is consistent with the social norms of Indian society, where males have to fulfill the role of the wage earner, and females that of the homemaker. A comparison of the age at marriage with the mean of the general population has also revealed some interesting findings: the mean age at marriage for the urban male is 25.09 years (sample survey, Tamil Nadu, Census of India 1991), whereas the mean age at marriage for male patients who fell ill before marriage is 30.17 years (SD 6.998) and for those who fell ill after marriage is 25.28 years (SD 4.112). The age at marriage for the urban female is 20.25 years. (Sample Survey, Tamil Nadu Census of India, 1991) The females in our study appeared to have married later than the general population. The mean age at marriage for the 21 females who fell ill after their marriage is 22.04 years (SD 4.61) and is 23.78 years (SD 2.728) for the nine females who were ill before marriage. The literature also reports that women are likely to get married before the onset of illness (Seeman, 1986; Reicher-Rossler, 1992), a finding that has also emerged to be significant in our study.

A comparison of clinical profiles revealed differences in positive symptomatology between the two groups. Residual syndrome was more common in females as compared to males. There was also a trend for depressive symptoms to occur more frequently in men as compared to women, although this difference did not reach statistical significance. Reporting on a five year follow up of first onset schizophrenia from India, Thara et al. (1992) drew attention to the presence of PSE syndromes of depressive delusions and hallucinations in males and obsessive symptoms in women.

A comparison of negative symptomatology revealed that both the male and female patients in our study cohort showed a significant presence of negative symptoms.

Biehl et al. (1986) have documented the correlation of negative symptoms with high disability scores, and also the predictive power of this relationship for future disability assesments. The World Health Organisation Study (WHO, 1979) has also reported on the relationship of negative symptoms and social role performance and has posited that functioning in the interactional domain is particularly influenced by the presence of negative symptoms.

The significant findings of this study (amongst both the sexes) include: (1) the weak correlations between disability and positive symptoms; (2) the strong correlation between negative symptoms and disability; (3) the correlation between intimacy (which is a measure of the ability to establish and

maintain intimate relationships in the context of the marital role) and global disability.

Other negative symptoms like attentional impairment and avolition apathy were also been found to influence global disability.

In discussing the relationship between disability and negative symptoms, it is important to highlight the problem of criterion contamination while using the DAS and the SANS as the instruments of measurement. For example, the section on social role performance of the DAS was rated on the basis of level of occupational functioning, lack of interest in one's job or a lack of initiative to obtain employment; whereas a similar rating is reflected in the SANS item dealing with impersistence at work or school in the avolition apathy subscale. Also items dealing with sexual functioning of the patient appear in both the DAS and the SANS. Hence, the strong correlation between disability and negative symptoms is not entirely unexpected. It is, however, appropriate to point out that this relationship between the negative symptoms and disability was equally significant in both the sexes.

Reporting on a gender based comparison of disability and clinical symptomatology, Chaves et al. (1993) have highlighted the correlation of positive symptoms with global disability in the case of males but not so in the case of females. They have hypothesised that the social roles of women were more interactional and less instrumental in nature and therefore likely to be influenced by psychotic features. In contrast to the above report, the positive correlations between disability and positive symptoms in the case of males but not so in the case of females have emerged as a significant finding in the present study.

Most studies focussing on gender differences have reported a worse clinical outcome for men (Watt et al., 1983; Salakongas, 1983) In their five year follow up study of first onset schizophrenia in India, Thara and Rajkumar (1992) have not only corroborated this finding, but also reported that one third of the men in their sample had lost their jobs and another one third had erratic occupational functioning. The authors attributed the better outcome for women to the greater social support they received, and also to into account the fact that women are relatively exempt from the pressures of wage earning and economic difficulties which constitute the major stressors for the urban male.

Chaves et al. (1993) have reported that males had higher disability ratings in the DAS section on overall behaviour but no gender differences on social role performance; also, the men were more globally impaired than women. In contrast to the present study, however, their sample was skewed towards men who were never married.

We would like to offer the following explanations for the lower disability ratings in the males who constituted our cohort.

1. There probably exists an a priori and perhaps an intangible selection process, in that only the employed and possibly better functioning males have marriages arranged for them by their families. This is borne out by data wherein 22 males were involved in some sort of wage earning activity at the time of marriage, and 4 of the male patients who were not employed at the time of marriage had worked in a temporary capacity on and off prior to marriage. Also, families appeared to have delayed arranging a marriage for 23 of the males who were ill before marriage, probably as measure of caution to allow them to develop occupational skills. Our sample therefore may have comprised of males who had acquired some of the gender appropriate social and employment skills and be perceived by their families as suitable for fulfilling the marital role. Since most of the women had fallen ill after marriage, it is probable that a similar selection process was not operative in the case of the females at the time of their marriage.

2. The importance of adequate occupational functioning and involvement in income generating activities and their contribution to the overall outcome in India has been emphasised by Thara et al. (1992). Since the primary role expectation of married males is in the area of wage earning, and as the males in our study were functioning adequately in this sphere, it is possible that this may have influenced the perception of the spouse leading her to perceive her husband as being less disabled in other spheres as well.

3. Marriage and the demands of child rearing may have had a detrimental effect on the function-

ing of the women. Most of them live in nuclear families and support for day to day activities of running the household are not readily available. This is in contrast to the finding that more male patients (in comparison to female patients) received financial help from either their parents or inlaws ($p < 0.01$)

Consequently, the stress faced by women in fulfilling their social role obligations may be accentuated.

