

Clinical Profile and Follow Up Of Older People Seen At the Outreach Clinics of a District Based Mental Health Program

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I. Introduction

Demographic transition is leading to a rapid increase in the number of older people in our population. Improvement in health, education and economic parameters has increased the life expectancy of the population in most of the developing countries which leads to this increasing trend in the percentage of old age population. They are a vulnerable group having significant health problems and psychosocial stressors that warrant attention. The large geriatric population has an equally high psychiatric morbidity.^[1] Various studies have been carried out in India to estimate the prevalence rates of psychiatric disorders in old age population. Dubey estimated psychiatric disorders in elderly to be 23.3/1000 population while Nandi *et al* estimated it to be 33%.^[2,3] Ramchandran *et al.* found that psychiatric disorders were present in 35% of the elderly population.^[4] Depression is another major public health problem in late life. It is also common in rural Kerala.^[5,12]

It is a well accepted fact that mental health forms an important aspect of old age health issues and many of them need continuous care and support. Providing services for the growing number of older people with mental health problems is a public health challenge which all aging societies will have to face.

In pursuit of the goal to provide health for all the citizens, most of the nations have categorized health care for children and adolescent and have definite policies and programs, but do not have a clear policy with regard to old age health problems. Lack of research and contributing evidence is one of the reasons for the absence of policy along with the low priority given by the policy makers. Health care for older adults is not categorized and both physical and mental health care continues to be provided as for adults.

The most frequently asked questions are about the best service delivery model suitable for the developing nations. Many models of care have been proposed and implemented with varying degree of success. Old-age mental health models involving case management in the community based multi disciplinary approach have been shown to be effective with good evidence support.^[6] But this is a resource intensive model that cannot be scaled up to meet the demands of a large community. Dedicated old age service with full range of long term hospital based and community based geriatric programs would be the ideal model as it takes care of many things which are unique to geriatric population. Many societies have considered the idea of discontinuing the categorized old age psychiatric care for an ageless mental health service due to reasons varying from health, austerity, legal issues to concerns about ageism.^[7]

In India programs specifically aimed at old age mental health have not been launched so far. In Kerala, even though the health parameters are comparable to that of developed countries, we cannot boast of geriatric mental care policy and dedicated geriatric department in any of the teaching institutions. We have a national mental health policy which outlines our aims and priorities in mental health of our population.^[8] District Mental Health Program(DMHP) is the flagship program currently being rolled out by the Government of India which has considerable community outreach. It aims to decentralize mental health-care in the community using the existing public health infrastructure and additional resources.^[8] Kerala is the only state in which the program is implemented in every district. In Palakkad, the program is run by National Health Mission, hence named as Community Mental Health Program (CMHP) which functions similar to the DMHP. The CMHP team which includes a psychiatrist, psychologist, social worker and a nurse, visits designated peripheral health centers. They deliver diagnostic and therapeutic services including medicines free of cost to the patients attending the clinic. The team provides general adult psychiatric care without any special services for special populations such as women, children and elderly,

An analysis of the clinical profile and pattern of service utilization by the elderly people is necessary prior to planning further strategies aimed at improving the mental health care of elderly. DMHP being a centralized program with a dedicated team may be more accessible to older people with mental health problems and their families but it should also undergo scrutiny with respect to its effectiveness in catering to the clients.

Follow up rates is an indicator of the client satisfaction and effectiveness of the intervention. This study is just a small endeavor in this area which needs further research.

II. Aims and objectives

1. To examine the socio demographic and clinical profile of older people attending a community mental health program. To find out the follow up rates of old age people utilizing the services of community mental health program.
2. To compare the follow up rate with that of others (persons who are less than 60 years of age) who are seeking the services of the program

III. Method

It is a descriptive analysis done on the data obtained from the community mental health program. Data of old age people (60 years or above) who have sought services from various centers of the community mental health program between first January 2015 and 31st June 2015 were assessed and compared with patients less than 60 years of age who attended the CMHP clinic.

The community based mental health program of Palakkad district started its operations in April 2013. Initially it had 15 outreach clinics, and this was increased to 20 later on. These clinics were held on a monthly basis on a fixed date at the community health centers (CHC) or taluk hospitals located in different parts of the district. All cases were evaluated and treated by clinicians trained in psychiatry.

We selected all the case records of those aged 60 years and above (n=110). The clinical details in the case records were reviewed by a psychiatrist and diagnosis was assigned based on ICD-10 classification.^[9] Subjects were categorized based on their diagnosis. Diagnosis, age, sex and number of follow up visits made till November 31st 2015 were recorded so that each person was entitled to get a minimum of five follow up visits. The follow up percentage was calculated from the actual number of follow up visits to the expected follow up visits. In the CMHP clinics all the patients were advised to have monthly follow up unless specified otherwise. The follow up date was recorded along with the prescription. Help of the peripheral field staff was not usually sought to remind the follow up dates. Those patients who died during this period were excluded.

