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Extension of Mental Health Services by Satellite Clinics as a Model

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With the object of providing mental health services in rural areas by involving the community in organising the services, four taluk headquarters were selected at a distance ranging from 50 to 115 km from NIMHANS. Satellite clinics, at Kanakapura (50 km), Maddur (85 km), Madhugiri (115 km) and Gauribidanur (85 km) were started in 1981. The community involvement helped in creating better awareness about mental illness. Epileptic patients predominated in all the four places. Under the existing circumstances and poor resources available, the professionals can effectively provide services to the neglected population of the rural areas by starting extension services as one of the innnovative approaches.

Key words—*Satellite clinics, Community involvement.*

The epidemiological studies in psychiatry, conducted in different parts of India have belied the misconception of mental illness being low in India.[1] The incidence and prevalence rates of psychiatric and neurological disorders are in general, the same as in Western and developing countries. The epidemiological surveys in India are all well known. The number of mentally as well as neurologically ill patients in rural and urban areas are not very different. The Mental Hospitals are located in major cities. Even the psychiatric departments in medical colleges are in urban and semi urban areas. Most of the trained professionals and those in practice are settled down in cities. As a result, the advances made in the management of psychiatric and neurological disorders have not been made available to the rural population.

The feasibility study carried out with a population of 76,000 at Sakalawara has clearly indicated the number of patients neglected and not getting any treatment[2]. This study has confirmed that not only severely mentally ill and epileptics are present in the villages, but many of them have been ill for several years with significant disability in personal, social and vocational functions.

Many of these patients had no access to professional help because of economic reasons and ignorance of the available facilities. The misconceptions, economic conditions and non-accessibility of the professional help, has resulted in the deprivation of proper treatment to these patients in rural areas. The same study has also indicated that by providing treatment in the villages by drugs and educating the public, majority of these patients can be improved and the disability can be reduced to a great extent. Only four percent of them needed hospitalisation. It is also a well known fact that relapses in mental illness as well as epileptic conditions are mainly because of irregular and short duration of treatment. The reasons for irregular and short duration of medication are often, poor economic condition, ignorance and/or improper guidance.

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Therefore, the necessity of providing professional services by involving community participation in the rural areas was keenly felt. The experience gained by one of the authors (GNNR) in running a neuropsychiatric clinic at Gunjur, from 1977 has revealed that majority of the neurological and psychiatric disorders can be managed by monthly clinics and follow ups[3]. Based on this experience and after detailed discussion, the faculty of NIMHANS decided to have multi-disciplinary regular monthly extension services in different parts of the State. The present report communicates the objectives, organisation and utility of these Satellite Clinics.

The main objectives are : to provide services in the rural areas, to study the efficacy of these services, to involve the community in organisation of services and provide free medicines to the needy and poor patients, to know the optimum frequency of follow-up of these patients for effective treatment, and to involve the local general health doctors, both in the Government and in practice, in these programmes.

In consultation with the Director of Health and Family Welfare Services of Karnataka and District Health and Family Welfare Officers of neighbouring districts viz., Bangalore, Kolar, Tumkur and Mandya, it was decided to select taluk headquarters which were at a distance of 50-115 kms. The main criteria of selection of place was lack of services and easy accessibility for surrounding villages through better transport services etc. After selecting the place, local voluntary organisations like Lions Clubs, Rotary Clubs, local bodies such as taluk boards and municipalities and the public, specially the philanthropic and social leaders were contacted about this programme. It was made clear that NIMHANS would provide only the professional services whereas the local community should take care of other functions such as spreading the news about the clinics, organisation of camps and providing free medicines. To develop better understanding and integration of professionals & community, local members will be providing hospitality in their homes by rotation. The only difference being that these services should be ongoing, continuous services, unlike eye camps or other medical camps. They were informed that the mental illness as well as neurological disorders require prolonged uninterrupted treatment. If the patient discontinues the drugs, either because of economic reasons or because of lack of professional advice, the patient will not improve and/or after improvement, will have relapses quickly. This point was emphasised and the importance of providing free drugs to the poor patients was stressed. After ascertaining the willingness for the involvement by the local voluntary organisations, the local bodies and others, extension services in four places viz. Kanakapura, Maddur, Gouribidanur and Madhugiri were started in July 1981. Before the commencing of these services, the date, the time and the place were fixed. The villages around the taluk headquarters were informed through various media such as pamphlets, posters, slides in cinema theatres and person to person communication.

