



## *Comparative Healthcare: Mental health.*

### **Abstract**

In the fourth in this series of 'comparative healthcare' medical practitioners explore the approach to mental illness in Bangladesh and the UK respectively. Differences and similarities in treatment regimens are illustrated with reference to patients with varying degrees of mental illness. Mental illness poses the greatest challenge in health care as national investment in services often reflects cultural attitudes and norms. While the authors describe very similar approaches to the diagnosis and management of severe psychotic illness there are striking differences in the availability of support services for people with substance abuse and those with relapsing conditions. The involvement and co-operation of the family is particularly important in Bangladesh where comprehensive access to mental health services is very limited. Private alcohol and drug detoxification centres are available although many are expensive and such treatment may effectively be denied to all but the wealthiest people. In the UK all people with serious and enduring mental illness are entered onto a register and therefore flagged for follow up at least once a year. General Practitioners, working within the nationally funded health service have been remunerated since 2003 for maintaining the register. In contrast in the absence of a case-management based psychiatric follow-up framework in Bangladesh, a general practitioner and treating psychiatrist would need to formulate a management plan involving recognition of clinical warning signs by the family. Indeed the co-operation and support of the patient's family is of paramount importance in maintaining outpatient appointments when supporting people with mental health problems in Bangladesh. Finally we emphasise that the views expressed are those of the authors and do not necessarily reflect health policy or practice in their respective countries. Nonetheless we believe they offer a valuable perspective on mental health issues and commend the article to our readers.



## ***Mental Health***

**Dr. Elizabeth Cottrell**



Dr Cottrell is a General Practice Specialty Trainee.

Staffordshire,

England, UK

**Dr. Ahmed Munib**



Consultant Psychiatrist

Bangladesh

Please cite this paper as: Cottrell E, Munib A. Comparative Healthcare: Mental Health. AMJ. 2009, 1, 6, 1-10, Doi 10.4066/AMJ.2009. 74



***An 18 year old lady is brought to your clinic. She tells you that she has been hearing voices that urge her to hurt herself because she is 'evil'. She believes your room is bugged by 'spies' and that she has 'special powers' and can communicate with people through her iPod. She refuses all treatment. How would you manage this case?***



It appears that this lady is experiencing a psychosis; however it is unclear whether this is a first episode. If so, then according to the UK National Institute for Health and Clinical Excellence (NICE) guidelines on Schizophrenia<sup>i</sup> all people presenting with first ever psychotic symptoms should be referred urgently to community-based secondary mental health services. While she is in the consultation I would undertake a full psychiatric history, trying to gain information that would indicate a diagnosis of schizophrenia, acute psychosis due to drugs or alcohol or secondary to another physical health problem. I would specifically ask about her hallucinations to determine how many people were talking and whether they talked amongst themselves (third person). It would also be useful to find out if she had hallucinations in any other sensory modality. I would enquire about her beliefs that my room is bugged to establish whether these are of delusional intensity. Is this paranoid ideation apparent away from my office? Does she think other people are watching her? If so, why? In addition, I would ask about her special powers and her ability to communicate through her iPod, again to find out if these are strongly held, unshakable and incongruent with the true facts. I would find out a bit more about the presence of a formal thought disorder. Does she feel in control of her thoughts? Does she believe anyone can insert or withdraw her thoughts? Does she believe the TV/radio/iPod is talking/communicating messages directly to her? If this was a first presentation then I would find out a bit more about why and how she has presented to the clinic. Was she brought by someone else? If so, can they provide any additional information about her recent and distant past if she is currently unable to provide this? Why did she think she was coming to clinic? Although it states she is refusing treatment perhaps she wants help in some other way and this may be a hook by which you may be able to get her to agree to some form of therapy or management plan. The NICE guidance regarding schizophrenia recommends that oral antipsychotic



