

Priority of Mental Health Care in the Psychiatric Outpatient Clinic (Ibn Sena Teaching Hospital) Mosul

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ABSTRACT

Mental health problems are responsible for a large proportion of disability cases, causing high direct and indirect costs, result in high numbers of hospitalizations, and impose a heavy burden of human suffering, including stigmatization of people with mental disorders and their families. The study describe the size of the problem (burden of mental illness) on the out patient population and to prioritize the type of mental disorders consulting Ibn Sena Teaching Hospital. Accordingly, correlation with the drug dispensed in the outpatient pharmacy will be do All patients records in Ibn Sena teaching outpatient clinic were reviewed (Registry of all the records for six months (May-October 2019) & the registry of the inpatients records of the psychiatric wards for mental disorders for two months' period (May October 2019 was included. In Iraq house hold population. 41% of pop less than 15years. In this study table 1 reveal inconsistent & non-significant differences in relation to age, but there is significant seasonal variation in relation to the consultation age. But still there is a significant difference in the age of patient who consult for O/P and I/P treatment (16-35): 55.6% I/P while 42.3% for O/P. probably most admissions are for psychotic mental problems & for ECT. The available evidence of this study indicate the urgent need for repairing the gap by a better planning of services starting from the definition of the problem, better recording (preferable electronic data base monthly reviewing &reporting. This is applied for both O/P and I/P in this study, mental consultations over 6 months during the year 2019 makes (1944) out of (67095) Which is equal to (3% of total consultations to the O/P clinic Ibn sena teaching hospital.

Keywords: burden, disorder, mental health care, psychiatric, mental illness,

INTRODUCTION

Mental health is "The capacity of individuals and groups to interact with one another and the environment, in ways that promote subjective well-being, optimal development and the use of cognitive, affective and relational abilities". A diverse range of social, environmental, biological and psychological factors can impact on an individual's mental health.

In turn, people can develop symptoms and behaviors that are distressing to themselves or others, and interfere with their social functioning and capacity to negotiate daily life. These symptoms and behaviors may require treatment or rehabilitation, including hospitalization^[1].

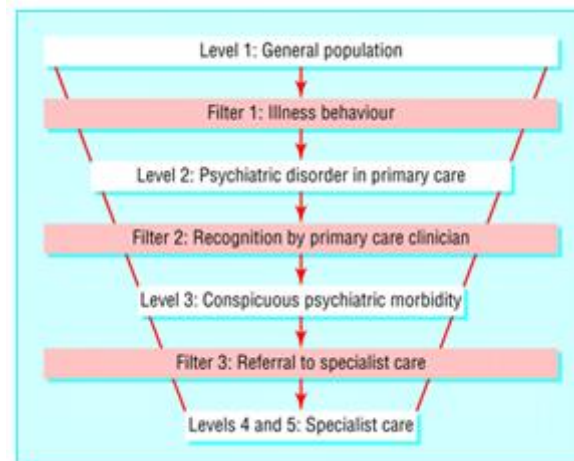
Mental health problems are an important source of burden worldwide, and a key recommendation of the World Health Organization is that treatment should be based in primary care.³ Mental health care in primary care has been defined as "the provision of basic preventive and curative mental health care at the first point of contact of entry into the health care system^[5,6]."

The structure of mental health care in primary care is generally understood in terms of the "pathways to care" model. below clarify that accessing mental health care involves passing through five levels and three filters between the community and specialist care (Fig 1). This model highlights the importance of the primary care clinician, whose ability to detect disorder in presenting patients (filter 2) and propensity to refer (filter 3) represent key barriers to care. The model also highlights the decreasing proportion of the total population who access higher levels

Goals of mental health care in primary care aimed at providing structured services and decreasing burden & less cost effective services, what are primary care mental health services supposed to achieve? The first two aims are the focus of conventional systematic reviews:

Effectiveness—services should improve healing Efficiency-limited resources should be distributed to maximize health gains to society.

Other aims are also important, however, and are highlighted by the pathways to care model but less often dealt with explicitly in systematic reviews:



Access—service provision should meet the need for services in the community Equity—resources should be distributed according to need. Government has instituted a number of policies designed to shift care from hospital into the community in4&5 the belief that it will be more cost-effective to treat the majority of illness in primary care. With regard to the management of people with severe and enduring mental health problems, there have been moves increasingly to involve primary care with regard to neurotic illness there has been no stated policy. Many see it as appropriate to refer patients with minor psychiatric disorders to secondary care specialists. Others, disillusioned with secondary care provision in their area, now employ counsellors and other mental health professionals to work within the practice^[2,4,5].