Organisation of extension service

A team consisting of Psychiatrists, Neurologists, Neurosurgeons, Clinical Psychologists, Psychiatric Social Workers, Nurses and post-graduate trainees from NIMHANS attend the monthly camps regularly. The same team continues to attend the camps except for the trainees, who change periodically. The Psychiatric Social Worker coordinates the activities with the community and professionals.

Centres
Gouribidanur (GBR)
Kanakapura (KNP)
Maddur (MDR)
Madhugiri (MGR)
Total

* upto March 1986, inclu

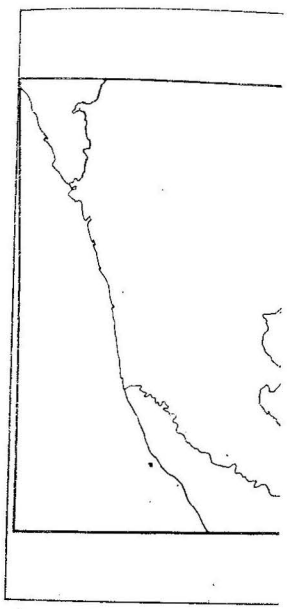

Fig. 1 : Area covered by Karnataka State.

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Table I
Number of camps and attendance.

Centres	No. of camps	No. of patients		Average per camp	
		New	Old	New	Old
Gouribidanur (GBR)	58*	5,100	7,348	88	127
Kanakapura (KNP)	58	3,265	8,941	56	154
Maddur (MDR)	54	4,855	7,176	90	133
Madhugiri (MGR)	55	2,292	2,496	42	45
Total	225	15,512	25,961	69	115

* upto March 1986, inclusive.

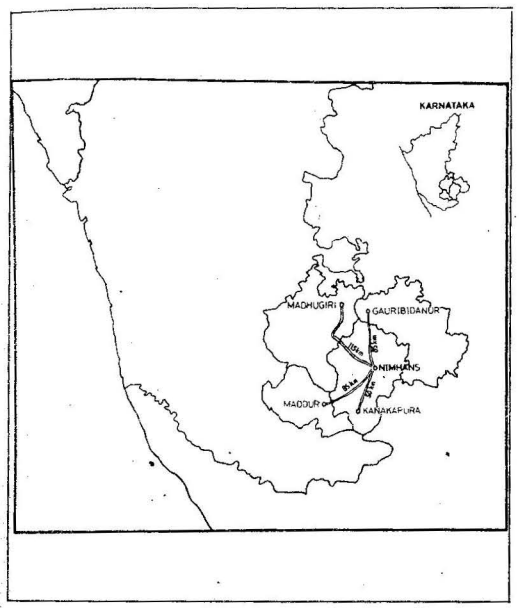

Fig. 1: Area covered by satellite clinics in Karnataka State.

Funds and organisation of the camps covered by the community are as follows: The participation of community is ensured through Lions Clubs, Rotary Clubs, Taluk Boards, Municipalities and village panchayats and other social organisations and leaders. The responsibility of the community is to provide free drugs to the poor, provide space, organise and manage the group attending the services. In each of the centres, though one of the voluntary organisations has taken the lead, other voluntary organisations, leaders of the taluk boards & the municipality have joined hands in maintaining and running these services.

During the first few months after the starting of extension services, the attendance was about 20 new neurological and psychiatric patients and about 35 to 40 follow-up cases. The medicines to be provided freely to the poor patients ranged from Rs. 400/- to Rs. 500/-. As the services continued the number of patients receiving the benefit steadily increased. Gradually, the general medical problem cases were eliminated through public education and now the services are confined to only neurological and psychiatric disorders.

As on March 1986, 58 camps were organised at Kanakapura and Gouribidanur, 55 camps at Madhugiri and 54 camps at Maddur. On an average 69 new patients and 115 old patients are being treated. The breakup of figures in each centre is given is Table I.