This group was compared with a group (n=220) consisting of younger patients (age less than 60 years). The comparison was carried out in the ratio of 1:2 i.e. for every one older individual (age>60) two younger individuals (age<60) who were preceding and following the elderly patient in the entry register were selected.

IV. Result

Total number of patients enrolled during the period in the CMHP was 769 out of which 110 patients (14.3%) were aged 60 years or more. There were 63 women (57.3%) and 47 men (42.7%) in the sample. The mean age was 68.4 years. 69 of the subjects (62.7%) were in the age group 60-69 years. 27 (24.5%) were in the age group 70-79 years and 14 (12.7%) of them were 80 years and above. 49 of subjects (44.5%) belonged to APL (Above poverty line) category. 34.3% were illiterate whereas 45.2% had primary education. 16.7% had education status above primary level and the status was not known for 3.8%.

Psychotic disorders (Schizophrenia, delusional disorder, unspecified non organic psychosis) were diagnosed in 29 (26.4%) subjects while 22 (20%) subjects received a diagnosis of Bipolar Affective Disorder (BPAD). A diagnosis of Recurrent Depressive Disorder (RDD) was made in 12 (11.45%) subjects and there were 25 (22.72%) older individuals who had Mild Depressive Episode, Adjustment Disorder or Anxiety Disorder. Dementia was diagnosed in 13 (16.36%) subjects. See table 1 and 2 for details regarding diagnosis. Sixty eight older subjects (51.9%) were not on active treatment at the time of initial evaluation while 11 (8.4%) of them never had any previous treatment.

Many subjects had co-morbid medical problems. 17.4% had systemic hypertension whereas 12.2% had diabetes mellitus. 3.8% had COPD and 1.6% of subjects had a history of cerebrovascular accident.

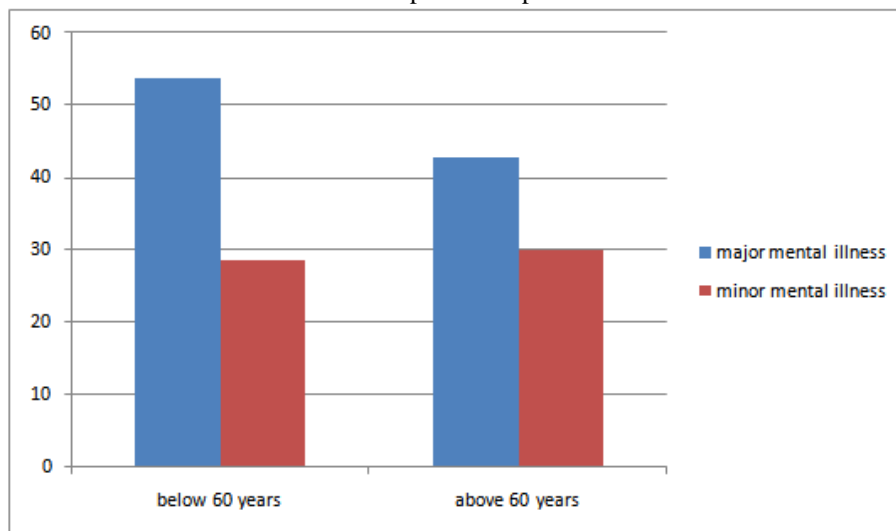
Older People attending DMHP Clinics

ICD -10 diagnosis	Number (%)
Schizophrenia/Delusional Disorder/Unspecified Non- organic psychosis	29(26.4%)
Bipolar Disorder	22(20%)
Recurrent Depressive Disorder	12(11.45%)
Mild Depressive Episode/Anxiety Disorder	25(22.72%)
Dementia	13(16.36%)
Epilepsy	5(4.5%)
Organic Psychosis-	2(1.8%)
Alcohol Dependence	1(0.9%)
Others (Benzodiazepine dependence)	1(1.53%)