The boundary between primary and secondary care has been necessarily flexible to accommodate the variation in the skills of primary and secondary care specialists, but two factors have been particularly powerful in driving change at this boundary. These are changes in government policy.

WHO is deeply committed to closing the gap between what is needed & what is currently available to reduce the burden of mental disorders worldwide& to promote mental health.

In Iraq there are three levels of care. The primary, secondary & tertiary, though referral is still not well organized .Mental health consultations to the outpatient clinics are self-referral .The burden of this type of consultations will be reflected on the hospital services in providing the care & medications to the patients plus the human resources from doctors & nurses, both for the secondary & the tertiary care .Special requirements of the mental health sector that impact on information priorities The integration of mental health into general health care is not a simple undertaking and raises ,challenges for information collections. Mental health care differs in its nature and organization from the conventional image of acute hospital specialties. Many of these differences are also characteristic, examples: Care may be long term or may occur in shorter but recurring episodes. Care is usually provided by multiple treatment teams working across hospital and community settings, this poses practical difficulties for clinical staff recording details of their work, and thus has implications for what information can become ‘national information’. Coordination of the overall care effort can be difficult, and is dependent on modern communication technologies, most of which are not currently available to the typical mental health service provider. Outcomes are relatively difficult to study as many facets of consumers’ and careers’ lives may be affected over long periods of time^[7]. In addition, there are some characteristics that are specific to mental health care Because mental illness may affect all aspects of living, including work, family, and social life, mental health care has significant overlap with the work of the welfare sector, particularly in the areas of housing and disability support services Special confidentiality and data protection issues arise from working with police and criminal justice agencies. The need to record, and report Concerns about public safety are high, with a relatively small number of service failures given substantial publicity Collectively, these factors impact at all levels of the information development chain. They create special challenges for local system developers, who are required to ensure that the information needed by^[13] mental health clinicians is included in general health information

systems. Current approaches to health information consist mainly of the collection and analysis of unlinked individual treatment episodes. A more complex data collection model is required that is consistent with the continuity of care and service integration themes of the National Mental Health Strategy. At the national level, the factors outlined above emphasize the need for a specific focus on the mental health sector that takes account of the whole and not just parts of the service system, that looks at care provided over the longer term, and gives proper consideration to the specific requirements of the National Mental Health Strategy. Information ‘building blocks’ required to support a comprehensive mental health system. The study aims to:

1. Analyze the type of mental disorder attending the psychiatric of outpatient clinic.
2. Describe the most prevalent 10 mental disorder.
3. Correlate the type of mental disorder with the available method and management.
4. Describe the demographic characteristic of the sample

MATERIALS AND METHODS

Study design: Ibn Siena Teaching Hospital of outpatient clinic.

- A. Type: parametric epidemiological study.
- B. Design: Observational study, descriptive study and biometry study.

Study sitting: Outpatient psychiatric clinic in Ibn Sina Teaching Hospital.

Method: Study population all mentally ill patients who consult outpatient clinic in Ibn Siena Teaching Hospital.

Sample: Six months' personal assessment and examination of all patients consulted the clinic by the investigator.

Outcome measures: ICD-10 checklist.

Statistical analysis: Statistical & correlation study collected from Ibn Siena Teaching Hospital.

Expected benefit: To plan a better mental health services depending on the available resources.

All data were subjected to Statistical analysis (Descriptive and correlation). The results revealed that only 3% of the whole consultations were for mental disorders, males out number female, the age showed seasonal variations according to the type of drug dispensed. Schizophrenia was on the top of the list of consultation for both in patient & outpatient consultations, followed by mood disorders and there was no correlation between the type of consultations for mental disorders & the available drug.

Statistical analysis: Statistical & correlation study collected from Ibn Sena Teaching Hospital to estimate the chi square value & p value (the statistical significance) of the psychiatric of priority of mental health care different socio-demographic variables, besides the odd ratio with confidence interval 95% for the socio-demographic variables^[21]. Z-test (which is a statistical test used in inference which determine if the difference between sample mean & population mean is sufficiently different as to be statistically significant), was used to calculate the p value in the distribution of psychiatric morbidity among different dermatological diseases.

