

**ORIGINAL ARTICLE**

## **Morbidity profile of patients attending the centers for mental health service provided jointly by the Government of Nepal and Community mental health service of Community Mental Health and Counseling- Nepal (CMC-Nepal).**

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**Introduction:** *Community mental health program initially conducted in Lalitpur district by UMN and later in the western region demonstrated the possibility of providing mental health services in the primary health care level if proper mental training is provided to different levels of health workers and the program is well supervised. Community Mental Health and Counseling- Nepal (CMC-Nepal) extended the same model of community mental health program to several other districts of the country after taking permission from the Ministry of Health and Population. The basic objective of the study was to prepare morbidity profile of patients attending the centers for mental health conducted jointly by the government of Nepal and Community Mental Health and Counseling- Nepal (CMC-Nepal).*

**Material and method:** *Ten days block training in mental health for health assistant (HA) and Auxiliary Health Workers (AHW) was conducted by the CMC-Nepal. Senior psychiatrists, psychologists and psychiatric nurse were the trainers. Materials like mental health manual, audiovisuals, flip charts and case stories were used during training by the facilitators. An especially developed patient record card was used for case record, diagnosis and treatment. The study was carried out in between July 2010 to June 2011. A total of 6676 cases were studied during the study period.*

**Results:** *Community mental health program identified 4761 total new cases in 12 months (July 2010 to June 2011), out of which 2821 were females (59%) and 1940 were males (41%). Similarly total old cases both females and males were 6676 registered in these centers for treatment. Out of all new cases patients with Anxiety Neurosis emerged as the largest group (50%) followed by Depression (24.88%). Other commonly diagnosed conditions were Epilepsy (7.5%), Psychosis (5.3%) and Conversion disorder (5.7%) and unspecified cases (6.5%). The implications of the results are discussed, in the current context.*

**Conclusion:** *Mental health services need to be provided at the community so as to prevent cases of prolonged subjection to mental illness and also prevent cases of stigma and discrimination.*

**Keywords:** *Morbidity profile, mental health, Community mental health program*

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## **INTRODUCTION**

In 2003, staffs working in a community mental health program of United Mission to Nepal (UMN), established a Non Government Organization named Community Mental Health and Counseling- Nepal (CMC-Nepal), and took over the mental health activities especially the community mental health programs carried out by the UMN. Community mental program initially conducted in Lalitpur district by UMN and later in the western region demonstrated the possibility of providing mental health services in the primary health care level if proper mental training is provided to different levels of health workers and the program is well supervised. So, CMC-Nepal extended the same model of community mental health program to several other districts of the country after taking permission from the Ministry of Health and Population. Psychosocial counseling was added as a component of this community mental health program by the CMC-Nepal.

In this model, a feasibility study of the selected districts and centers are done initially, by visiting the centers, meeting with district health officer, hospital chief, doctors, paramedical staffs, health management committee, local NGOs etc and if found feasible, permission is taken from the Ministry of Health and Population to run the program. Then, mental health block training is planned for the health professionals and health workers of the selected centers. Mental health block training is planned in such a way that the trainees are able to diagnose, treat or refer the most common mental disorders and epilepsies namely depression, psychosis, anxiety neurosis, conversion disorder, epilepsy of grand mal type (generalized tonic-clonic convulsion), alcohol use disorder, mental retardation and to provide counseling to patients and their families. The basic objective of the study was to prepare morbidity profile of patients attending the centers for mental health conducted jointly by the government of Nepal and Community Mental Health and Counseling- Nepal (CMC-Nepal).

## **MATERIAL AND METHOD**

Ten days block training in mental health for health assistant (HA) and Auxiliary Health Workers (AHW) was conducted by the CMC-Nepal. Senior psychiatrists, psychologists and psychiatric nurse were the trainers. Materials like mental health manual, audiovisuals, flip charts and case stories were used during training by the facilitators. Mental hospital or psychiatric departments of teaching hospitals were used to interview cases for diagnosis and management of mental patients. An especially developed patient record card was used for case record, diagnosis and treatment. The study was carried out in between July 2010 to June 2011.

This patient record card was developed in such a way that after taking a proper history and exploring the symptomatology and duration of illness, health workers can easily reaches to a diagnosis. Important symptoms of each condition were given in the card, health workers had to ask the relevant questions for the given symptoms and mark them in the card, and the conditions included depression, psychosis, epilepsy, anxiety neurosis, conversion disorder among others. Then either these cases are treated in the centers or referred to a specialist in the nearby referral hospital. In case of difficulties, health workers could consult the psychiatrist in Mobile phones. Refresher training after one to one and half year is organized for these health workers to refresh their knowledge and share their experience in the field.