It is also interesting to note that the significant differences in disability between the sexes were found in those areas which are critical to the role of a woman as a home maker, viz. slowness, participation in household activities and social contact friction, especially with neighbours and friends. Many of the male spouses spoke at length about the additional domestic responsibilities they were undertaking as a result of their wives' inability to perform adequately in the role of the homemaker.

4. The sampling procedure adopted was one of convenience and the ratio of male patients to female patients who attend the centre is 2:1. It is therefore likely that the better functioning married female patients do not access our service, in contrast to the males who seek help in order to maintain their crucial wage earning acivity.

In both the sexes, negative symptomatology has constituted the main variables influencing global disability. These have included attentional deficits, and the related deficits of avolition apathy and impersistence at work.

However, the contribution of the PSE syndromes of hypomania and religious grandiose delusions to global disability amongst females cannot be adequately explained. These PSE syndromes were rated in very few patients and the occurrence of type II error due to the sample size cannot be excluded. Additionally, our study suffers from the handicaps of convenience sampling and a cross-sectional design, thereby limiting the generalisability of our findings.

There are however, some trends to suggest that marital status may influence disability patterns in sexes differently. But it must be emphasised that as "social role performance" is a function of "social role expectation", it is important to explore such differences in larger samples, in social settings where role expectations of spouses differ from the one prevailing in a traditional society such as India.

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Physical and Mental Disabilities

07 Akash is not drunk ! He drools and slurs over his speech because he suffers from cerebral palsy - a result of permanent brain damage which makes it difficult to co-ordinate his movements, or to sit or stand as we do. This damage which occurs before birth, at birth, or as a baby, cannot get worse nor better with time. However, Akash's movements and body posture **can** with encouragement and appreciation. Repeat this information correctly, to advance 2 steps.

11 Have another turn for inviting eight year old Satya to participate in the Spelling Contest. He is very intelligent and could easily win the prize! Though he can neither sit nor speak, he is learning to communicate in a different way. 40 - 50% of those who have cerebral palsy have average or above average intelligence as the damage is only to the parts of the brain that control movement and posture. This is sometimes not known.

15 You did well to stop Rini's companions from ridiculing his clumsiness. He walks with irregular steps, bent forward and with his feet wide apart to maintain his balance. The children now understand Rini has poor balance because of the damage to some parts of his brain. Advance 2 steps.

20 Go back 5 steps. Rahul was disturbed by the pity and embarrassment in your eyes. He senses he is a 'family disgrace; that he was not expected to be 'like this' ! He wants people to look at him as a person with special strengths, recognizing his determination to do as much as he can for himself. Bring this message to people in a street play.

22 You did well to let Anwar know how much everyone appreciates his efforts at exercises not to allow his joints to stiffen, his muscles weaken, or his thinking processes slacken. He has become the hero of his neighbourhood for trying to do everything he can for himself. Take 3 steps forward to organize a party for him.

26 No, you are quite wrong. The disabled are not always dependent and a burden. Most disabled persons have the same need for independence, achievement, and self-actualization as we do. Miss 2 turns to get rid of this generalized negative attitude.

30 Move back 2 steps. Never massage those with cerebral palsy. It further tightens the muscles. Also, never massage in the early stages of polio as it only spreads the virus.

34 Miss a turn to insist that pregnant women need to be well fed. One of the main causes of disabling conditions in India is protein and calorie deficiency. Underweight, anaemic babies risk cerebral palsy and mental retardation. 35% of the babies born in India every year weigh less than two and a half kg.

38 Well done ! Advance 4 steps for delaying your sister's marriage until she is l8 years old. Asha, at seventeen, had birth difficulties because she was so young. The baby suffered brain damage due to a lack of oxygen during a difficult and prolonged labour. The result - he is now mentally retarded !

40 Asha's goitre is not a mere cosmetic problem ! Iodine deficiency, which causes goitres, affects the development of the brain in early pregnancy and in the newborn child, causing mental retardation, hearing and speech difficulties, stunted growth; it

is also linked with spontaneous abortions, still birth, and low birth weight. Repeat this information correctly for another turn.

43 Two children are born mentally retarded **every hour** in areas where the soil lacks iodine. If there is no iodine in the soil, there will be no iodine in the crops, vegetables, and fruit.Miss a turn to stress the importance of using iodized salt.

48 Exposure to direct sunlight and moisture can destroy iodine. Advise people to use air-tight containers for salt and to finish it within six months of buying it. Fish is also a rich source of iodine. Remember that **all** of us need 0.15 mg of iodine everyday. For pregnant and lactating women it is a must.

51 Deforestation leads to the erosion of the top soil which contains iodine. The entire foothills of the Himalayan region, other deforested areas as well as flood prone areas are red alert zones for iodine deficiency disorders. Organize an eco-health awareness programme challenging people to protect the environment to safeguard their own and the mental and physical development of their children.

54 Children of mothers with severe iodine deficiency are stunted, unable to walk, talk, or think normally. Those of mothers with minor deficiency look normal, but mental retardation shows later in poor performance at school. 90% of the brain growth and development occurs during early pregnancy and continues until the age of two during which time iodine is essential.No brain damage can be corrected later by iodine intake. Repeat this information, to advance 2 steps. If not, go back 4 steps.

58 Advance 3 steps.Clarify Om's ideas about mental retard -ation. Explain to him that mentally retarded persons find it difficult to learn normal growing or developmental skills at the same pace as others. They are much slower.