medication is offered to people with newly diagnosed schizophrenia.<sup>i</sup> Therefore, if you felt that schizophrenia was the diagnosis it would be important to discuss this and the medication options in attempt to try and persuade the patient to take medication from you. Of course I would perform a physical examination to exclude an obvious structural cause of her symptoms, if she would allow this. The crux of the immediate management of this lady lies upon the risk assessment you formulate as a result of the consultation. Is her condition likely to present a danger to herself or others? If this is the case and she is refusing treatment and admission to hospital she may be eligible for be assessment under Section 2 of the 1983 Mental Health Act (Amended in 2007) for involuntary admission for up to 28 days assessment. Once a diagnosis is clear, if the lady is still refusing treatment and continues to present a danger to herself or others and you feel she would benefit from treatment you could apply for assessment under Section 3 of the 1983 Mental Health Act (Amended in 2007) which allows for involuntary admission and treatment of the mental disorder for up to 6 months. If you do not feel that the lady's condition presents a risk to herself or others and she is refusing treatment then appropriately intensive follow-up should be arranged, for example through medical outpatient appointments, home treatment team visits or community mental health team home or clinic visits.



The scenario described above suggests a case of a psychotic illness (possible early or first episode psychosis) affecting a young person. The patient clearly portrays command-type auditory hallucinations, self-harm ideations, delusions of paranoia and impaired insight into her mental state. Potential ideations of reference and delusions of thought-broadcasting or thought-insertion should be examined. The constellation of psychopathological symptoms is indicative of a psychotic illness such as schizophrenia, although further collateral information is required before establishing a conclusive diagnosis. Schizo-affective disorder or substance-induced psychosis are included in the differential diagnoses and need to be excluded.

Based on the socio-cultural context in a developing country such as Bangladesh, it is particularly relevant to explore further information about the duration of symptoms and clinical history from family members or acquaintances, or previous contact with mental health services. The patient demonstrates the propensity of



risk to herself and to the community due to her self-harm thoughts, persecutory ideations and perceptual disturbances. Illicit substance usage history and possible organic aetiology are to be explored and investigated. The initial clinical intervention for such a patient would be more appropriately managed by referral to a tertiary hospital with psychiatric facilities, for acute inpatient admission, psychopharmacological treatment and observation. The involvement and co-operation of the family is particularly important, taking into consideration the lack of a comprehensive and updated mental health policy in Bangladesh. Such limitations certainly present practical challenges in treating patients with acute psychosis, as well as the lack of a structured community-based psychiatric case-management model. Psychotropic treatment should preferably involve an oral anti-psychotic, although in the likely event of complete loss of insight and non-compliance, an injectable depot anti-psychotic (for example Zuclopenthixol depot 200mg IM fortnightly) may be necessary. Many tertiary hospitals utilize Inj. Fluphenazine decanoate 25mg IM 2 to 4 weekly, for treatment of schizophrenia or related psychotic disorders, (subject to funding supported by external donor agencies). Inj. Risperidone depot (Risperdal Consta), more commonly prescribed in Western nations, is limited in availability in Bangladesh due to higher costs, and may not be a feasible and viable treatment option.

As with general psychiatric services in the public sector, youth-oriented mental health services are lacking in Bangladesh. There remains a significant disparity in the availability of mental health services with disproportionate psychiatrist availability for the general population. Most public psychiatric services are located in district medical college hospitals, which involve inpatient acute psychiatric and outpatient community facilities. The capital city Dhaka incorporates a number of public hospitals with mental health services, including the Institute for Mental Health, a relatively modern, tertiary-level hospital, which provides dedicated psychiatric treatment services for the general public. It is also important to note that a number of private clinics offering psychiatric services are available in many major cities throughout Bangladesh. For the socio-economically viable, such services may provide a more convenient and preferable option, although the costs involved would be prohibitive for large segments of the population.



***A 35 year old man admits to drinking 10 units of alcohol every day. He doesn't believe it is doing him any harm although he starts drinking earlier each day. If he could be persuaded to address his alcoholism what support is available to help you manage this case in your healthcare system?***



