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## Citation

Chowdhury, A. N., D. Sanyal, A. K. Chakraborty, R. De, S. Banerjee, and M. G. Weiss. "Community Psychiatry Clinics at Sundarban: A clinical and cultural experience." *Indian Journal of Public Health* 49, no. 4 (2005): 227-230.

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# Community Psychiatry Clinics at Sundarban: A Clinical and Cultural Experience

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## Summary

A series of Community Psychiatric Clinics were conducted in different blocks of Sundarban region of West Bengal. One of the primary objectives of this was to collect clinical epidemiological data on psychiatric morbidity in the region. A total of 26 clinics were conducted in Sagar, Kakdwip, Canning and Gosaba block of the Sundarban region during the period from end 1998 to end 2000. A total of 451 psychiatric cases with diagnostic categories (male 239, female 212) and 215 non-psychiatric cases (male 107 and female 108) were seen in these clinics. Diagnostic Interview Schedules (SCID) and Clinical rating scales like Hamilton Depression Rating Scale and Brief Psychiatric Rating Scales were used to ascertain clinical diagnosis quantitatively. Special emphasis was given on common psychiatric disorders.

**Key words:** Mental disorders, Primary health care, Community psychiatry, Sundarban.

## Introduction

Mental disorders are quite common and causes a huge social burden in most countries<sup>1,2</sup>. Recent World Health report by WHO highlighted to the magnitude of this problem<sup>3</sup>. The report states that 20-25% of world population is affected by mental problems at some time during their life, while 10-15% of people suffer at any one point. 20% of people seeking treatment at primary health care facilities have emotional disorders. Mental problems are one of the biggest contributors to loss of DALY. The report puts emphasis for the provision of mental health care by developing community mental health services (at least 20% coverage), integrating such services to general health care. Provision of psychotropic drugs (at least 5), developing human resources and intersectoral co-operation and refresher training to primary care physicians (at least 50% in 5 years) were the other recommendations.

In order to formulate a proper plan for a comprehensive community mental health service of a region, it is necessary to have a clear picture about the epidemiology of the mental illness in this community, especially in a rural setup, information about which is scarce. This study intends to find out the mental health problems in remote rural Sundarban region of West Bengal in order to take a step in this direction.

Sundarban (forest comprising Sundari trees) is

an area of active delta of the river Hooghly at its confluence in the Bay of Bengal. It is the largest delta on the globe in the estuarine phase of the River Ganges. There are 54 islands in the region and the total area measures about 9,630 sq. km of which 4,264 sq. km. is reserve forest for tigers. The total population of the region is 2,232,011 approximately. Sundarban region is an under served area in by all yardsticks of socio-economic development. Inaccessibility, poor agricultural yield, constantly changing landmasses, lack of industry and hostile climatic conditions have made this area one of the most backward regions of the state. The literacy level as well as the per capita income is far lower than the state average and 42.5% of the family lie below the poverty line<sup>4</sup>.

The objective of this study was to gain insight about the distribution of mental disorders in the community. The patients attending psychiatry clinics organised for this purpose were clinically diagnosed by standardized clinical tests. Explanatory model interview were done to explore their knowledge and perception regarding mental illness. This clinic-based study attempt to explore the morbidity load of categorized mental disorders in the region. ['Categorized' means the identification of mental disorders by using the diagnostic yardsticks of either DSM-IV of American Psychiatric Association<sup>7</sup> or ICD-10 of WHO<sup>8</sup>.

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## Materials and Methods

A community mental health clinic was organized at the Rudranagar Rural Hospital at Sagar block, at Kakdwip Rural hospital at Kakdwip, at Canning Rural hospital at Canning I and at Rangabelia Tagore Society hospital, Gosaba on some pre-determined dates during the period from end 1988 to end 2000. The last mentioned health facility was run by an NGO; others are government hospitals. A total of 19 clinics at Sagar, 2 in Canning, 3 in Gosaba and one in Kakdwip were conducted during this period.

A diagnostic register was maintained to record the clinical assessment of each case. A section of patients from each clinic was given SCID (Structured Clinical Interview for DSM-IV)<sup>9</sup> to assess the reliability of clinical diagnosis, specially in the rural setting and to make detailed diagnosis regarding co-morbidities, if any. A set of Depressed and Somatoform patients were assessed with HDRS (Hamilton Depression Rating Scale)<sup>10</sup> and Schizophrenic patients with BPRS (Brief Psychiatric Rating Scale)<sup>11</sup> to get a quantitative estimate about the severity of these conditions in the rural patient population. The total of 240 patients who were interviewed using Structural Interview Schedule SCID apart from usual clinical interview to make DSM-IV diagnosis valid for international comparison. All the patients were also assessed by Global Assessment of Functioning scale<sup>12</sup>. Clinically, 80 patients (33.3%) were suffering from psychotic disorders while rest were suffering from various non-psychotic conditions.