Conclusion, poor recording system is reflected on the results of this study plus discrepancy between what is needed for drug treatment & the disorder to be treated. Data base recording system is urgently needed throughout all the steps of mental health care. Drugs should be available continuously & 1 constantly in the O/P&I/P units.

RESULTS

Priority of mental health care in the psychiatric outpatient clinic (Ibn Sena Teaching Hospital) Mosul. Collect the data from outpatient clinic (Ibn Sena Teaching Hospital) Mosul. 67095 divided the result according to the

- 1-Age
- 2-Sex
- 3-Diagnosis
- 4- Seasonal variation
- 5-Durg availability

The results put in a table as the fallowing: -

**Table 1. (%) Total Psychiatric & None Psychiatric Visited Ibn-Sena Outpatient Clinic
According to Age from May to October 2019**

Age	May n=10276		June n= 11543		July n=12258		August n=9320		September n=12844		October n=10854		χ^2	p-value
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		

<15	2160	21.1	2491	21.6	3482	28.4	1938	20.8	3016	23.5	1912	17.6	9791.95**	0.000
16-25	1875	18.2	1560	13.5	1380	11.3	3516	37.7	1316	10.2	1875	17.3		
26-35	986	9.6	3925	34	4720	38.5	1917	20.6	2827	22.1	2450	22.5		
36-45	2470	24	2720	23.6	1285	10.5	1025	11	3175	24.7	3520	32.5		
>45	2785	27.1	847	7.3	1391	11.3	924	9.9	2510	19.5	1097	10.1		

** Significant at the 0.01 level.

Table 2. (%) Total Psychiatric & None Psychiatric Visited Ibn-Sena Outpatient Clinic According to Sex from May to October 2019

Sex	May n=9815		June n=9152		July n=6991		August n=7382		September n=9828		October n=8892		χ^2	p-value
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
Male	5393	54.7	6387	69.8	4067	58.2	3257	55.9	5350	54.4	5367	60.4	1202.274**	0.000
Female	4458	45.3	2765	30.2	2924	41.8	4125	44.1	4478	45.6	3525	39.6		

** Significant at the 0.01 level.

Table 3. (%) Total Psychiatric Illness & None Psychiatric for Month May to October 2019

Month	May n=10804		June n=11643		July n=10473		August n=9320		September n=12844		October n=10804		χ^2	p-value
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
Psychiatric illness	367	3.0	259	2.2	314	3	289	3	291	2.3	424	3.9	80.284**	0.000
None Psychiatric illness	11644	97	11384	98	10159	97	9031	97	12553	97.7	10380	96.1		

** Significant at the 0.01 level.

Table 4. (%) Total Psychiatric Illness in Ibn-Sena Outpatient Clinic According to Diagnosis from May to October 2019

Diagnosis	May n=367		June n=259		July n=314		August n=289		September n=291		October n=424		χ^2	p-value
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
Schizophrenia	235	64.1	143	55.2	103	32.8	132	45.7	122	41.9	160	37.7	280.333**	0.000
Depression	3	0.8	23	8.9	95	30.3	35	12.1	58	19.9	55	13.0		
Anxiety	41	11.2	32	12.4	78	24.8	87	30.1	49	16.8	117	27.6		
Bipolar	6	1.6	8	3.1	3	1.0	7	2.4	12	4.2	13	3.1		
ADHD & AUTISM	72	19.6	42	16.2	28	8.9	26	9.0	42	14.4	47	11.1		
Others	10	2.7	11	4.2	7	2.2	2	0.7	8	2.8	32	7.5		

** Significant at the 0.01 level.

Z₂ Proportions = 16.74314

Table 5. P- Value Out Patient to in Patient for Month May and October 2019 According to Seasonal Variation

Seasonal Variation	May n=10280		October n=13637		OR	95 % Confidence Interval	χ^2	Z ₂ Proportions	p-value
	No.	%	No.	%					
In Patient	66	0.6	86	0.6	1.02 ⁽²⁾	(1,1.454)	0.012	0.1095	0.913
Out Patient	10214	99.4	13551	99.4	0.98 ⁽¹⁾	(1,0.683)			

⁽¹⁾ Protective.

⁽²⁾ Risky.