61 Miss a turn to explain to Uma that people with M.I. usually have normal intelligence. However, because of a traumatic environment together with chemical imbalances in the brain, they are not in touch with the real world (psychosis) or could find it difficult to cope with life (neurosis).

63 Miss a turn.Encourage Anup who is depressed that mental retardation cannot be cured or removed by surgery, and that it can only be minimized or prevented from becoming worse. other turn.

65 Miss a turn. Tell people the importance of treating a child's fits. Frequent fits damage a child's brain and affect his / her thinking, learning and mobility. If too frequent or prolonged, fits can even cause death. The child can also fall down stairs, or into a fire during a fit.

68 Appiah spent time explaining some of the known causes of mental retardation to many anxious mothers : poor inadequate nourishment, uro-genital infections, alcohol and drugs, even some medicinal drugs, severe head injuries, epileptic fits, exposure of pregnant working women to x-rays and toxic substances. If you can repeat this information correctly, have an

72 Move 4 steps ahead organizing talks on diseases in a pregnant mother which cause mental and physical disability:German measles, Aids, Diabetes, Hypertension, V.D. Thyroidism, shingles (herpes zosta) and RH incompatibility.

75 If your first child is mentally retarded, do you know

that it is mandatory for both parents to undergo a chromosal test before the birth of the second child to ensure that the child is normal ? The test can be done at St.John's or at NIMHANS, if you are in Bangalore, or at any genetic counselling unit in a recognized hospital.

78 Advance 3 steps. Persuade Mr. Desai not to send Arun to a Home for the Disabled. He would benefit more from the real life experiences in his daily life at home: from the personal attention of the family and their involvement in his management, and from the interaction with children of his age in his own neighbourhood.

83 Don't hesitate to admit your disabled child to a regular school. Being with non-disabled children will increase his self-esteem, ensure greater self-acceptance, and challenge him to increase his range of activity. Miss a turn. Meet children attending school with the non-disabled to check out the advantages and disadvantages for yourself.

86 You will learn a great deal by sitting next to a disabled child : to be observant of his needs and those of others; to celebrate his strengths and your own; to accept problems as they come along and to persevere despite odds, to be helpful. Go back 4 steps and reflect on this.

90 Well done ! Take 2 more turns for helping Maithili, who is mentally retarded, to develop her capacity to think and to absorb what she reads by discussing with her the books you bring her. Do the same for the TV programmes she watches.

96 Go 4 steps forward. You organized indoor and outdoor games which have worked wonders for Srinath. The games stimulate his mind and challenge him to do better. His capacity to socialize and to communicate also improves as he gets to meet many children.

99 Miss a turn. Aovid playing strenuous games that make those with the Down's Syndrome jerk their necks. No somersaults either as these are dangerous as well.

102 Move back 2 steps. Amina was badly bitten by Ravi. If you had quickly held his nose firmly, he would have been forced to open his mouth to breathe and Amina could have pulled away.

105 As a career guide, you told Shekar to follow the existing vocational programmes for the disabled: assembly line work, chalk making, etc. Miss 2 turns for not identifying his special interests and skills, his family resources and their ideas that might have led to more relevant vocational training programmes.

107 The children of the colony got over their fear of Anjali, 'the 'strange mad child' their parents had told them to avoid, and began to play with her. They then convinced their parents that Anjali was like themselves in many ways and helped them to correct their misconceptions of retardation and to accept the little child.Organize a drama for Mother's Day to help mothers acccept mentally challenged children, be it their own or someone else's. Advance 4 steps.

111 Have another 2 turns to create more support groups for parents of mentally challenged children. Sustain their morale as they must provide for stimulation and challenge for the child without which the he/she cannot tap his/her full potential.

114 You noticed some children were teasing and avoiding the disabled children in your school. You did well to organize a play to focus their inner suffering caused by rejection, mockery, a lack of respect and understanding which is much greater than the problems and inconvenience resulting from the handicaps of appearance, speech, hearing and movement. Move 4 steps ahead. Many of the non-disabled told me that your play had a deep impact on them.

118 Miss a turn. Aruna is normal and intelligent. Her tantrums, screaming, running out of the house, breaking and throwing things around, are not signs of mental retardation, but of boredom, pampering, efforts to get attention or what she wants.

122 Advance 5 steps to organize more meetings to create an awareness that the Disabled have no rights and must be given them.They seem to be an invisible section in our society.

126 Is Murugan a result of his own past or that of his parents. "How can you say this is bad Karma?" he asks. "You cannot tell how actualized a disabled person is; how inwardly peaceful or spiritual. All you can see is the exterior." Miss a turn to think about his views on karma.

MH-8

packages

Uttarayan, Pithoragarh
3 days/ 2 nights
Cost: Rs 2,800 MAP per couple
Accommodation in double room on Sales basis

Sunjara Camp, Chail
3 days/ 2 nights
Cost: Rs 3,999 per couple
Accommodation, all meals, taxes.

Ayurgram, Bangalore
3 days/ 2 nights
Cost: Rs 9,500 per couple
Accommodation in standard cottages, all meals, cost of treatment as per programme, a consultation with the chief ayurvedic physician, daily sessions of yoga and meditation, transfers.

Sterling, Ooty
4 days/ 3 nights
Cost: Rs 5,999 per couple
Accommodation, welcome drink, bed tea and breakfast, 2 bottles of soft drink or mineral water everyday, stay for two children below 12 and all taxes.

AVISHEK GANGULY

Knocking on Heaven's Door...

