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SHORT-TERM FOLLOW UP TREATMENT OUTCOME AND REFERRAL PATTERN OF MENTAL ILLNESS AT A PSYCHIATRIC OUTPATIENT CLINIC OF DHAKA CITY, BANGLADESH

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Abstract

Psychiatric problems are increasing day by day through out the World as well as in Bangladesh. Psychiatric services have shifted its` focus from historical in patient service towards community based outpatient services which is even more important in a resource scarce country like Bangladesh.[1] It is important to assess the impact of present outpatient services to identify the strength and weakness of such services to provide comprehensive service to the patients in future.

This study was a cross sectional study conducted in 2015 at a private psychiatric outpatient service center located at Dhaka. Data was collected from 300 consecutive patients who gave informed consent. Patients' socio-demographic data and referral information were recorded and treatment outcome was measured subjectively. Results were compared with data from another study conducted in 2007 at the same centre. For these two studies done in 2007 and 2015, patient registry book and their history of information in the form of questionnaire were used. Information was recorded both in hardcopy and softcopy. In this study, it was found that patients or their relatives reported subjective improvement in 94% of cases. Sixteen percent of patients were referred by GP/specialist and 84% of patients were referred by self/relative/cured patient which higher than the previous study done in 2007.

This small study has shown the effectiveness of outpatient psychiatric service and has indicated the increased awareness about and acceptance of psychiatric illness among the population.

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Introduction

Psychiatric problems have been gradually increasing throughout the world. As Bangladesh is a developing country and has been gradually progressing through market competitions, multiple pressures are also coming from many sides in people's lives.

Pressure, competitions, society and family problems are gradually increasing in the communities of Bangladesh.[1]As a result, many patients of urban and rural areas everyday have been rushing to the psychiatric clinic for treating their mental illness.

Treatment outcome of psychiatric illness may be delayed or may be not satisfactory due to many reasons. For serious mental illness, it takes time for having satisfactory results of treatment. Sometimes patients or their attendance suddenly stopped taking drugs. That's also a reason for not improvement. Sometimes patients drop out or migrated to other areas. So that they may do not come for follow up. Sometimes people undergo several pressures of problems. That is also a reason for suddenly stopping of taking drugs.

National survey on mental health in Bangladesh shows that 16.1% of the adult population of the country are suffering from some sort of mental disorders and require immediate care.[3] Nationwide survey on mental health in Bangladesh in 2003-2005 among people aged 18 years and above revealed that 16.05% of adult populations are suffering from mental disorders.[3]As a developing country of south-east Asia Bangladesh has many socio-economic problems contributing to the causation of mental disorders. Poverty, unemployment, rapid urbanization, rising trends of substance abuse, are among the common factors contributing to mental disorders.[1]

About the psychiatry clinic in brief

The clinic named as Dhaka Monorog Clinic was established in 1984 and gradually became a pioneer clinic in the specialty of psychiatry in Bangladesh. Everyday many people come here even from village and remote areas of Bangladesh for psychiatry treatment. It is located at Mirpur, Section 11 at Dhaka.

At its ground floor, there is an outdoor clinic. It has also a branch at Dhanmondi area at Dhaka. From 2nd to 6th floor it has indoor clinic. There are separate arrangements for males and females.

Besides psychiatry specialists, there are medical doctors at this clinic. Besides treatment, there are also arrangements for psychotherapy, music therapy and group therapy.

Psychiatry problems throughout the world and the WHO report

According to the WHO, one in four people in the world will be affected by mental or neurological disorders at some point in their lives.

Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide.

Treatments are available, but nearly two-thirds of people with a known mental disorder never seek help from a health professional. Stigma, discrimination and neglect prevent care and treatment from reaching people with mental disorders, says the World Health Organization (WHO). Where there is neglect, there is little or no understanding. Where there is no understanding, there is neglect.

In a new report entitled "New Understanding, New Hope" the United Nations' health agency seeks to break this vicious cycle and urges governments to seek solutions for mental health that are already available and affordable.[2] Governments should move away from large mental institutions and towards community health care, and integrate mental health care into primary health care and the general health care system, says WHO.

"Mental illness is not a personal failure. In fact, if there is failure, it is to be found in the way we have responded to people with mental and brain disorders," said Dr Gro

Harlem Brundtland, Director-General of WHO, on releasing the World Health Report of 2001.

The report invites governments to make strategic decisions and choices in order to bring about positive change in the acceptance and treatment of mental disorders. The report says some mental disorders can be prevented; most mental and behavioural disorders can be successfully treated; and that much of this prevention, cure and treatment is affordable.