In attempt to get the man to address his drinking I would ask him some screening questions about his alcohol use. The simplest of these are the “CAGE” questions:<sup>ii</sup> Do you ever think you need to Cut down your drinking? Do you get Angry when people comment on or criticize your drinking? Do you feel Guilty about your drinking? Do you ever have an Eye opener (i.e. a drink early in the morning)? If the patient answers yes to at least 2 of these questions then alcohol dependence is likely and this could be explained to him. However this has been criticized as having a low sensitivity (71%)<sup>ii</sup> so further questions regarding his drinking should be asked. Another commonly used *pro forma* to assess patients’ drinking is the Alcohol Use Disorders Identification Test (“AUDIT”) questionnaire.<sup>iii</sup> This is a 10-item questionnaire which directs enquiries about frequency of consumption, quantity consumed, frequency with which more than 6 drinks are consumed on one occasion, inability to stop drinking once started, impact on daily living, morning consumption, guilt about drinking, memory loss from drinking, drink related injuries and concern from others about drinking. If a score of at least 8 is achieved this “indicates a strong likelihood of hazardous or harmful alcohol consumption”<sup>iv</sup>. The results from the CAGE or AUDIT questionnaires can be relayed to the patient in attempt to get him to appreciate the fact that his drinking is excessive. In addition to this I would relay the current UK guidelines that state that drinking is classed as hazardous when men drink more than 21 units a week. I would suggest that although he may not feel that any harm is being caused to his body, there can be silent damage occurring for example to the liver, with fatty deposits occurring that can later lead to cirrhosis and to the bone marrow, altering blood cell development causing the cells to become larger. If he remained unconvinced I may offer a blood test to



check his liver enzymes and a full blood count in attempt to provide objective evidence of the damage described previously.

No intervention for hazardous drinking or alcohol dependency will be appropriate and services will be unwilling to accept a patient who is not ready to change. However, if he does decide he wants to address his alcohol intake I would assess his risk of having complications of doing so. For example, I would ask whether he has previously experienced seizures related to his alcohol consumption and whether he had experienced symptoms of delirium tremens. In view of his need to drink earlier and earlier, it is likely that this gentleman has a physical dependence to alcohol. If this is the case, UK national guidelines recommend that the gentleman is referred to a specialist where possible.<sup>v</sup> In my local area we can refer to a local drug and alcohol abuse service that will assess the patient's risks and will create an inpatient or outpatient detoxification regime as appropriate, often with the assistance of chlordiazepoxide or diazepam to treat withdrawal symptoms. The patient would be prescribed thiamine for at least the duration of the detoxification. While the patient is waiting for this assessment advice regarding managing his alcohol intake, such as gradual reduction in alcohol or gradual increase in time between drinks. Alternating alcoholic drinks with non-alcoholic drinks and undertaking activities to distract from the alcohol. Other options locally include privately funded detoxification centres and charities providing free access to advice and assessment (e.g. ADSIS<sup>vi</sup>).



There are limited alcohol detoxification services in the public mental health service in Bangladesh, although opportunities in the private sector have substantially increased over the past decade. Non-governmental organization supported alcohol and illicit drug detoxification and rehabilitation centres are available, although many involve substantial costs.

The patient mentioned in the scenario described should ideally be referred to a suitable alcohol detoxification service, with the support of any available family members, subject to feasibility. Religious and social support is instrumental in ensuring compliance with clinical advice. The involvement of a General Practitioner is



particularly important in screening for organic pathology relating to potential hepatic and nutritional impairment. Neurological assessment for possible alcohol-induced cognitive deficit is available at district-level and tertiary hospitals. The patient's recognition of alcohol as a significant health risk is paramount, as well as his taking responsibility for his own actions and their consequences.

Alcoholism tends to be a relatively less frequent mental health concern in Bangladesh compared to Western nations. This is in the context of strong religious and socio-cultural reservations and restrictions on alcohol consumption in Bangladeshi society. Licensed venues for alcohol availability are generally government regulated and aimed towards the expatriate community. Consequently, misuse of alcohol is often limited to socio-economically disadvantaged individuals with access to locally and illicitly manufactured beverages with questionable properties.