VICTOR Hugo once talked of A Bird's Eye-View and An Owl's Eye-View of his favourite Paris. Flying into Leh over the Himalayas, with a bird's-eye-view like none other, I suddenly remembered the old Frenchman. Gliding across the Himalayas, the last frontier of all my dream adventures...it dawned on me I was doing the forbidden... but before I knew it, we landed in Leh on a clear sunny morning.

PHAL S. GIROTA

PHAL S. GIROTA

Compelled to stay indoors on my first day (which was good in a way I later realised), I decided to sneak out after dark when all my fellow travellers had happily succumbed to the temptation of their warm quilts. Nights in Leh often go without power and the first thing that caught my eyes in the moonlit darkness was a 'Fire on the Mountain'...a castle on a hilltop, set ablaze by what I later discovered were just unromantic halogen lamps! And that was my first impression of the magnificent Leh Palace, watching over the sleepy town like an aging monarch over his subjects.

On the second day, I drove out of Leh along the desolate road, into cavernous terrain. And the sheer expanse of flatness, arid flatness in burnt sienna, instantly shocked me out of my high-rise urban sensibilities. The blinding sun beating down on the unforgiving barrenness all around, the whole place looked bombed out like a nuclear test site, with the eerie drone of a stray Indian Air Force helicopter hovering above.

Returning from Alchi on the last day of my visit, my worldview changed. Looking out of the jeep window to where the dust was swirling up in the air, for the first time in my life I felt I was in a holy land. Blessed by the benevolent spirit of Bon and Buddhism, which broods invisibly, like a huge prehistoric bird, on the endless expanse of a primeval country. The *chortens* (stupas) and Gompas that appeared out of nowhere looked like pathmarks of that divine spirit. And that benediction in the air is what we felt in the least when we reached Leh sans punctures and breakdowns on the 230-km stretch from Kargil.

The Hinayana Buddhist way of life, the footprints of travellers through the ages and the unbridled reign of the elements... together evoke a passion that rends the still air. And there's something more that Ladakh inevitably does, I realised... it makes you come back...albeit on a battle-worthy Gypsy but without the pistols and the whisky shots of the Wild West!

—Avishek Ganguly

For more details, log onto www.outlooktraveller.com

The ubiquitous free market with its promise of the modern and its emphasis on a brutal productivity ethic has only reinforced traditional structures of exploitation. India's untouchables—there are many kinds of them—stay out of sight... till calamity strikes.

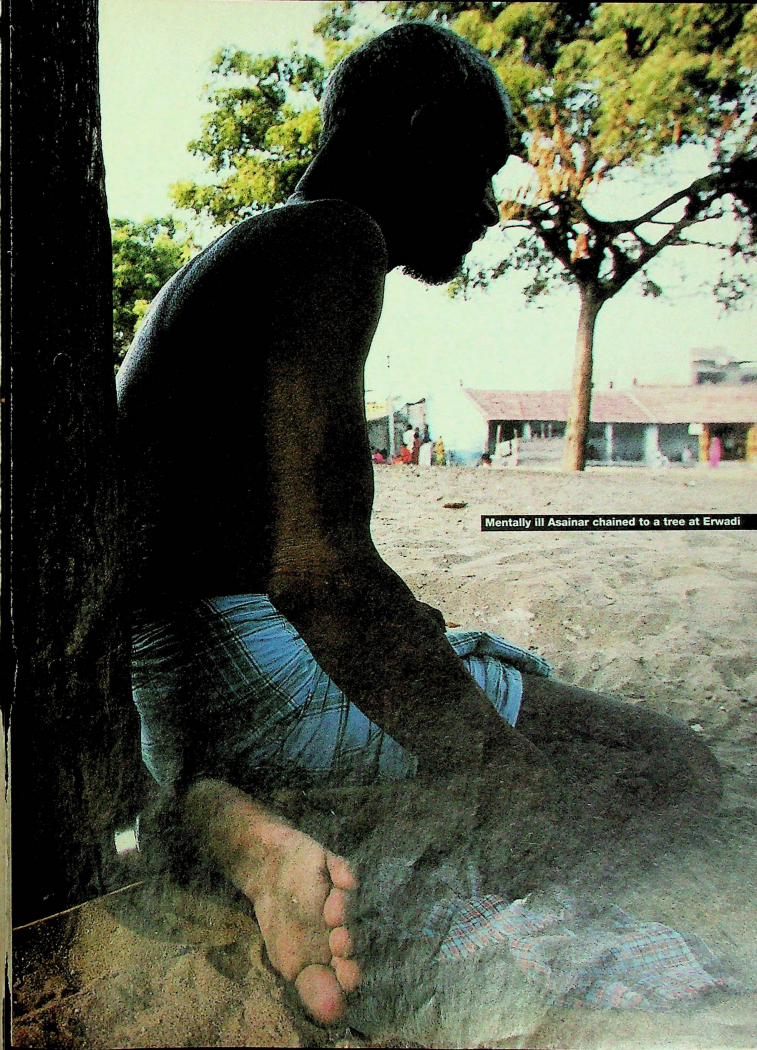
EDGE OF TOWN

By **SOMA WADHWA**

CHAINED to a tree for two years, Asainar has little hope of escaping his madness. Or the insanity that surrounds him at the Erwadi dargah in Tamil Nadu. Where hundreds of mentally ill like Asainar are left to rave, rant and rot. Some are shackled for days, others for decades. Two weeks after 27 mental patients were charred to death in one of Erwadi's many hellish 'mental homes' near the dargah, the others are still fettered and already forgotten in India's amnesiac collective consciousness. On that fateful morning, the inmates had shrieked and struggled violently to free themselves from the shackles even as the blaze consumed them. But Asainar, the odd inmate, still bound to his tree at Erwadi, a pilgrim's village in Ramanathapuram, is oblivious of their horrific tragedy, and to his own...