Despite the chronic and long-term nature of some mental disorders, with the proper treatment, people suffering from mental disorders can live productive lives and be a vital part of their communities.

Over 80% of people with schizophrenia can be free of relapses at the end of one year of treatment with antipsychotic drugs combined with family intervention. Up to 60% of people with depression can recover with a proper combination of antidepressant drugs and psychotherapy.

A lack of urgency, misinformation, and competing demands are blinding policy-makers from taking stock of a situation where mental disorders figure among the leading causes of disease and disability in the world, says WHO. Depressive disorders are already the fourth leading cause of the global disease burden. They are expected to rank second by 2020, behind ischaemic heart disease but ahead of all other diseases. [2]

The responsibility for action lies with governments, says WHO. Currently, more than 40% of countries have no mental health policy and over 30% have no mental health programme. Around 25% of countries have no mental health legislation.

A limited range of medicines is sufficient to treat the majority of mental disorders. About 25% of countries, however, do not have the three most commonly prescribed drugs used to treat schizophrenia, depression and epilepsy at the primary health care level. There is only one psychiatrist per 100 000 people in over half the countries in the world, and 40% of countries have less than one hospital bed reserved for mental disorders per 10 000 people.

The report says new knowledge can have a tremendous impact on how individuals, societies and the public health community deal with mental disorders. We now know that large mental institutions no longer represent the best option for patients and

families. Such institutions lead to a loss of social skills, excessive restriction, human rights violations, dependency, and reduced opportunities for rehabilitation. Countries should move towards setting up community care alternatives in a planned manner, ensuring that such alternatives are in place even as institutions are being phased out.

The policy directions have never been so clear, says WHO. Governments who are just starting to address mental health will need to set priorities. Choices must be made among a large number of services and a wide range of prevention and promotion strategies. WHO's message is that every country, no matter what its resource constraints, can do something to improve the mental health of its people. What it requires is the courage and the commitment to take the necessary steps.

The report is part of a year-long campaign on mental health. For the first time, multiple events at WHO including its premier report, technical discussions at the World Health Assembly and World Health Day, have all focused on one topic–mental health.[2]

Current psychiatric condition of Bangladesh

A recent review led by ICDDR,B found that mental disorders in Bangladesh are a serious but overlooked problem.[3] Better data, awareness and more mental health practitioners are needed to address the unmet needs for mental health care.

Mental health disorders– such as depression, anxiety, addiction, schizophrenia and neurosis – have a serious impact on health: they contribute up to 13% to the global burden of disease.

Low- and middle-income countries experience a higher burden of mental disorders, and yet mental health conditions are often not perceived as serious health problems in these countries and are not prioritized in prevention programmes and in health care delivery.

In addition, in countries like Bangladesh, there are often few prevalence data, making recognition of the problem difficult and posing a challenge to developing effective health care responses.

A new systematic review led by ICDDR,B investigators examines the current prevalence and trends in the rates of mental health disorders in Bangladesh in order to fill the

knowledge gap and to point the way towards addressing the burden associated with these conditions.

The authors of that review of ICDDR,B collected and evaluated literature on prevalence of mental disorders such as depression, anxiety, psychiatric and behavioural disorders, along with comorbidity with chronic diseases and service delivery and treatment options in Bangladesh. They focused on published articles that presented quantitative data and were published in English between 1975 and October 2013.

The review found that the overall prevalence of mental disorders in Bangladesh is between 6.5 to 31% among adults, with psychiatric and psychogenic disorders such as depression, anxiety and neurosis most commonly reported. The prevalence of mental disorders was much higher in overcrowded urban communities than rural ones, and among the poor. Women were vulnerable across all settings, consistent with findings from other South Asian countries like India and Pakistan.

The review authors of ICDDR,B found that data on mental disorders among children are scarce, but prevalence is estimated to be between 13.4 to 22.9%. Behavioural disorders were most common among children, but psychiatric disorders were also reported among socially disadvantaged children, such as those living in urban slums. The evidence suggests that psychiatric disorders among children are associated with malnutrition, low education of fathers and a family history of mental illness.

Chronic diseases and mental disorders are mutually reinforcing– mental disorders can increase the risk of chronic diseases and the intensity of symptoms by deteriorating an individual's immune system, and chronic diseases can increase the risk of mental disorders. This study found that a third of patients with diabetes and half of cancer patients had depression. Similar findings were reported among patients with hypertension and chronic obstructive pulmonary disease.

They review authors of ICDDR,B found a major shortage of qualified mental health practitioners in Bangladesh for both adults and children, and few referrals to specialists.

