Community Mental Health in Nepal- The First One Year's Experience

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Abstract

The Planning and initial implementation of a community mental health programme in parts of Lalitpur district is described. The need to develop such a programme within the structure of an existing primary health care project is highlighted.

The six major components of the programme: community involvement, training, case finding, weekly clinics, record keeping and research are described. The potential for replication in other areas of Nepal is stressed.

Introduction

Community Mental Health is not a new concept. In 1978 at Alma Ata, of the eight components considered necessary for community health, 'promotion of mental health' was included. (1) Before and since that time the World Health Organisation in at least seven countries (2) and other national health services in every continent have experimented with various models of community mental health care (3-8). Some of these have sought to provide specialist psychiatric services in a community setting. Others particularly in Asian and African settings have sought to truly integrate mental health care into primary health care services. There are many documented reports of these services, some of which have expanded to district, state or national level. (5,9).

The Indian National Mental Health Programme of 1982 (10) strongly emphasises a community model of "minimum mental health care for all" with community participation in the service development.

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In Nepal also there has been discussion and comment on the need for dispersed mental health services within the community (11, 12). This takes on particular relevance in rural Nepal where terrain and transportation difficulties, as well as other factors make attendance at a centralised treatment centre difficult.

Multiple epidemiological studies in many countries have shown remarkably consistent incidence and prevalence rates of major neuropsychiatric illnesses (13 - 16). These have been echoed in Nepal in an epidemiological study carried out in Bhaktapur district (17).

This paper describes the first attempt to implement such a community mental health programme within Nepal and documents the first year's experience of an on-going programme.

Description of the project area

Lalitpur district is situated to the south of Kathmandu and includes both hill and valley areas. United Mission to Nepal (UMN) has had an integrated community health programme functioning in parts of this district for approximately 13 years, while the rest of the district has been served by the HMG Department of Health Services. The population of the district is approximately 210,000 and the approximate non urban population serviced by the UMN's services is 82,000. At the start of this mental health programme the UMN's services were based on four health posts and 5 MCH sub centres, with staffing of Health Assistants, Community Medical Auxiliaries, Assistant Nurse Midwives, Village Health Workers and supervisory staff along HMG guidelines.

Though Lalitpur is close to Kathmandu there are some areas in the south of the district which present problems similar to other remote areas of Nepal.

In choosing Lalitpur for the initial implementation of a community mental health programme the need to be based in a well functioning primary health care system was recognised. The diversity of terrain in Lalitpur was also seen as an advantage, while its proximity to Patan allowed easier referral to HMG Government's specialist psychiatric services in the Lagankhel Mental Hospital if required.

Early Planning for Community Mental Health in Lalitpur

In the early discussions about community mental health service provision in this area, an integrated philosophy was determined to be the most appropriate.

Preliminary work included multiple field visits, which included discussions with health workers and community leaders within the area, in an effort to orientate team members and bring the mental health needs of the community into focus. In this planning process the support and discussion with administration of the UMN community health project and the Government psychiatrists at the mental hospital were vital.

Alongside the implementation of the service aspects of the programme a prevalence study was planned. This was done because it was considered that for the wider acceptance of a mental health programme early service provision was an essential component. Several earlier research studies carried out by different agencies in the same area, having not resulted in satisfactory service provision had caused some frustration in the community.

For the prevalence study a Nepali translation of the Indian Psychiatric Survey Schedule (18) was used with modifications. (see appendix). It was hoped that this questionnaire would be administered by Village Health Workers in the course of their regular visits to each house, and that prevalence rates could then be calculated. In the event, the administration of this questionnaire was very difficult for the Village Health Workers for several reasons and the prevalence study had to be abandoned as unworkable, after about 6 months.

However by this stage service facilities were already functioning and this paper will describe in more detail these activities.

Programme activities

These six components were undertaken concurrently.

(1) Community involvement

Discussion with the community and involvement by them was sought on every possible occasion. In particular through Village Health Committee meetings; house visits to suspected mentally ill people; non formal education; seminars; visits to local schools; individual discussions with community leaders; and where possible with faith healers, shop owners and social workers, as well as with relatives and patients attending the health posts for other reasons.

(2) Training

During the first seven months of the program, clinical contact and training for Health Assistants and Community Medical Auxiliaries was undertaken through the weekly health clinics, with teaching sessions for Village Health Workers organised on a monthly basis. For Village Health Workers this was initially based around the modified Indian Psychiatric Survey Schedule on case finding by symptom detection. Later this was changed to teaching on particular diagnostic groups. Some individual sessions on specific topics as an introduction to the programme were undertaken in these early months for central office and field staff.

The second stage of training for supervisory and curative health staff consisted of a 7½ or 8½ day block training, each block consisting of only four staff of approximately the same level.

Training methods included a strong clinical bias with much patient contact (made possible by the kind cooperation of the Government Mental Hospital).

More formal teaching of diagnostic entities was based around cases seen and discussion. Role playing was also found to be useful.