**Table 6. P- Value Out Patient to in Patient for Month May and October 2019
According to Seasonal Age**

Age	In Patient n=153		Out Patient n=67095		χ^2	p-value
	No.	%	No.	%		
< 15	1	0.6	14999	22.3	56.003**	0.000
16 – 25	48	31.4	11522	17.2		
26 – 35	37	24.2	16825	25.1		
36 – 45	34	22.2	14195	21.2		
> 45	33	21.6	9554	14.2		

** Significant at the 0.01 level.

**Table 7. The Comparison Between the Total Number of Outpatients & The Drugs in The Ibn-Sena Hospital by
Using the Correlation Coefficient According to Diagnosis from May to October 2019**

Diagnosis	Total Number of Outpatients n=1944		Available Drug n=4470		Correlation	p-value
	No.	%	No.	%		
Schizophrenia	895	46.1	1300	29.1	0.714 (No Significant)	0.111
Depression	269	13.8	1200	26.8		
Anxiety	404	20.8	700	15.7		
Bipolar	49	2.5	500	11.2		
ADHD & AUTISM	257	13.2	350	7.8		
Others	70	3.6	420	9.4		

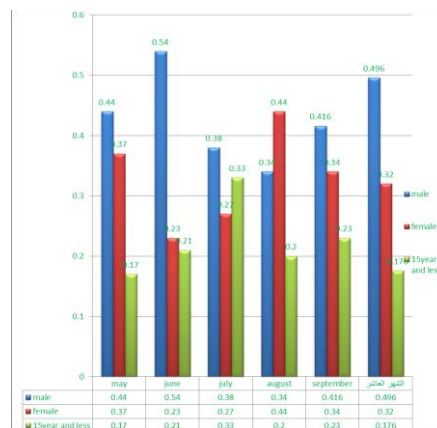


Figure 1.

Figure 2. Total psychiatric & none psychiatric visited ibn - sena outpatient clinic according to sex from May to October 2019

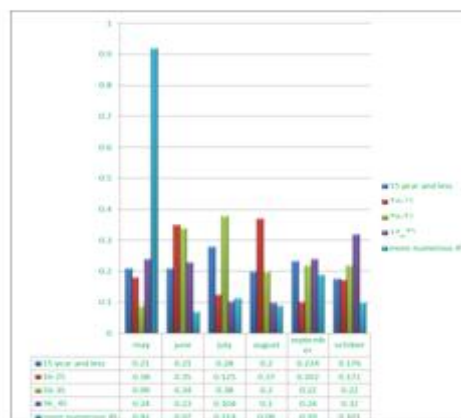


Figure 3. (%) Total psychiatric & none psychiatric visited ibn -sena outpatient clinic according to age from May to October 2019

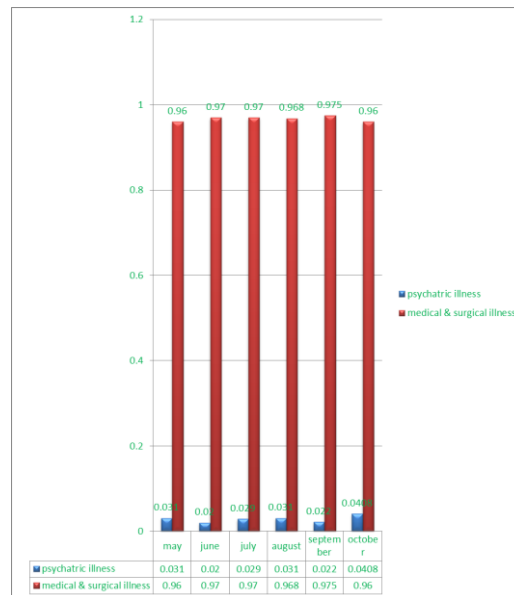


Figure 4. (%) Total psychiatric illness & non psychiatric for month May to October 2019