At the same time, lack of knowledge, superstitious beliefs and social stigma prevents individuals with mental health conditions from seeking care. Beliefs that mental disorders are untreatable or the result of evil influences also play a role. Women are both

more vulnerable to experiencing mental disorders and less able to access treatment due to their lower social status.[3]

Rationale of the study

In very less studies, usually the treatment outcomes were measured especially in psychiatric cases like in the studies of Goodwin and Fleischhacker[11] and Blais *et al*[12]. In that sense, this study was very important. Besides this, referral pattern were also measured.

Materials and method

This was a cross-sectional study done within a month started from 7th October in 2015 and ended in 7th November 2015. Survey was done to measure treatment outcome, referral and socio-demographic status with the help of a structured questionnaire.

The questionnaire included the questions about age, marital status, socio-economic condition, living in urban or rural area, treatment outcome, coming since which year and referred by whom.

A comparative study was also done to measure the improvement of referral with the year 2007 (24 October 2007 to 24 January 2008 with 230 patients).[4]

Results

A total number of 300 patients were included in this study. Among the patients, male was 149 in number and 151 was female. 199 patients came from urban area whereas 101 patients came from rural area.

Among the patients, 6 people came from upper socio-economic society and 44 patients came from lower socio-economic society. Majority patients came from middle class family (250 in number).

In the result of treatment outcome it was found that 283 patients (94%) were improved and only 17 patients (6%) were not improved.

Family history is very important for mental illness. It was found that among 300 patients, 45 patients had family history.

Referral by self, relatives, family or friends was 163 among 300 patients which was 54%. Referral by general physicians or specialists was 16% and by cured patients was 29% respectively.

Table 1: Socio-demographic characteristics of patients in 2007 and 2015 (%)

Characteristics	**2007**	**2015**
Sex		
Male	54%	49.66%
Female	46 %	50.33%
Marital Status		
Married	56 %	69.66%
Unmarried	44%	30.33%
Residence		
Urban	56%	66.33%
Rural	54%	33.66%

Table 2: Comparison with referral pattern in year 2007:

Referred by	**2007**	**2015**
GP/specialists	20%	16%
Cured patients/ Friend/relative/self	80%	83%

From the table 2, it has been found that in 2015, referral by GP/specialist had decreased by 4% and referral by Cured patients/Friend/relative/self had increased by 3%.

Table 3: Treatment outcome in 2015 (1 month survey)

Treatment Outcome	**number**	**percentage**
Improved	283	94.33%
Not improved	17	5.67%

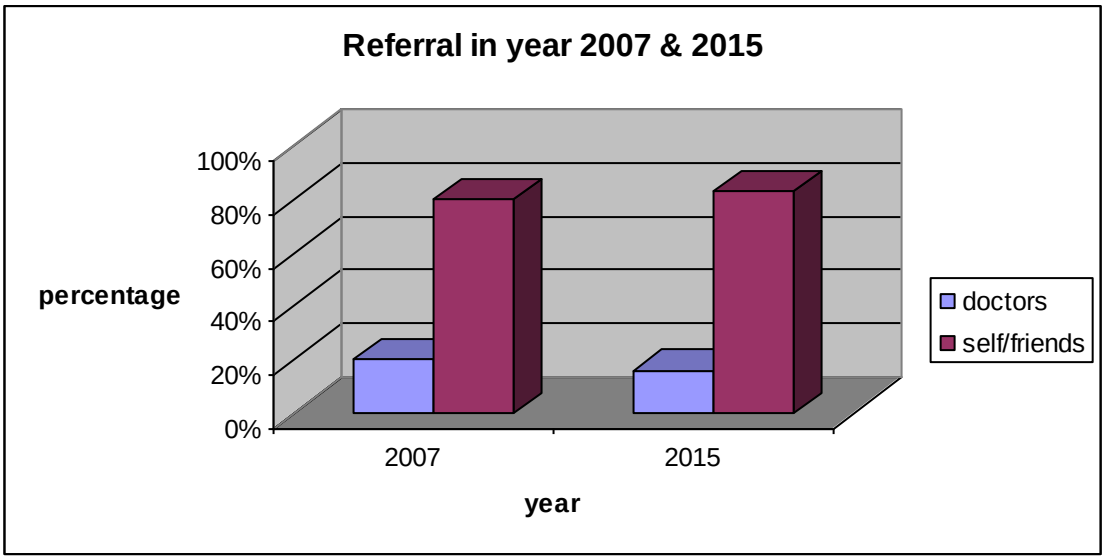

Fig. 1: Referral in year 2007 and year 2015 at Dhaka Monorog Clinic

Figure one describes about the comparison of referral pattern in the year 2007 and 2015. It was found that in 2015, referral by GP/specialist had decreased by 4% and referral by Cured patients/Friend/relative/self had increased by 3%.