This is the tragedy of being an Unequal Indian. Of managing to eke out a tenuous survival on the fringes, a member of a multiplying underclass that no one cares for. Maimed and marginalised by the nation's history as also by the processes of her frenetic progress. They are our weakest citizens—too faceless, voiceless and geographically segregated to mobilise themselves into protesting groups. Abandoned variously by the State, community and even their

SATISH KUMAR



Mentally ill Asainar chained to a tree at Erwadi

families. Because of caste, gender, disability, illness, age, or for being born into paucity.

They are 21st century India's oustees, left to a hardscrabble near-destitute existence. They include:

- Landless migrant labourers building our highways.
- Scavengers scraping excreta off our latrines.
- Beggar widows pleading for our charity.
- Children of pauperised tribals sold for survival.
- The disabled or mentally unsound, who are discarded and chained at temples and dargahs like at Erwadi.
- Stigmatised and shunned patients of ailments like AIDS.

"Historically, marginalised populations, like say the Dalits, always existed in India. But today, the types, numbers, degrees of marginalisation and neglect have increased manifold and taken on grim proportions," says Dhirubhai L. Sheth, political sociologist and editor of development journal *Alternatives*. Indifference and callous disregard for those who don't find a place in the feelgood middle-class-India Club is increasing alarmingly. Says Sheth: "Poor relatives have been disowned." Which in turn, observes public interest researcher Akhila Sivadas, has given rise to a new underclass that never existed before. Old people's homes are not new institutions, not even in a society like India where family ties and values have till recently been rather strong. But with productivity becoming the new buzzword in these times of the unbridled market, the 'unproductive'—comprising the old, sick, disabled—has led to the burgeoning of the new underclass. In more humane times, however, these people were taken care of by the family. Their sense of economy, largely uncontaminated by the germ of efficient productivity, allowed that. The village barter economy and the joint family premised on an agrarian economy are two such key instances.

Says Sivadas: "Now, they've all been left to fend for themselves in neo-pragmatic, monetised India." With its welfarist values on the wane, the State has ceased making any meaningful interventions to help the weakest, adds JNU sociologist Imtiaz Ahmed, "thus completely leaving them to the vagaries of their existence".

Revisiting Erwadi's macabre realities verify these theories on ground. Last year, an Institute of Mental Health report on the asylums that proliferate in Erwadi testified: 87 per cent of the 550 mentally ill in tin-shed asylums are without toilets, average period of stay for inmates 15.8 years, "no patient is given any medical treatment". The government did nothing for these ill. Nor does the modern nuclear family, with its own peculiar economic compulsions. "My son Zakir left me here," sobs Mohammed Kasim, 73-year-old inmate at Erwadi's Shifa Mental Home, "He wouldn't give me enough money, and then say he didn't like me begging on the streets."

Kasim's story of abandonment finds a chilling echo in distant Vrindavan. Where thousands of poor old widows, discarded by their families, end up singing Lord Krishna's praises for sustenance. Five branches of the Vidhwa Bhagwan Bhajan Ashram here dole out 250 grams of rice, 50 grams of pulse and a princely Rs 2 per widow for eight hours of mandatory chanting. The indignity, sheer inhumanity that is unleashed as the hungry old women clamour and battle for this pittance is repugnant. Exhausted chanters till moments ago, they turn fanatic fighters determined to get a bite of charity before anyone else does. Widow pushes widow, kicking those who are older, weaker, for a place in the queue that promises deliverance from starvation for the day. Pompous men in authority bombard expletives from the sidelines, threatening the hapless women to fall in line.

The frenzy subsides, till another such queue is to be formed in the evening, to distribute Rs 2 per widow. For now, the first few women walk out clutching small polythene bags half filled with some rice and dal. Most proceed to beg on Vrindavan's streets for

WIDOWS

How many: 16,000 in Vrindavan, Mathura, Barsana, and Gokul in west Uttar Pradesh alone
Where they largely come from: West Bengal
How much do they earn: 250 gms rice, 50 gms pulse and Rs 2 in lieu of eight hours of mandatory chanting daily for Bhajan Ashram, Vrindavan
Proposed Policy: A West Bengal government-sponsored survey on the Vrindavan widows, released in March 2000, recommends widow pension and setting up of old-age homes in Vrindavan. Besides, it also suggests a joint investigation by the UP and West Bengal governments into alleged trafficking of women in and around Vrindavan.

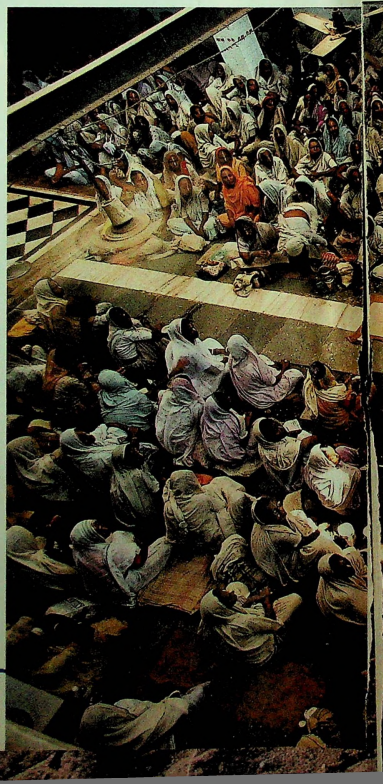
WIDOWS OF VRINDAVAN KICK AND SHOVE IN THE QUEUE FOR MEAGRE FOOD AND RS 2.

