

BRIEF RESEARCH COMMUNICATION

## Identifying the 'mentally disabled' in the community: How much more is to be imparted to the interneers in training?

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### ABSTRACT

**Background:** Studies have been conducted on the skills of physicians in general hospitals in identifying mental disorders, but there are no studies assessing the proficiency of interneers in identifying mental disorders.

**Aim:** To confirm the diagnosis of the cases identified by 40 interneers in the community as 'mentally disabled'.

**Materials and Methods:** Of 15,583 people, 29 were identified in the community by the interneers as 'mentally disabled'. This was followed by home visits to the houses of these 29 individuals conducted by two qualified psychiatrists and one clinical psychologist, and these cases were screened for their psychiatric status using MINI Plus.

**Results:** Most of the cases identified by interneers as having 'mental disability' were cases of mental retardation and the others were mood and psychotic disorders and epilepsy. Cases of mental retardation and mental disorders other than those identified by the interneers could also be identified while visiting the respective geographical areas.

**Conclusions:** There is a need to hone the skills of the medical students during the course of their training in identifying cases of mental retardation, severe as well as minor psychiatric disorders, as a part of their training. There is also a need for the use of structured scales for the same.

**Key words:** Epidemiology, psychiatry, undergraduate training

### INTRODUCTION

Most of the screening in epidemiological studies is conducted by research workers from the mental health profession. There are not many epidemiological studies wherein the general physicians in a general hospital or community have collected the data. However, studies have assessed the skills of physicians in general hospitals in identifying mental illnesses.<sup>[1,2]</sup> Singh *et al.* evaluated the psychiatric knowledge of 52 nonpsychiatrists, and only one doctor could give satisfactory diagnoses to the cases.<sup>[1]</sup> The deficits in the way nonpsychiatrists interview patients also hinder the identification and treatment of psychiatric disorders.<sup>[2]</sup> Mayou and Hawton opined that many cases are overlooked because the treating doctor lacks substantial

skills and research techniques in gathering more evidence about the nature of the disorder.<sup>[3]</sup>

Improving the psychiatric knowledge and skills of the undergraduate students can go a long way in increasing and improving the psychiatric care across the nation.<sup>[4-6]</sup> Training undergraduates to identify psychiatric disorders will also prevent them from misdiagnosing organic conditions with psychiatric manifestations as functional in the community or in the emergency setup.

Screening of psychiatric cases in the community helps in assessing the extent of the problem and also paves way for organizing community-based mental health programs. Epidemiological studies conducted in the recent years

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have used newer methods of screening. Screening tools like General Health Questionnaire (GHQ),<sup>[7]</sup> and Composite International Diagnostic Interview (CIDI)<sup>[8]</sup> have been used. Surtees and Tansella recommended the use of interval GHQ<sup>[9]</sup> in situations where there are time constraints. While key informant method is used as a screening instrument,<sup>[8]</sup> Arrol *et al.* used a brief and easy approach for screening depression which involved asking only two questions.<sup>[10]</sup> Patients with neurosis sometimes presenting only with somatic complaints may be missed when questions based only on psychological symptoms are posed. Hence, for screening, one should be trained to interview patients based on somatic complaints, using tools like Bradford somatic inventory.<sup>[11]</sup> Clinical interview schedule-revised has also been used<sup>[12]</sup> in epidemiological studies.

In this study, we tried to confirm the diagnoses of the cases identified as 'mentally disabled' by the internees while conducting a comprehensive community survey of assessing disability in the rural and urban populations of selected areas in Mysore using MINI Plus.

## MATERIALS AND METHODS

### Phase I

The Department of Community Medicine, JSS Medical College, JSS University, conducted a comprehensive community survey of all individuals in their field action area in 2007–2008. The areas included were JSS urban health centre (5,945) in Mysore district and the rural areas of Suttur (2,821), Hadinaru (2,968), Sargur (1,216), and Nagarle (2,633) of the Nanjangud Taluk, with a total population of 15,583. The survey was carried out by the internees under the supervision of the faculty of the Department of Community Medicine. The head of each household was contacted to elicit information regarding chronic illnesses and disabilities including mental disability in each individual in the respective household. No screening tool was used for the survey. Of the urban population of 5,945, there were 3,048 men and 2,897 women and of the rural population of 9,638, there were 4,834 men and 4,804 women. Of 15,583, 29 individuals were identified in the community by the internees as 'mentally disabled,' that is, 9 men and 20 women.

### Phase II

The 29 cases identified by the internees were evaluated by two qualified psychiatrists and one clinical psychologist through home visits. Visits were paid to these houses over a period of 10 days and an effort was made to trace the individuals with the help of the community health worker. The urban health centre was visited on 6 days because the houses or individuals could not be traced easily.

### Tools used and procedure

Informed consent was taken from the patients or their legal guardians before conducting the interview. The cases were screened for their psychiatric status using MINI Plus, and the diagnoses confirmed. In cases of children and adults with whom interview was not possible, history was collected from the significant family member/head of the family of each house hold.