Content included prevalence and identification of mental illness; introduction to brain functions and behaviour; practical issues of mental health care in the community; mental health assessment of general medical patients; rehabilitation and community education and sessions on each of the target conditions chosen

-Psychosis, Neurosis, Depression, Mental Retardation, and Epilepsy.

Pre and post training assessment was also undertaken, and there was opportunity given for discussion of other topics as students wished.

To facilitate training and as an on-going resource a mental health manual suitable for this level of health worker was prepared, drawing heavily from manuals of mental health prepared for other levels of health workers in India (19,20).

Following block training, a mental health newsletter and occasional seminars have continued the training process.

(3) Case finding

As discussed above, this was initially planned around the use of the modified Indian Psychiatric Survey Schedule questionnaire by the Village Health Workers. Later, when this was abandoned Village Health Workers were still encouraged to identify and refer suspected mentally ill in their areas. In addition a programme of visits by both Village Health Workers and Project Staff to certain key individuals (key informants) in the panchayat was undertaken. The modified Indian Psychiatric Survey Schedule was also used in these interviews by the staff member along with more informal discussion about mental illness and any suspected mentally ill in that community.

People attending the health posts were also informed of the programme and asked about known mentally ill.

Non medical health post staff were found to be extremely helpful in identifying potential patients living in their community and proved a major source of referrals. As the programme gained momentum it was also found that successfully treated patients and their families were motivating other patients to attend.

(4) Weekly Clinics

Initially in two health posts (one in the valley and one in the hills) and later in all four UMN health posts and one MCH sub centre regular mental health clinics were established. This allowed for close supervision by the team initially. With gradually increasing autonomy being handed over to Health Assistants and Community Medical Auxiliaries, as their training allowed and as their skill and confidence increased. Potential patients identified were referred to these clinics, assessed and treated as appropriate.

In seeking to provide psychotropic medication for health Posts, a limited drug list was decided on, taking into account cost, availability, safety and WHO recommendations. As phenobarbitone was already available in the Health Posts, permission was sought to

add only chlorpromazine 50 mg amitriptyline 25 mg and trihexyphenidyl 2 mg to the list of available drugs. Initially only the visiting psychiatrists were permitted to prescribe the drugs but after block training this was extended to include Health Assistants and Community Medical Auxiliaries, under supervision.

(5) Record Keeping

Standardised record sheets were implemented for mentally ill patients, to allow accurate data to be simply and quickly recorded. Where possible the use of check lists (e. g. for symptoms) were used to facilitate faster recording and to highlight important management issues. Again we were indebted to the previous work done in this area by the community mental Health unit of the department of psychiatry NIMHANS Bangalore.

(6) Research

The use of standardised record keeping allowed for the collection of data on patients seen. Some examples are distance of residence from treatment facility; duration of illness; mode of onset; symptoms; previous treatment sought; family history; past history and family structure. Details of the data collected will be made available elsewhere. The pre and post training assessments allowed for research into the level of background knowledge and attitudes of the health workers about mental health issues.

Discussion

By the completion of the first year of this programme 150 mentally ill patients had been seen. From an estimated 2% major neuropsychiatrically ill in the community it would be expected that there are approximately 1640 mentally persons in the project area. This means that the programme has so far identified approximately 9% of the seriously mentally ill in this area. The vast majority receiving medical treatment for the first time.

It is considered, though much work remains, that an encouraging start had been made. Issues such as distance from treatment facility, and community attitudes are felt to have been among the important factors in influencing attendance for treatment.

There were initially some misgivings on the part of the primary health care staff to involvement in mental health care, and what this might involve and expose them to. These attitudes reflected commonly held beliefs about mental illness, its causes and nature. As the programme has developed, staff acceptance has also grown, and certain individuals have taken a special interest in this area of their work.

In general, acceptance of the programme by the community varied in different villages, and amongst different groups. However where there has been notable treatment successes community interest and acceptance has often dramatically increased. It appears that such a visible success is very important to the programmes promotion in an area.

The Way Ahead

Despite an encouraging start, major challenges remain. Case identification methods; motivation for the completion of treatment; community and family attitudes to the mental ill and their rehabilitation; continued stimulation of staff enthusiasm and the need to train new staff as they join the programme all present challenges.

In the area of research, issues that need addressing include community and health staff attitudes; factors influencing patient care; prevalence of mental illness; syndromes encountered; the role of traditional healers in mental illness and many others.

In conclusion, this programme offers the mental health planners of Nepal, a model of mental health service delivery that can be made available at relatively low cost to the rural population of Nepal. The next few years hold exciting potential for innovative developments.