AP

Charred remains of patients killed in the August 6 fire at Erwadi

MENTALLY DISABLED

How many: 7 million with severe psychiatric disability, 25 million need psychiatric care
No. of mental health centres: 36 government run, a handful private ones
Mental Health Professionals Available: 3,500
Mental Health Professionals Needed: 400,000
What the Law says: The Mental Health Act, 1987, stipulates that the government will care for the mentally ill, lays down procedures for care by mental institutions, forbids chaining
(Sources: SAARTHAK, India)



Widows singing to Krishna at Vrindavan: dirge

PRASHANT PANJIAR

Underage migrants work on Ladakh's roads

PRASHANT PANJIAR

LABOURERS ON LADAKH ROADS ARE ILL BECAUSE THEY INHALE NOXIOUS TAR FUMES.

more; more to pay rent for the cubbyhole shacks that they share with others for shelter, and more for times when they won't be strong enough to fight others in the exhausting charity queue.

THEIR tired resignation wrenches the heart even more. Sixty-something Jamuna Dey, dumped at the Vrindavan station by her family 39 years ago, declares: "There's little to complain. I'm a woman, a widow and old, to suffer is my fate."

This absence of protest rings shrill. "But then, bereft of access to mainstream language, the marginalised don't have what it takes to be heard in this country today. That is precisely one of the reasons for their marginalisation," contends social scientist Ashis Nandy. English and now Hindi, he argues, are the only languages which evoke concerned response in a modern India impatient—and unconcerned—with whimpering dialects. "MTV sounds better than the muddled angst verbalised by people who can't speak our language, or even cope with our idea of progress," says Nandy wryly.

Like the Lambada tribals of Andhra Pradesh. Who, pathetically outpaced by the new economy of a liberalised India, have taken to routine bartering of their girl children for paltry sums of money to sleazy adoption shops. This year, in April, the state department of women and child welfare raided such unlicensed adoption centres in Hyderabad, and the neighbouring districts of Mehboobnagar and Rangareddy. To find and rescue 192 children on sale. These babies were appropriately produced before the media as photo-ops, then promptly dumped in the state-run Shishu Vihar (infant home).

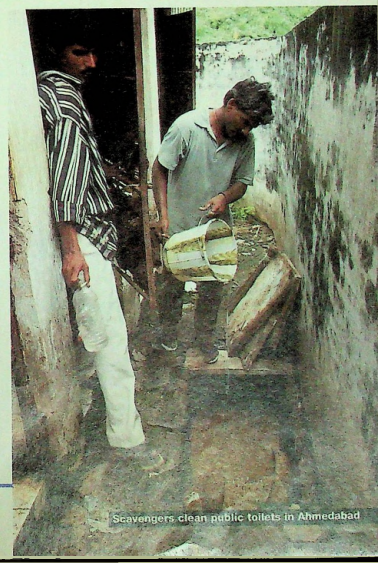
Lambada mothers, meanwhile, are still waiting to be rescued from deprivation. So excruciatingly needy are they that they've been known to sell their newborn offspring real cheap to keep the older ones alive. Soon after the raids, Bheemi Bai, mother of four daughters and Pedda hamlet resident, had confessed to selling her unborn baby for an advance of Rs 100 to agents of an adoption agency. Later, when Bheemi's girl was born, the buyers took her away. Bheemi's stone-faced statement to the police was: "I do not know where she is, I don't want to know. And I don't want to talk about it."

For there seems little sense in relating the agonising compulsions that pushes a mother into selling the flesh and blood she's carried in her womb. Yet a Lambada mother living on Hyderabad's outskirts decides to verbalise her pain, but only after repeated assurances of anonymity: "I've sold two of my five daughters. My husband beats me everyday, demands that I conceive a son. We're construction labourers and have no money to feed our children. My husband feels a son will bring us fortunes. What can I do?"

Nothing really. Not till, armed with its selfish and myopic understanding of progress, middle-class India continues to set the agenda for development. To mindlessly urbanise, industrialise and encourage impersonal contractual business and social relationships. And ironically sometimes use the same villagers, tribals and Dalits they harm most by these processes to implement their self-seeking plans. Like on Ladakh's inhospitable heights, where 25,000 migrant labourers are paid a meagre daily wage of Rs 80 to lay some of the world's highest metalled roads. They are called 'Biharis', because few know or care to know that these outsiders from Dumka are recent Jharkhandis, a new state which raises very little hope anyway.