## RESULTS

Of the 29 cases identified as having 'mental disability' in the phase I, only 24 could be traced, of which only 19 could be given a diagnosis and 5 were not found to have any 'mental disability' at all. Of these 19 cases, only 16 were found to have a psychiatric disorder, that is, four were cases of schizophrenia, one bipolar affective disorder, two depression, nine mental retardation, and the remaining three consisted of two cases of epilepsy and one with speech and hearing problem without any signs of mental disability [Table 1]. Also, the cases with only epilepsy, which is a neurological disorder, have been wrongly identified as having 'mental disability.' The prevalence rate as found by the internees was 1.9 per 1 000. However, the prevalence rate as confirmed through MINI Plus was only 1.02 per 1000.

Twenty cases other than those identified by the internees could be identified during the visit to the community. The information was given by the community dwellers about individuals afflicted with mental disorders while enquiring about the target cases, though this was not the objective of the study. These included 11 mental retardation, two schizophrenia, four bipolar affective disorder (BPAD), one depression, one conversion disorder, and one epilepsy cases.

## DISCUSSION

As per the results of the phase I, the prevalence was found to be 1.9 per 1 000. This is far less compared with what other studies have shown. The fact that more cases could be identified during the visit to the community, though it was not the objective of the study, shows that

**Table 1: Diagnoses of the identified cases**

	Urban		Rural		Total
	Males	Females	Male	Females	
Schizophrenia	0	2	0	2	4
BPAD	0	0	0	1	1
Depression	0	0	0	2	2
Epilepsy	1	1	0	0	2
MR	3	2	2	2	9
Dementia	0	0	0	0	0
Substance use	0	0	0	0	0
Anxiety	0	0	0	0	0
Other disabilities	0	1	0	0	1
Total	4	6	2	7	19

the prevalence rate could be higher as substantiated by studies on psychiatric epidemiology in India that found a prevalence ranging between 9.5 and 370 per 1,000.<sup>[13,14]</sup> Other community studies in India have shown a prevalence of 5.8% and as estimated by the World Health Organization, 10% of the world's population suffers from mental disability. In a study conducted in rural Karnataka, Kumar *et al.* found the rate to be 2.3%.<sup>[15]</sup>

Thacore *et al.* in India showed a high prevalence of neurosis, alcohol dependence, mental retardation, and nocturnal enuresis in a community in north India and this data was obtained by doing a house to house survey for 1 year.<sup>[16]</sup> The present finding of a low prevalence could have happened due to a host of reasons like interviewing only one informant without actually interviewing the patient as opined by Suresh Bada Math *et al.*,<sup>[13]</sup> lack of substantial interview skills, absence of a tool to screen the population, and a lack of awareness among the individuals in the community regarding mental health and mental disorders.

Another factor could be that the internees were unsure as to what comprises 'mental disability.' A search for the literature on 'disability' yields information mostly on 'mental retardation' and Indian disability evaluation and assessment scale (IDEAS); the scale to measure mental disability includes schizophrenia, bipolar disorder, dementia, and obsessive-compulsive disorder without any mention of mental retardation.<sup>[17]</sup>

Probably it reflects the undergraduate education in psychiatry too. Sethi and Trivedi have highlighted the need for revamping the psychiatric training of the undergraduate medical students.<sup>[18,19]</sup> Though there is an increasing need for mental health care, there seems to exist an apathy among the medical fraternity toward learning and teaching psychiatry. As a result of this, there is a dearth of professionals with psychiatric skills to identify and treat mental disorders. Students do not get enough clinical exposure in psychiatry and hence lack the skills to elicit a psychiatric history or make a psychiatric diagnosis. They are not trained to use structured scales which aid in making a psychiatric diagnosis. These could have led to the underdiagnosis of the cases in this study. There definitely is a need for adequate mental health training at the undergraduate level, but it is not reflected in the medical curricula.<sup>[20]</sup> The percentage of the lecture time dedicated for psychiatry is only 15 days and Jacob suggested that a teaching period of at least 1 month is required.<sup>[21]</sup> It has also been suggested that this training is mostly required for nonpsychiatrists.<sup>[22]</sup>

Despite all this evidence of epidemiological studies and the usefulness of scales, there are certain shortcomings. Math *et al.* reported that the epidemiological studies in India have been inadequate in identifying panic disorders,

social phobia, OCD, sexual dysfunction and substance use in the community.<sup>[13]</sup> Also, the validity of the information gathered by using scales may be questionable. Hence, the use of key informant interviews has been suggested by Charles Parry.<sup>[23]</sup>

One of the limitations of the phase 1 of the study is that the internees were not provided with a screening tool. However, there are epidemiological studies that have been conducted with only 'two questions' to screen depression in the community.<sup>[10]</sup> In addition, in the phase II, the cases were interviewed by one investigator only and hence, inter-rater reliability in making a diagnosis could not be determined. Moreover, the level of exposure of interns to psychiatry was not taken into account.

## CONCLUSION

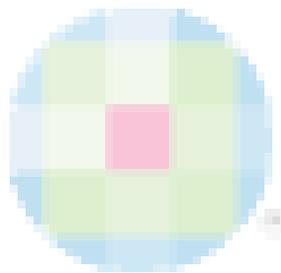
Though there is evidence for a high prevalence of mental disorders in the community, the internees had found the prevalence to be very low. This may be a reflection of the skills of the internees in identifying the mentally disabled and also a lack of awareness regarding mental health in the community. Therefore, there is a need to hone the skills of the undergraduate students by improving undergraduate psychiatric training and teaching them to use screening tools to identify mental disorders and also improve awareness in the community.

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