## Results and discussion

The distribution of total patient attendance (both psychiatric and non-psychiatric) at the Rudranagar Clinic, Sagar during the study period revealed that the number of clinics in 1998 and 1999 were same but the patient attendance in 1999 was poor in comparison because there was some uncertainty in the clinic dates and some logistic weakness in the local communication network. The clinics in 2000 were prescheduled and thus both new and old case attendance is gradually progressive. Most attending patients were male. According to diagnostic category (as per DSM-IV criteria), among new cases the patients of affective disorder headed the list (overall 27.7%) followed by Schizophrenia (12.4%). As a single diagnostic category Major Depressive Disorder was the most frequent

diagnosis (19.9%). Anxiety disorders were less common. Generalised tonic-clonic seizure (9.9%) and mental retardation (6.4%) also constitute a significant portion of the clinic patients. 21.9% cases could not be placed in definite diagnostic categories (mixed disorders, diagnosis deferred until further investigations etc.) and 34.4% of the total patients were having non-psychiatric complaints (mostly medical and surgical problems). A total of 14 cases from other blocks attended the Rudranagar clinic, mostly affective disorder cases, viz, major depressive disorder (42.9%) and manic psychosis (21.4%). In the clinics at Kakdwip and Canning I major depressive disorder was the most common diagnosis (30.4%) followed by Schizophrenia (10.9%). More than half of the patients (56.2%) attended the clinic were suffering from non-psychiatric problems. In the Gosaba clinic 21% patients in the psychiatric group suffered from major depressive disorders with a female dominance (36.7%). 16.3% cases were Schizophrenia. Mental retardation and GCTS constituted 17.9 and 6.5 percent of cases respectively. 8.9% cases could not be put into any definite psychiatric diagnostic categories and only 8.2% of the total cases were non-psychiatric complaints.

However, from the probable number of mentally ill likely to be present in these areas as per projections of WHO report, numbers reporting to the clinics were far less. Indeed it is likely that large number of psychotic patients remained untreated in spite of our clinics' presence. Need for more awareness about mental illness becomes all more essential.

Male patients seemed to outnumber females in our clinics. This is unexpected, as most studies worldwide showed clear female predominance in psychiatric clinics (perhaps higher female vulnerability due to biological factors, stress and social pressure). Perhaps lack of proper information about mental illness and clinics, apathy of family members to get women treated, stigma about mental illness prevented many women from attending the clinics.

Comparison between the attendance of non-psychiatric patients in different clinics showed that the number of non-psychiatric patients were least in Gosaba (6.6%) while it was highest in Canning (59.1%) followed by Kakdwip (41.2%) and Sagar (34.4%). The observed differences were statistically significant ( $p = 0.000001$ ).

Despite being publicized in the locality to be a specialist Psychiatry Clinic, a large number of non-psychiatric patients attended the clinics. This may be due to general ignorance about psychiatric diseases and its presentation, or due to poor information dissemination about the clinic by local health workers. Considering the fact that Gosaba clinic had least number of non-psychiatric patients despite being most remote of the clinics, the second factors seems to be more likely, as NGO managed Gosaba clinic had better information dissemination and screening by local health workers.

Majority (87.4%) of psychotic patients were diagnosed as Schizophrenia, Paranoid type being the commonest. Of considerable clinical concern is the sizeable presence of Disorganized Schizophrenia cases, (30%) who are known to be affected more severely and tend to show poor response to conventional neuroleptic medications.

The psychotic patients had high degree of psychopathology as indicated by high mean BPRS score. They also showed gross impairment in global functioning as indicated by low mean GAF score (score of about 30 indicates inability to functioning as almost all areas, serious impairment in communication or judgement or behaviour considerably influenced by delusion and hallucination).

Among the 160 non-psychotic patients 80 had Major Depression and 80 had Somatoform Disorders. A sizeable proportion (25%) of Major Depression patients was cases of recurrent episodes, meaning a long-standing morbidity. The Somatoform Disorder patients mainly consisted of patients suffering from Pain Disorder. 51.8% of the patients had co-morbid psychiatric conditions (mainly anxiety group of disorders). The HDRS scores indicate a moderate degree of depression amongst the patients. Moderate degree of anxiety was also present as indicated by HARS score.

GAF score indicate moderate difficulty in social, occupational functioning. The effect on GAF was considerably less than that in psychotic patients, the difference in GAF in the 2 groups was highly significant ( $t=1.97$ ,  $d.f.=238$ ,  $p<0.001$ ).

## Recommendations

Practical issues which were focussed during the program which may help develop community based mental health care.

A. Organisational: The BMOH and other staff of the centre should be sensitized and motivated about this service. Community awareness through health staff, the NGOs, patients treated in the clinic. The regularity of the clinic dates is an important factor for the patient attendance also. Training of the supporting staff of the clinic is very essential.

B. Treatment facilities: Psychotropic medicines are comparatively costly and that too need a long time continuation. This is a practical impediment in the treatment compliance of the cases. There should be some provision of dispensing some medicines from the clinics, otherwise many poor patients fail to follow the course of the treatment properly. It was noted that patients and their family members took good interest about these community clinics and they regularly came for check up and treatment.

C. Human Resource Mobilization at Primary Care level: The community mental health service always need active community participation, otherwise the sustainability of the service will be compromised. The existing human resources should be properly motivated and mobilized with proper training so that in the long run they will take the responsibility of these clinics.

D. Panchayat and Public Awareness: Panchayat system is a very powerful medium for the successful implementation of any health programme in the rural setting. There should be a knowledge transfer orientation module for the Panchayat members on mental health, so that they can actively participate in to the programme. Active participation of Panchayat is necessary for the effective implementation of a community mental health programme, to site few example: in the alleviation of stigma against mental illness, raising of mental health awareness in the community, provision of social support to those who are distressed, mitigating the social stresses which are operating behind deliberate self harm attempts. The construct of social treatment in cases of mental disorders would only be achieved if the Panchayat is

sufficiently oriented to mental health and illness paradigm.

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