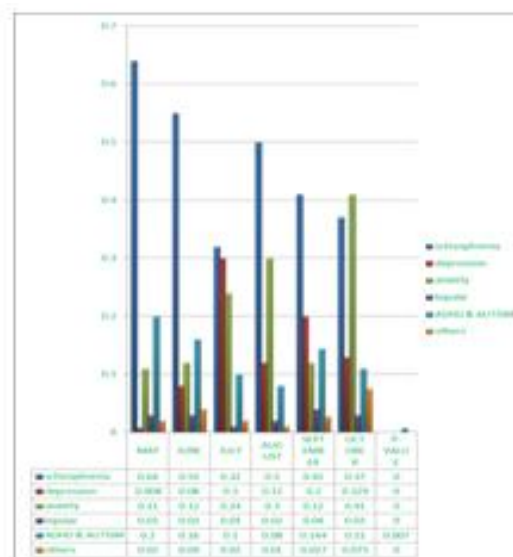


Figure 5. (%) total psychiatric illness in outpatient clinic 5-10- 2019

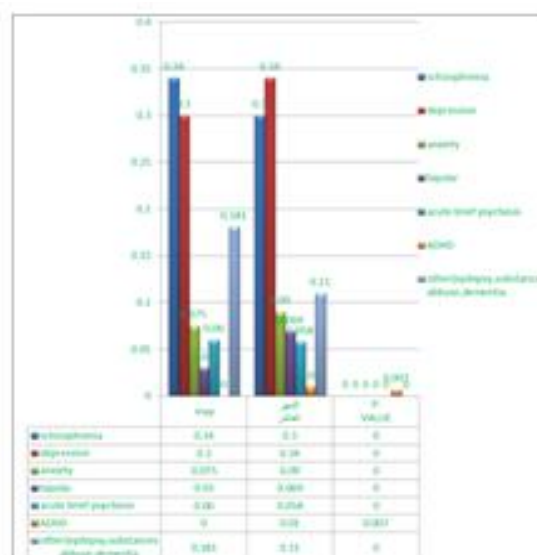


Figure 6. P - value out patient to in patient for month may and october 2019 according to seasonal variation

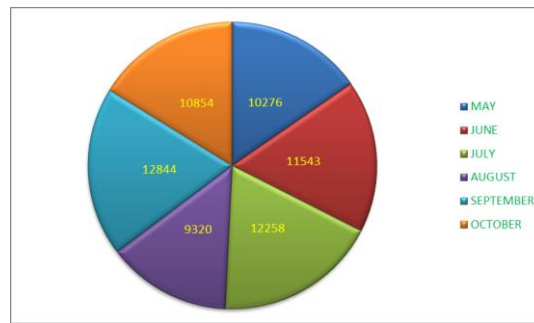


Figure 7. Total psychiatric illness and non-psychiatric illness visited outpatient ibn sena teaching hospital from May to October 2019

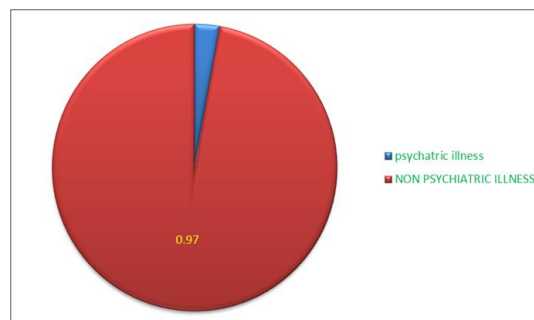


Figure 8. %psychiatric patient to non-psychiatric from May to October 2019

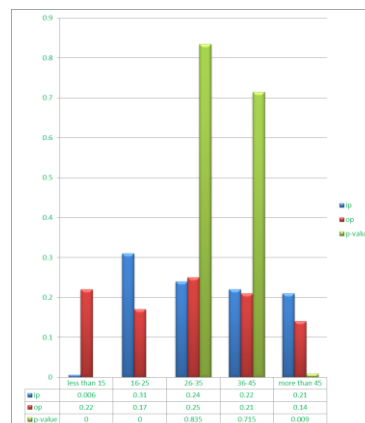


Figure 9. (%) inpatient to outpatient according to age

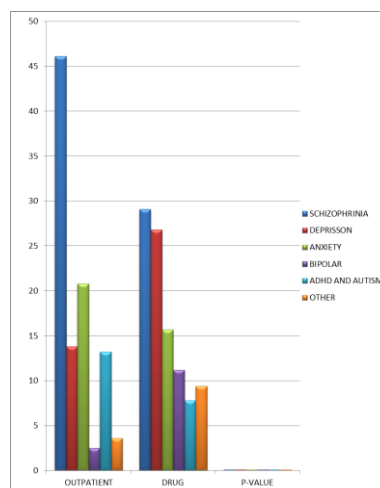


Figure 10: Drug availability outpatient to in patient from May to October 2019

LIMITATION

1. Poor recording system in the O/P clinic.
2. Poor registry of the drugs dispensed in the O/P clinic
3. Local Iraqi references are lacking for the sake of comparison
4. The Chaos after 2003 Which was reflected on all the health care system which needs urgent and well planned services in order to follow the World standard of care.