***A 50 year old lady has manic depressive illness. She has been known to behave inappropriately and to accumulate a great deal of debt. When she was depressed she has attempted suicide. How would you support such a patient in your practice?***



This lady's bipolar disease obviously presents great risks to herself when she is high or depression. Therefore it is crucial that she is closely followed up, that her medications are regularly reviewed and her mental health and associated risks are monitored. She should have a documented plan of action for if she becomes high or low and early warning should be identified and documented. Crisis plans may include home treatment team becoming involved, a brief inpatient admission or addition of a medication that has previously been successful. It is a UK recommendation that all people with bipolar disorder are entered onto a register of serious and enduring mental illness and therefore are followed up at least once a year; GPs have been remunerated since 2003 for holding such a register.<sup>vii</sup> It is likely, however, that more frequent follow-up is likely to be necessary to assess this lady's mental health in view of her risks. However, annual physical health review may be appropriate, in which routine blood tests investigating lipid and glucose levels are assessed, weight and blood pressure is measured and smoking and alcohol status is recorded and managed appropriately.<sup>vii</sup> UK guidelines





recommend that all patients with new or suspected bipolar disorder are referred for a specialist mental health assessment.<sup>vii</sup> Therefore, this lady may have a named contact at a secondary care mental health unit. As a GP you should check upon reviews that the patient is attending her secondary care appointments and that any information that you feel would be useful to them is shared and vice versa.



There are significant risks associated with the patient's Bipolar mood disorder and clinical presentation; risk to personal safety and reputation and to the community in general, due to mania-induced disinhibited behaviour. Close monitoring of her psychiatric symptoms is imperative and the support of any available family members is of particular importance. In the absence of a case-management based psychiatric follow-up framework in Bangladesh, the General Practitioner and treating psychiatrist would need to formulate a management plan involving recognition of clinical warning signs by the family through appropriate psychoeducation. Adequate mood-stabilizing medication is essential and physical parameters should be regularly monitored by the GP and/or treating mental health service. Subject to the family's and the patient's circumstances, a private psychiatrist may also be involved in monitoring for medication blood levels (eg. Lithium, Sodium valproate), compliance, therapeutic response and screening for any adverse effects. Inpatient admission to the appropriate mental health service may be required for manic relapse or for depressive features involving suicidal ideation.



***A 30 year old chef is known to have obsessive compulsive syndrome and is undergoing treatment. He is unable to work at the moment. What support is available to allow the patient to take time off for treatment?***



If the gentleman is unable to work as a result of a medical problem and is going to be off for more than 1 week then his GP would provide him with a medical certificate, formalizing the reasons for his need to be off work and an indication of the length of time he would require time off. Initially, if his terms of contract did not include any time off sick with full pay, if he worked for an employer under a contract of service, he may be entitled to Statutory Sick Pay of £79.15 per week. This may pay for up to 28 weeks.<sup>viii</sup> If his time off is prolonged and his Statutory Sick Pay ends or he becomes unemployed he may be eligible for Incapacity Benefit. If he is eligible for this benefit he may receive between £67.75 and £89.80 a week.<sup>ix</sup> If he required help with personal care as a result of his symptoms he may be eligible for another benefit called Disability Living Allowance, which can result in payments of up to £70.35 a week.<sup>x</sup> Secondary care mental health services offer people called “advocates” who can help patients find out which benefits they are entitled to and they will also assist them to complete application forms. In addition, patients can be direct to the Citizens Advice Bureau who can also advise on this.



The patient’s General Practitioner or treating psychiatrist would be able to provide a medical certificate to support the inability to work for medical reasons. Individual employers in Bangladesh, depending on either public or private sector, have stipulated, yet variable rules and regulations applicable for medical leave. In specific situations where extended periods of leave are applied for, the employer may request the expertise and opinion of a panel of specialists. Such a panel may review the efficacy of the existing treatment for



Obsessive Compulsive Disorder and suggest additional interventions, such as an employer-supported psychotherapy program accessible from an appropriate mental health service or private psychologist.

***A 56 year old man was first diagnosed with schizophrenia is his early teens. He has been in and out of hospital for many years and now lives in the community. He now seldom suffers from acute psychotic episodes but requires depot medication and close supervision. How is this organized in your practice?***



Depot medication is often provided by the community secondary care mental health services although some GP practices may undertake this role. Whoever administers the depot must provide services of administering the depot, alerting the patients' psychiatrist or care-coordinator if they have concerns about the mental health of the patient and undertaking appropriate blood, weight, blood pressure and drug level monitoring for the depot. As stated previously, GPs are recommended and remunerated for holding registers of people with severe and enduring mental illnesses such as schizophrenia, this provides a basis on which routine monitoring and reminders can be set up.