The broad diagnostic group of patients attending these clinics is provided in

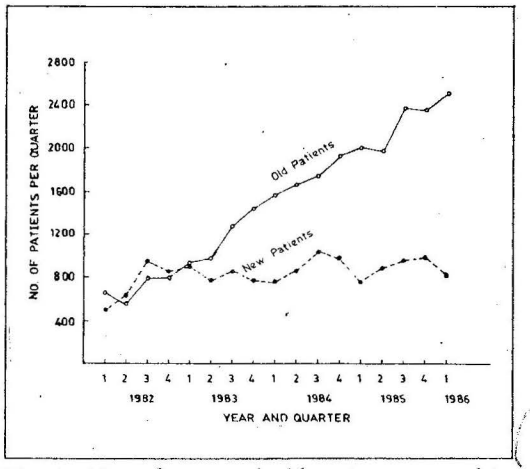

Fig. 2: No. of new and old patients treated in four centres per quarter.

Table II

Distribution of patients by diagnosis

Diagnosis	GBR	KNP	MDR	MGR	Total
Epilepsy	36.9*	33.7	31.3	28.6	33.2
MR	5.7	7.9	4.0	5.0	5.7
Psychiatric illness	16.6	30.7	18.9	28.7	22.7
Neurological illness	32.7	18.6	26.8	25.9	26.4
Other illness	8.2	9.1	19.0	11.8	12.1
No. of patients	5100	3265	4855	2292	15,512

* Percentage figures

Table II. It is of interest to note the predominence of epileptic patients.

Discussion

The experience gained during the past four years by running these extension services, has confirmed that majority of the serious psychoses, neurological disorders like epilepsy and mental retardation can be managed without sophisticated investigations. The involvement of the community has helped in eradicating the misconceptions, stigma and provide better awareness regarding mental illness. This has also proved that crucial aspects of management of these patients are continuous, uninterrupted, prolonged medication and the involvement of the family members in the management. Therefore, under the existing circumstances and poor resources, the professionals can provide services to the neglected population in the rural areas, by starting extension services as one of the approaches.

The extension services should not be mistaken to routine medical camps such as eye camps, tubectomy camps etc. The main difference is that this is a regular service provided by the specialists at the door steps to ensure uninterrupted prolonged management.

Table III

Distribution of patients by reference.

	GBR	KNP	MDR	MGR	Total
Referred to NIMHANS	13.3*	8.3	9.0	13.9	11.0
Referred to general hospital	13.4	4.1	12.9	7.2	10.4
Continued Rx at camp	62.7	79.5	70.1	71.7	69.8
No drug treatment	10.4	8.1	8.1	7.0	8.7
Referred to MR home	0.2	–	–	0.2	0.1
No. of patients	5100	3265	4855	2292	15512

* Percentage figures

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IDR	MGR	Total
9.0	13.9	11.0
12.9	7.2	10.4
70.1	71.7	69.8
8.1	7.0	8.7
–	0.2	0.1
4855	2292	15512

Psychiatrists and neurologists working in medical colleges, district hospitals or mental hospitals, can earmark one day in a week for extension services and can easily take up four villages or Primary Health Centres in a month by fixing up regular and continued services. It has been clearly shown that monthly follow-up is adequate. There is no need for more frequent check ups. By this approach services become available, and accessible to majority of the population.

Involvement of the community, has helped to reduce the misconceptions, and in creating better awareness among the public regarding neurological and mental illnesses. This will pave the way for gradual elimination of the stigma. This experience has shown that the family members are willing to take care of the patients in the community. This is probably an indication of greater acceptance of services by the community.

Though the main problem would be to provide free medication, this can be solved by tapping and pooling the resources of the community and the governmental agencies. Government agencies alone will never be able to solve the problem especially in the present financial restraints.

Conclusions

This model of extension services requires minimum input by the Government and/or the professional persons. The involvement of the local community, and pooling up of all resources will help in providing free medicines and creating better awareness. Considering the present status of mental health services, this is one of the innovative approaches that can be implemented by most of the professionals. This will definitely benefit many neglected patients in the rural areas.

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