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- (1) Primary Health Care (1978) Report of the International Conference on Primary Health Care, Alma Ata, USSR 6-12 September 1978. Health For All Series No. 1. WHO.
- (2) World Health Organisation (1975) Organisation of Mental Health Services in Developing countries. 16th Report of the Expert Committee on Mental Health. Teacher Representative Secretary, 564, Geneva, WHO.
- (3) Climent C. E., Diop B. S. M., Harding T. W. et al (1980) Mental Health in Primary Health Care. WHO Chronicle 34:231-6.
- (4) Giel, R and Harding, T. (1976) Psychiatric priorities in developing countries. Brit Journal of Psychiatry, 128, 513-22.
- (5) Ben-Tovim, D. (1982) A psychiatric service to remote areas of Botswana. Brit Journal of Psychiatry 142: 199-203.

- (6) Beasher T., El-Hakim A., Galal, A., and Habbashy E. (1979) Rural psychiatry, the Fayoum experiment. *Egyptian Journal of psychiatry* 2, 77-87.
- (7) Wig. N. N., Srinivasa Murthy R., and Harding T. W. (1981) A Model for rural psychiatric services, Raipur Rani experiences. *Indian Journal of Psychiatry* 23 (24), 275-290.
- (8) Shepherd M. (1980) Mental Health as integrant of primary health care. *Journal of Royal College of General Practitioners, England.* 30, 657-664.
- (9) Mental Health Care in Primary Health Care, project protocol. ICHR Advance Centre for Research in Community Mental Health NIMHANS Bangalore (1985).
- (10) National Mental Health Program for India (1982) D. G. H. S.
- (11) Shrestha D. M. (1985) Development of mental Health Services in Nepal. *Journal of Nepal Medical Association*, 53 (74), 2.47- 2.56.
- (12) Pokharel N. (1985) Mental health services in primary care. *Journal of the Nepal medical association*, 73, 45-49.
- (13) Harding T. w., De arango M. V., et al (1980) mental disorders in primary health care, a study of teeir frequency and diagnosis in 4 developing countries. *Psychological medicine.* 10, 231-241.
- (14) Dube K. C. (1979) A study of prevelence and biosocial variables in mental illness in a rural and urban community in uttar pradesh. *Acra. Psych. Scan.* 46, 327-359.
- (15) Goldberg D. and huxley p. (1979) mental illness in the community. Tavistok publ-ications. London.
- (16) Leighton A. H. et al (1963) Psychiatric disorder among tha yoruba. Ithaca N. Y. Cornell university press.
- (17) Shrestha D. M., pach A and Rimal P. K. (1983) A social and psychiatric study of mental illness in Nepal. Handicapped services co-ordination committee, UNICEF, Nepal.
- (18) Kapur R. L., Kapur M., and darstairs G. M. (1974) Indian psychiatric survey schedule. *Social psychiatry* 9, 71-76.
- (19) Srinivasa murthy R. (ed) (1985) Manual of mental health for multipurpose workers. ICMR Advanced centre for Research or community health No. 3 NIMHANS Bangalore.
- (20) Isaac MK, Chandra Shekhar C. R., and srinivasa murthy R. (1985) Manual of mental health for medical officers, community mental health unit, Department of psychiatry NIMHANS Bangalore.

घरको मानिसको नाम:-

वार्ड नं.:-

के तपाईंको परिवार छिमेकी या साथी भाईहरूमा...

१. कोही पागल [बौलाहा] भएको, नचअहिने कुरा गर्ने या अनौठो वानी व्यहोरा भएको छ ? ☐
२. कसैलाई छारे रोग भएको या छोप्ने व्यथा छ ? ☐
३. के कोही चुपचाप बसिराख्ने कसैसंग बोल्न नचाहेने छ ? ☐
४. के कसैले अरूले नसुन्ने आवाज सुन्ने या अरूले नदेख्ने कुरा देखे भन्ने गर्छ ? ☐
५. के कोही अरुमाथि संकागर्ने र अरु मानिसहरूले उसलाई कुट्ने, पिट्ने वा मार्ने कोशीस गर्दछन् भन्ने गर्छ ? ☐
६. के कसैले आफुठूलो मानिस नभएपनि म धेरै ठूलो मानिस हुँ भन्छ । त्यो मानिसलाई ठट्टा गरेर हसाउँछ र चाहिने भन्दा बढि खुसी हुने गर्छ ? ☐
७. के हालसालै कोही एकदम दुखी निराश भएको र बिनाकारण रुने गर्छ ? ☐
८. के कोही जन्मदेखि बुद्धि नभएको, मूर्ख या केटाकेटी जस्तै वानी भएको छ ? ☐
९. के कसैले आत्महत्या (मर्ने) कोशीस गरेको छ ? ☐
१०. के कसैलाई भूत लाग्ने, बोक्सी लाग्ने या देउता लाग्ने हुन्छ ? ☐
११. के कोही काम गर्न सक्ने भएपनि अलछ्छी गर्ने र काम नगरिक्न वग्ने गर्छ ? ☐
१२. के कोही नाझै हिड्ने, जथाभावी लुगा लगाउने र फोहरी भएर बस्ने गर्छ ? ☐
१३. के कोहीधेरै बक बक गर्ने, फोहुर गाली गर्ने, कराउने र चिन्त्याउने या छटपट गर्ने गर्छ ? ☐