DISCUSSION

Mental disorder as a whole makes up a high proportion of the disease burden throughout the world^[10,11] WHO is deeply committed to closing the gap between what is needed what is currently available to reduced the burden of mental disorder worldwide& to promote mental health. Early intervention and treatment for mental disorder can have economic benefit that goes beyond health sector^[12-14].

Greater income inequality is associated with higher prevalence of mental illness & drug misuse in rich societies^[1]. It has been found that serious mental health is associated with a reduction of population level earning equivalent to 0.8% of all earning in high income countries & 0.3% of all earning in all low & middle income countries. These result in massive losses of productive human capital, not only at individual level but also at societal level^[16] based on the strategies of the above mentioned projects this work revise really available and what is needed to be done.

The available evidence of this study indicate the urgent need for repairing the gap by a better planning of services starting from the definition of the problem, better recording (preferable electronic data base monthly reviewing & reporting. This is applied for both O/P and I/P in this study, mental consultations over 6 months during the year 2019 makes (1944) out of (67095) Which is equal to (3% of total consultations to the O/P clinic Ibn sena teaching hospital.

Table 8. Prevalence of DSM–IV mental disorders in different countries

Country	Iraq	Lebanon	China	Nigeria
Diagnosis				
Affective Disorders				
Major Depressive disorder	4.0	4.9	2.0	1.0
Dysthymia	0.2	0.8	0.8	0.8
Bipolar I and II	0.2	1.5	0.1	0.0
Any affective disorders	4.1	6.6	2.2	1.3
Anxiety Disorders				
Panic Disorders	1.0	0.2	0.2	0.1
Agoraphobia without panic	0.5	0.3	0.0	0.2
Social phobia	0.7	1.1	0.2	0.3
Specific phobias	3.8	8.2	1.9	3.5
Generalized Anxiety Disorders	2.3	1.3	0.8	0.0
Posttraumatic stress Disorders	1.3	2.0	0.2	0.0
Any Anxiety Disorders	10.4	11.2	2.7	11.2
Substance Disorders				
Alcohol Abuse	0.1	1.2	1.6	0.5
Alcohol Dependence	0.0	0.3	0.6	0.1
Drug Abuse	0.1	0.2	0.1	0.2
Drug Dependence	0.0	0.1	0.0	0.0
Drug substance Disorders	0.2	1.3	1.6	0.8
Any Disorders	13.6	17.0	7.0	5.8

The reason behind this most probably due to the fact that mentally ill patient consult if drugs are available otherwise their main consultation where to the private clinic. The inconsistency of drugs supply this will be reflected on the difference in the diagnosis, gender and seasonal variation the male consultation outnumber those for female respectively, on the contrary of many studies which indicate that mental disorders are more prevalent among females^[12]. The reason 33 behind it probably related to poor recording or the fact that psychotic male patients consult more

than the neurotic female for the antipsychotic drugs (Moderate) which is available on most occasions, more than the antidepressants as revealed by table (7).

This study revealed also that most frequent O/P consultations in order of frequency were (schizophrenia (46%), disorder (16.3%), anxiety disorder (20.8%), Autistic spectrum disorder) (13.2%), compared to I/P admissions (Schizophrenia (40%), mood disorder (17%), anxiety disorder (7%), substance abuse, epilepsy & Dementia (18%). Putting in mind the type of mental disorders needs showed the non-significant correlation between the diagnosis & the drug dispensed in the hospital pharmacy, which is regarded as a defect in management of mental illness at this level & off course is not cost effective step in health care for the mentally ill patients. A defect that needs urgent remedy which is very simple on the local level or the central level in health management.

CONCLUSION

1. Poor recording system in the O/P clinic
2. No correlation between the drugs dispensed in the hospital pharmacy & the type of mental health problems that consult the clinic
3. The high % of schizophrenic patients consulting the clinic & admitted for inpatients care needs further assessment of the reasons behind it
4. The high % of male /Female ratio needs explanation through further studies.

RECOMMENDATIONS

1. Electronic data base recording programmer for all the mental health system at the three care levels. With a network connection of all the concerned mental health care systems
2. Using the data presented in this study, drugs should be available at the hospital pharmacy.
3. Depending a card system for follow up of cases to prevent the patients from consulting other centers.

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