Discussion

Mental illness cases have been increasing in Bangladesh day by day like other countries of the world. From the study it was found that people from urban areas accessed the clinic more in comparison to rural areas. It was also noticed that younger patients, like school going children were also affected by mental illness.

The treatment outcome was satisfactory as 94% patients were improved within a short-span.

Referral by GP and cured patients has increased in the year 2015 comparing to the year 2007. A systematic search and meta-analysis of controlled trials using outcome management in mental health services published in English or German language was published in British Journal of Psychiatrists in June 2009.

Twelve studies met inclusion criteria. The outcome results showed a small, but significant (d = 0.10; 95% CI 0.01–0.19) positive short-term effect on the mental health

of individuals that did not prevail in the long run. Subgroup analysis revealed no significant differences regarding feedback modalities. Outcome management did not contribute to a reduction of treatment duration.[5]

In this study, treatment outcome was measured by patient's own feeling or from the observation of their nearest ones. The other methods are as follows:

a. Real world functional indicators (e.g. school grade, disciplinary action)
b. Clinician intuition/feelings.
c. Progress towards individualized treatment goals.
d. Other informants' reports of client functioning.
e. Client self-report of symptoms/functioning.
f. Standardized measures or scales.[6]

A study was done by Crawford *et al* to assess the views of service users for treatment outcome. It was done as very little is known about service users' views of measures used to evaluate treatments in mental health. The aim of the study was to identify the views of people with psychosis and affective disorder about the relevance and acceptability of commonly used outcome measures.

In that study, 24 widely used outcome measures were presented to expert groups of service users. Nominal group methods were used to develop consensus about the appropriateness of each measure. Comments made by service users about how outcomes should be assessed were also recorded.

Group members expressed concern about the ability of some outcome measures to capture their experiences. Patient-rated measures were assessed as more relevant and appropriate than staff-rated measures, and the need to examine negative as well as the positive effects of treatments was emphasized. Specific concerns were raised about some widely used measures including the Global Assessment of Functioning and the European Quality of Life scale.[7]

Another study was done to assess short-term treatment outcome of Schizophrenia at a tertiary hospital of Bangladesh. In that study, psychopathological measurements were

applied at baseline by researchers and at 6 week and at 6 month by research assistant for the study population. Patients were 42 in number at baseline survey. For follow up, only 38 patients were available at 6 months and among them 87% patients got partial remission and 8% didn't respond. Drug treatment outcome for schizophrenic patients was found better for short-term.[8]

For the current study, we found that treatment outcome was better for short-term follow up patients of mental illness.

From a study of year 1977 on psychiatric patients, the results of improvement have given below:

Table 9: Rates of improvement in schizophrenics, manics and depressives:

Year	Improved			No Change%			Otherwise%		
	Schi.	Manic	Depr.	Schi.	Manic	Depr.	Schi.	Manic	Depr.
1967	83.5	90.0	83.5	1.2	0	1.2	15.9	10.0	15.9
1968	87.1	86.0	86.4	0.8	0	1.3	11.9	14.0	12.1
1969	95.3	97.7	89.4	0.5	0	0	4.1	2.2	10.5
1970	93.9	96.8	87.7	0.2	0.4	0	5.8	7.1	12.2
1972	86.8	84.0	85.4	0.4	0	2.7	12.6	15.9	11.8
1974	92.7	94.1	84.2	0	0.7	0	7.2	5.1	15.7

From the above table, it was found that most improvement year among psychiatric patients was 1974.[9]

Conclusion

Most of the patients who came at Dhaka Monorog Clinic for follow up had improved (94%). It was found that in 2015, referral by GP/specialist had decreased by 4% and referral by Cured patients/Friend/relative/self had increased by 3% in comparison with the study done in 2007.

A systemic review was done on 32 articles published between year 1975 and October, 2013. The reported prevalence of mental disorders varied from 6.5 to 31% among adults and from13.4 to 22.9% among children. Some awareness regarding mental health disorders exists at community level. There is a negative attitude towards treatment of those affected and treatment is not a priority in health care delivery. Mental health

services are concentrated around tertiary care hospitals in big cities and absent in primary care.[10]

Common software can be produced in future which includes scores to measure the patient mental condition to determine the progress of the treatment for mental illness.

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