## **RESULTS**

Total new cases seen during the study period were 4761, of which 2821 were females (59%) and 1940 were males (41%). Similarly, total old cases were 6676. Total new and old cases were 11437.

**Table 1: Number of participants in each study site**

SN	Centre	Female	Male	Total
1	Bajhang ( Bajhang hospital and Royal PHC)	126	81	207
2	Dadeldhura ( Dadeldhura hospital, Jogbudha PHC and Nabadurga PHC)	281	189	470
3	Doti ( district hospital , Sanagaun HP and Kedarakhda PHC )	123	180	303
4	Achham ( Achham hospital, Kunchi HP, Kamal bazaar PHC and Bayalpata hospital)	96	85	181
5	Surkhet ( salkot PHC, Dasarathpur PHC, Mahelkuna PHC)	49	33	82
6	Dailekh ( District hospital,, Dullu PHC,and Naumule PHC )	81	65	146
7	Salyan ( District hospital, Tharmare PHC and Lekhpokhara PHC)	115	88	203
8	Rolpa ( district hospital, Holeri PHC and Sulichaur PHC)	81	58	139
9	Dhadhing ( District hospital, Salayantar PHC, Gajuri PHC, and Jogimara SHP)	290	200	490
10	Okhakhungu ( Okhakhungu hospital)	140	85	225
11	Morang ( Letang PHC )	0	3	3
12	Ilam (Ilam hospital, Mangalbare PHC and Fikkal PHC)	92	81	173
13	Palpa ( Tansen Mission hospital )	1344	810	2154
	Total	2821	1940	4761

**Table 2: The diagnostic breakup of the new cases**

SN	Mental Illness	Female	Male	Total
1	Depression ( includes depression, dysthymia and post partum depression)	739 ( 62.3% out of new depression cases)	446 ( 37.7 % out of new depression cases)	1185 ( 24.88 % out of total new cases)
2	Psychosis( includes acute psychosis, mania, and chronic schizophrenia)	112 (43.7 %)	144(56.3 %)	256 ( 5.3 % out of all new cases)
3	Anxiety Neurosis ( generalized and panic types)	1503 ( 63.2% out of total anxiety cases)	874 (36.8%)	2377 ( 50 % out of all new cases )
4	Conversion Disorder	217 ( 80 % out of total conversion cases)	55 ( 20 % of total conversion cases)	272 ( 5.7 % out of all new cases)
5	Epilepsy ( Grand mal type only)	173	186	359 ( 7.5% out of all new cases )
6	Unconfirmed diagnosis but symptoms suggestive of neurotic disorders	77 (24.6%)	235(75.4 %)	312 ( 6.5% out of all new cases)

## DISCUSSION

Anxiety neurosis has emerged as the most common disorder, 50 % of the total new cases (63.2% females and 36.8 % males). Anxiety symptoms in panic disorder, generalized disorder, social phobia, obsessive compulsive disorder and post traumatic disorders all were grouped under this heading. As any of these disorders just mentioned can present with anxiety symptoms, they all were diagnosed as anxiety neurosis. This was one of the reasons of very high percentage of cases in this study. The ICD-10 generalized anxiety disorder and depressive episode were the commonest mental disorders identified by the Composite International Diagnostic Interview (CIDI) <sup>1</sup>. Prevalence estimates of anxiety disorders based on community epidemiological surveys vary widely, from as low as 2.2 percent<sup>2</sup> to as high as 28.5 percent<sup>3</sup>. Anxiety disorders have consistently been found in epidemiological surveys to be highly co -morbid both among themselves and with mood disorders. More than half the people with a history of either anxiety or mood disorder typically have both type of disorder. In one of our hospital data, 11.6 percent of patients attending psychiatric outpatient were of anxiety disorders (generalized, panic and phobic anxiety combined) <sup>4</sup>. Both anxiety neurosis and depression are more common in woman; our data also confirm the same.

Somatic complaints such as chest pain, palpitation, respiratory difficulty, headache, dizziness, pain in nape of the neck and epigastric discomfort are very common symptoms in patients attending hospital / primary health care centers. In the absence of any physical cause for these symptoms, possibility of anxiety neurosis, depression or depression associated with anxiety is high. This may be one of the reasons for such high morbidity.