In the absence of a concrete community-based case management service for psychiatric care in Bangladesh, follow-up for depot injections would be arranged and administered by the treating mental health service on an outpatient basis. The co-operation and support of the patient's family is of particular value in maintaining outpatient appointments with the treating psychiatrist/medical practitioner. If the patient resides in a rural community with practical difficulties in periodically accessing the treating mental health service, a shared-care arrangement with the patient's GP and local community health centre would be encouraged. This set-up has limitations, but when appropriately applied and executed, is expected to be successful in monitoring for psychiatric symptoms and therapeutic response to depot anti-psychotic treatment.



## Authors' Information

Dr Cottrell is a first year Academic General Practice Specialty Trainee (3<sup>rd</sup> Year Post-grad) currently working in a psychiatry placement.

Dr. Ahmed Munib is a Consultant Psychiatrist presently working in the public mental health service in Western Australia. He has previously worked as a Psychiatrist in his country of origin, Bangladesh.

## References

<sup>i</sup> National Institute for Health and Clinical Excellence. Schizophrenia. Core interventions in the treatment and management of schizophrenia in adults in primary and secondary care. NICE Clinical Guideline 82. Quick Reference Guide. 2009. Available at: <http://www.nice.org.uk/nicemedia/pdf/CG82QuickRefGuide.pdf> Accessed on 22<sup>nd</sup> June 2009.

<sup>ii</sup> Clinical Knowledge Summaries. Alcohol – problem drinking – Making a diagnosis. Available from [http://cks.library.nhs.uk/alcohol\\_problem\\_drinking#-263230](http://cks.library.nhs.uk/alcohol_problem_drinking#-263230) Accessed 22<sup>nd</sup> June 2009

<sup>iii</sup> Audit questionnaire: screen for alcohol misuse. Available at [http://www.mentalneurologicalprimarycare.org/downloads/primary\\_care/11-2\\_audit\\_questionnaire.pdf](http://www.mentalneurologicalprimarycare.org/downloads/primary_care/11-2_audit_questionnaire.pdf) Accessed 22<sup>nd</sup> June 2009.

<sup>iv</sup> Clinical Knowledge Summaries. Alcohol – problem drinking – Making a diagnosis. AUDIT questionnaire. Available at [http://cks.library.nhs.uk/alcohol\\_problem\\_drinking#-263228](http://cks.library.nhs.uk/alcohol_problem_drinking#-263228) Accessed 22<sup>nd</sup> June 2009

<sup>v</sup> Clinical Knowledge Summaries. Alcohol – problem drinking – Management. Clinical Summary: Dependence on alcohol. Available from [http://cks.library.nhs.uk/alcohol\\_problem\\_drinking#-255026](http://cks.library.nhs.uk/alcohol_problem_drinking#-255026) Accessed 22<sup>nd</sup> June 2009.

<sup>vi</sup> Adsis. Alcohol and Dependency Specialists in Staffordshire. Available from <http://www.adsis.org.uk/about-us/> Accessed 22<sup>nd</sup> June 2009.

<sup>vii</sup> Clinical Knowledge Summaries. Bipolar disorder – Management. Clinical summary: Known bipolar, routine follow-up. Available at [http://cks.library.nhs.uk/bipolar\\_disorder/management/quick\\_answers/scenario\\_known\\_bipolar\\_routine\\_follow\\_up#-353171](http://cks.library.nhs.uk/bipolar_disorder/management/quick_answers/scenario_known_bipolar_routine_follow_up#-353171) Accessed 22<sup>nd</sup> June 2009.



<sup>viii</sup> Directgov. Statutory sick pay. Available at [http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAndOtherSupport/Illorinjured/DG\\_10018786](http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAndOtherSupport/Illorinjured/DG_10018786) Accessed 22nd June 2009

<sup>ix</sup> Directgov. Incapacity Benefit. Available from [http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport/DG\\_10016082](http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport/DG_10016082) Accessed on 22nd June 2009.

<sup>x</sup> Directgov. Disability Living Allowance – rates and how to claim. Available at [http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport/DisabilityLivingAllowance/DG\\_10011925](http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport/DisabilityLivingAllowance/DG_10011925) Accessed on 22nd June 2009.