MIGRANT LABOUR
How many landless labourers: 25,000 in 13 road projects
Where they largely come from: Jharkhand and Bihar
Caste: Predominantly Santhal tribals
Wages: Between Rs 75 to Rs 80 daily
(These figures are for labourers working on the border roads in Ladakh alone)

MANUAL SCAVENGERS
Number of scavengers/excreta carriers: 8,25,572
How much they earn: Rs 30 a month to Rs 5,000 (when employed as 'sweepers' by the government in cities)
Category: Bhangis (also called Valmiki)
What the law says: Employment of the Manual Scavengers and Construction of Dry Latrines Prohibition Act, 1993: Officials responsible for the continuance of the practice are liable for prosecution; so they are now listed as sweepers
(Source: Ministry of Social Justice Report 1998-99)



ABHIJIT BHATLEKAR

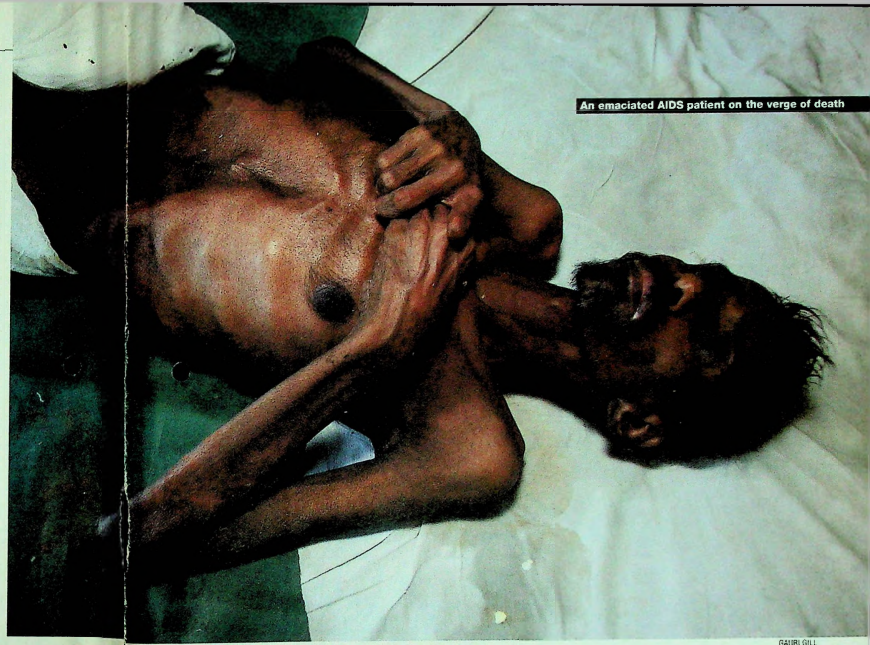
Scavengers clean public toilets in Ahmedabad

ABHIJIT BHATLEKAR

An inmate at a Parsi old-age home in Mumbai

THE OLD

How many of them: 77 million, projected at 140 million by 2025
No. of NGOs working for the old: 547
How many institutions for the old: 495
What the law says: Article 41 says the state should provide for the elderly without ways and means of sustaining themselves, there are also provisions for the same under the Directive Principles of State Policy and also under the Hindu Adoption and Maintenance Act, 1956. The states of Himachal Pradesh and Maharashtra have enacted legislations to ensure the elderly are taken care of by their children. The National Policy for Aged Persons, 2000, stipulates that the State should encourage the building of Day Care Centres, formation of a second career, and improve pension and health Care facilities for the aged.
Source: Directory of the Centre for the Development of the Aged, Chennai; Dignity Foundation



An emaciated AIDS patient on the verge of death

GAURI GILL

HIV/AIDS PATIENTS ARE THE NEW UNTOUCHABLES, THE NEW OUTCASTS OF INDIA.

Sanjay Saha, 16, is a fresh arrival from Dumka. The frail boy has taken on Leh's hazardous and temporary employment so that he can feed his mother and sister: "The weather is bad here, we get dirty clothes to wear, have to pay Rs 700 for food." Sanjay's skin is charcoal black because of noxious tar fumes, and he suffers from stomach-aches, shortness of breath, sunburns and wind-chapped lips. Naseem Ansari, 22, explains why he prefers it to the acute deprivation back home: "We don't have our own land in Dumka. And too many poor people are looking for work there."

SO, any work that feeds the stomach suffices, however inhuman or revolting. Even cleaning filthy dry latrines by hand will do for those who don't know how to cope better. That's what men and women from the Bhangi caste do for survival in affluent Ahmedabad. Despite patron-saint Gandhi's strong will to the contrary. In fact, in many cases, it's the government which employs them as 'sweepers' to bypass laws banning the practice. Armed with two small tin plates and a plastic sheet, these 'sweepers' clean up nauseatingly stinking public toilets which are always out of water.

Not surprisingly, Bhangis, 'the lowest among the lower castes', continue to be untouchables for the upper castes even in AD 2001. They are marginalised and treated with disdain, they say, even by other Dalits like the Chamars and Vankars. Confesses Bhanubhai Chauhan, a 'sweeper' in Ahmedabad: "I am very nervous about entering the house of anybody who is not a Bhangi. It would be pompous on my part." To be Bhangi is to live a vermin-like existence. Asked why the Ratnapur Jain temple in Gujarat's Surendernagar town doesn't instal flushes in its open latrines, the temple authority replies matter-of-factly: "Jainism forbids killing germs, flushing would kill germs." Instead, they get Bhangis to pick up excreta. This in itself is not a new phenomenon. Gujarat's inhuman social practices vis-a-vis the Dalits, particularly the Bhangis, have a long history. Ketan Mehta's *Bhawni Bhawai* brought this exploitation before a larger audience as early as 1980. The productive principle driving the glittering tableaux of the free market has only exacerbated these cruel disparities and has made them even more stark. This clearly shows how the market, with its promise of the modern, has only served to heighten the age-old traditions of caste apartheid.

And that's not the end of the story. The same process has simultaneously produced new outcasts, the New Untouchables. People with HIV-AIDS. Riddled with prejudice and suspicion: perceived as sexually immoral people, licentious gay men, prostitutes, eunuchs, who could pass on their contagious disease if not kept away. But with 3.7 million HIV-AIDS cases already in the country, and many from the upper class, it's becoming increasingly difficult to marginalise them.