Depression was found as the second most common disorder. Out of 24.88 % of all new cases, 62.3% were females and 37.7 % were males. The core symptom of depression is a disturbance of mood: sadness is most typical and the person is not able to experience pleasure and may feel hopeless. But in Nepal, patients usually complain of weakness, fatigue, ache and pains, no affection towards self and others and death wishes as the symptoms of depression. When asked about their mood state, then only they report sadness of mood, hopelessness and worthlessness. Many patients talked about past *Karma* either in this life or in their previous life for such illness. Co-morbid anxiety symptoms were often present. In this study, major depression (endogenous depression), dysthymia (chronic depression of more than two years duration), post-partum depression and depression secondary to many physical illnesses were all included in the single heading of depression.

Epilepsy was found as the third common disorder in the study. Seven point five percent out of total new cases were of epilepsy with almost equal male and female cases. The health workers are trained to diagnose and treat only generalized tonic - clonic seizures and when the diagnosis is doubtful, they have to refer these cases to a referral hospital for confirmation of diagnosis and treatment. In our experience, and according to one study<sup>5</sup> most of the well trained health workers correctly diagnose grand mal epilepsy.

The generally accepted estimate of the prevalence of active epilepsy globally is in the range of 5 to 8 per 1,000 population. The difference between the number of people with active epilepsy and the number who are appropriately treated in a given population at a point in time is known as the treatment gap. Meinardi et al estimate that 90 percent of people with epilepsy in developing countries are

inadequately treated<sup>6</sup>. Poverty, lack of awareness, unavailability of free drug at the primary health care level, difficulty in continuing treatment for a long period of five years, and in some cases lifelong were the major difficulties faced by patients. As long as the free drug is provided, epilepsy follow-up is very good, when the patient or the family member has to buy the medicine out of pocket, many cases tend to stop treatment and relapse. Epilepsy case identification and initiation of treatment alone does not serve the purpose. In addition to financial factors, repeated follow-ups, counseling about the nature of illness and long term medication can only help the people suffering from epilepsy. Epileptic children in the rural community often do not go to school because of this illness, school children and even some teachers falsely believe that epilepsy is contagious. This wrong belief needs to be removed for the successful treatment of epilepsy and for the education of the child.

Conversion disorder (hysteria) was the fourth common disorder covering 5.7 percent of all new cases in the study. Eighty percent hysteria cases were females and 20 percent cases were males. These data show that conversion disorder though mainly seen in females; it is not rare in males also. Both hysteria and mass hysteria are common in Nepal. They present with different symptoms like fainting attacks, aphonia, possessions, different types of pain disorders without any physical basis and paralysis of one or both limbs. Majority of such patients are adolescent girls and young women. Mass hysteria cases have been seen mostly in school, both in cities and urban areas<sup>7</sup>. Pseudo seizures or hysterical fits, though not life threatening, are often recurrent, difficult to treat and sometimes difficult to differentiate from epilepsy. There are many cultural and traditional factors related to this disorder. Traditional healers are playing significant role to sustain the belief system of the community in the evil spirit and witchcraft. So,

this illness is not likely to decrease in the many years to come.

Of all new cases, 5.3 percent were of functional psychosis. May be males suffering from psychosis are brought for treatment more frequently than the females. Diagnosis of florid psychosis is easy, but trained staffs have less confidence to start medication or even to interview psychotic patients. Fear of harm by the patient or aggressiveness of the patient is the most likely cause. Aggressive psychotic patients are often brought by a group of people in a restrained state; it is not easy for the inexperienced staffs to deal with such patients. Such cases are mostly referred to centers where psychiatric care is available. Once their acute symptoms are controlled, trained primary care staffs can do follow-ups successfully in the community.

Lastly, 6.5 percent of all new cases were in others / unspecified group. Many cases of headaches (migraine and tension headaches), alcohol use disorder, mental retardation, childhood mental disorder, psychosexual disorder or cases whose diagnosis was difficult are grouped in this category.

## **CONCLUSION**

Mental health may often be a neglected entity in resource constraint health economy as ours. Even more people with some form of mental illness may be subjected to prolonged period of state of illness due to lack of access to relevant medical care and support. In context of our country mentally ill people often become victims of stigma and discrimination. Therefore it is utmost importance mental health services are provided at the community level.

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