"But it's in the upper-middle class that there's lesser degree of tolerance," says Somu who tested HIV positive in 1993, and is being treated by YRG-Care, a Chennai-based NGO working with AIDS patients. Unable to cope with Somu being an HIV-positive homosexual, his "embarrassed" brother took a transfer to Coimbatore. Alienated from his family and relatives, and thus more sensitive to the travails of his kind, Somu has plunged into gay advocacy. But Chennai resident Jaya still hasn't been able to muster courage to tell her in-laws about her positive status: "If they know, they'll blame me for both my husband's and my own infection. And in this they aren't alone. Doctors too are prejudiced. A private hospital, on learning of my positive status, refused to admit me for delivery just a week before my daughter was to be born."

Sheth points out: "The idea today is to atomise. To detach the problem from its rootedness, to isolate and forget it. Not to unearth it

HIV-AIDS PATIENTS

How many: 3.7 million. Women (15-49 years): 1.3 million. Children: (0-15 years): 1,60,000
General hospital bed availability: 0.08 per 1,000 population. According to an expert view, at the current rate of progression, India would need six times the number of hospital beds it has today to accommodate just cases of AIDS.
What the law says: Bombay High Court ruling in 1997, MX vs ZY case says people with HIV/AIDS cannot be refused a job unless they pose a "significant" risk. A Supreme Court ruling in 1998 in the 'Mr X vs Hospital Z' case, while dealing with the issue of doctor-patient breach of confidentiality, said that an HIV positive person does not have the right to marry, till she/he is cured. It was deemed that under Sections 269 and 279 of the IPC, the marriage of a HIV+ person amounts to "negligently or malignantly transmitting a contagious disease". This is being reexamined by the apex court
(Source: NACO, Lokayan Collective HIV-AIDS Unit, Mumbai)

Children rescued from 'adoption' homes

P. ANIL KUMAR

A LAMBADA SOLD HER UNBORN CHILD IN ADVANCE.

within the community, or the family and treat it. And that is why it all seems even more heartless." Erwadi's mentally ill, Vrindavan's widows, Ladakh's 'Biharis', the abandoned Lambada children in Hyderabad's Shishu Vihar, Ahmedabad's excreta carriers are all misfits. Clinging onto the peripheries of societies alien to them.

IF old, they are doubly marginalised by these societies. For, the modern Indian family has decided to go aggressively nuclear, with little time, space and money to spare. Posing an incredible predicament for the country's growing populace of the aged. Some are already looking desperately for succour and accommodation. Says T.C. Narayan, vice-president of the Dignity Foundation, an NGO working with the elderly: "We receive at least 10 calls at our Mumbai office every day from senior citizens who complain of abuse." Barely two years ago, a 76-year-old couple had jumped to their death from their eighth-floor apartment in Mumbai's Kemps Corner. Their suicide note said: "Because of the constant abuse and harassment from our son and daughter-in-law we ended our lives."

And those who live on are often dumped in dargahs like the one at Erawadi, or temples which abound in places like Vrindavan. These hell-holes, which had hitherto provided refuge to the victims of traditional prejudices, are being reinvented to serve the same purpose produced by a completely different reality. For her part Meena Kelkar, 65, managed to get herself into the All Saints Old Age Home in Mumbai's Mazgaon when her son threw her out nine years ago. She'd taken a year's refuge at her sister's before moving into the Home. Her son hasn't met her since. Cheated out of her property by her brother's family, Jyotsna Gomes was thrown out of the little tenement she had purchased with her savings at the ripe age of 70. She was lucky to have met a pastor that day as she sat desolate at a station. He brought her to the old home.

But life in old-age homes can be very lonely. In the 17 years that Mary Phillip has been an inmate at the Shepherd's widow home at Byculla, she's had only one visitor. The octogenarian speaks wisdom: "When you are old, you are nobody."

But surely 77 million old people together can't be nobodies. Why indeed is it that even as they grow in numbers, these dispossessed and disowned Indians tot up to nothing in electoral politics? Political analyst Yogendra Yadav has an answer: "Perhaps because they have no awareness of themselves as groups that might be able to affect vote-swings and exert pressures. Also, critical to electoral politics is the theory of aggregation, and geographically scattered as the marginalised are, they don't amount to much. That, indeed, is a grim epitaph for the "dregs" of India's troubled humanity. ■

With **S. Anand** in Erwadi, **Manu Joseph** in Ahmedabad, **Dhiraj Singh** in Leh, **M.S. Shanker** in Hyderabad, **Priyanka Kakodkar**

CHILDREN ON SALE

How many: 192 rescued in Andhra Pradesh alone (April 2001)
For sale at: Adoptions centres at Rangareddy, Mehboobnagar, Medak and Nalgoda districts
Category: Lambada tribals
How much they are sold for: Between Rs 1,000 and Rs 2,000
How much they are bought for: Up to Rs 25,000 by Indians, up to Rs 50,000 by foreigners
What the law says: The Hindu Adoption and Maintenance Act,1956, stipulates that accepting or giving a child for adoption has to be done with the court's permission; and such adopted children are eligible for all rights of a natural (biological) child. Christians and Parsis are governed by the Guardians and Ward Act,1890, under which those who adopt remain just "guardians" of the child. Both Acts ban selling/relinquishing children, and make them non-bailable offences