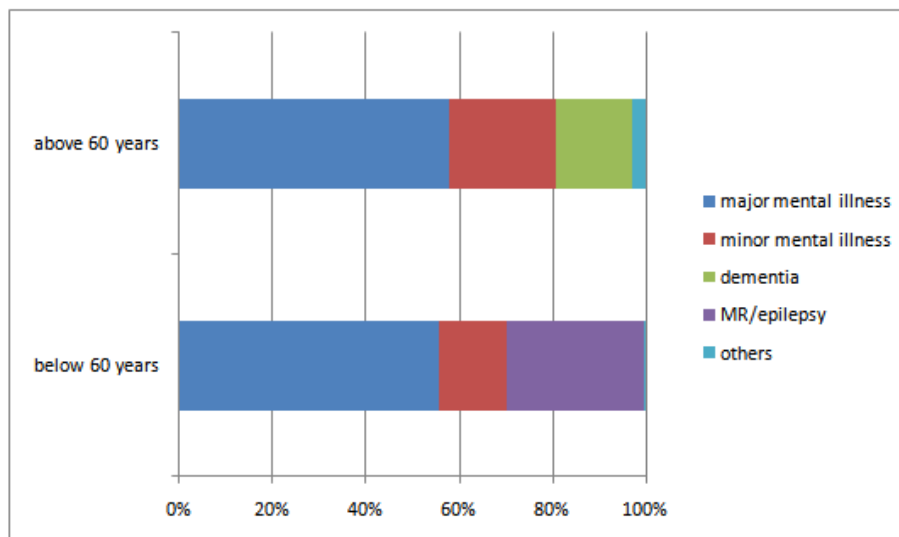
Clinical profile and follow up of older people at district based Mental Health Program.

Both the groups were again categorized based on the diagnosis as those with major mental illness (schizophrenia, delusional disorder, BPAD, RDD, Severe depressive episode and other psychotic disorder) and minor mental illness (mild to moderate depressive episode, anxiety disorders, adjustment disorder, primary insomnia). Follow up rates for these groups were found out and compared. The average follow up rate of older patients was 36.3% while that of younger patients was 43.82%. In case of major mental illness the older patients had a follow up rate of 43% while the younger patients had a higher follow up rate of 53.8% while in case of minor mental illness the follow up rates of older patients was higher at 30.46% in comparison to younger patients which was 28.46%

Follow up rate comparison



Clinical profile of the patients



Follow up rates of the groups

	Below 60 yrs	Above 60 yrs
Group average	43.82%	36.3%
Minor MI	28.46%	30.46%
Major MI	53.8%	43%
Dementia	0%	17.25%
Mental retardation, Seizure	33%	5%

V. Discussion

A significant proportion (14.3%) of people attending DMHP programs were 60 years or older. This is similar to earlier reports from Kerala.^[10, 11] It is interesting to note that major mental health problems like psychotic disorders, bipolar disorders and dementia were the problems for which most people were seen. This probably indicates that help seeking is determined by nature and severity of behavioral disturbance in older people. It is quite possible that a more prevalent condition like depression do not fit in with the notion of mental illness and thus people with depression are unlikely to seek help from specialized services even when they are available, but the fact is minor mental illness has high prevalence and can cause significant functional impairment, but seldom get regular treatment from the decentralized system like CMHP. This calls for some important intervention to improve the treatment needs of this group. Follow up rates of older people are low (36.3%) when compared with the other group (43.8%). It was observed that those who have minor mental illness have low follow up rates (30.46%). It was also observed that the follow up rates of older people with minor mental illness (30.46%) was slightly higher than the other group (28.46%). This requires careful interpretation as the underlying factors need to be studied properly. It could be due to the fact that minor mental illness in older people causes more functional impairment that warrants regular medical help. Follow up rate of those who received a diagnosis of dementia was 17.25%. This is significantly lower than the average follow up of the group which is 36.3%. Since a diagnosis of dementia or probable dementia warrants referral to higher centers for investigation, we may assume that even if the diagnosis was confirmed after investigations the clients are not reporting back to the CMHP clinic. This could be due to the physical morbidity or lack of liaisoning at different levels.

This study does not mention and quantify the medical care this group obtained from mental health facilities other than the CMHP clinics, which may have a bearing on the follow up rates.. The follow up rates and clinical profile of older people in other health facilities like primary health centre, taluk hospital, Ayurveda, Yoga and naturopathy, Unani, Siddha and Homoeopathy (AYUSH) centers need to be studied before promulgating a delivery model. Other factors that influence the follow up rate which includes drug availability, physical comorbidity and medication related side effects needs to be studied. As older people are in general more sensitive to the side effects of medications, issues related to safety as well as usefulness of many medications needs to be addressed. Psychotropic drugs are not generally considered as safe in older people. Recent evidence demands due diligence in the use of anti psychotic drugs for older people, especially in those with dementia.^[13] Judicious use of drugs and adherence to guidelines will help to reduce potential for harmful effects. This is important while initiating pharmacological treatment for those with minor illness.

Even though the search for the best possible delivery model continues, strengthening the existing model is the need of the hour. The important challenge arises when we deliberate on the larger question of meeting the growing need for mental health care of aging societies. The focus will have to be on making services available across the country. To scale up mental health services for older people, we need to consider task sharing as an important option. Our experience with the DMHP calls for the following action to make it more efficient with regard to the old age mental health care. There is a need to get the primary care doctors involved in monitoring pharmacological management as the specialists will be available only once in a month. We should think of developing a mechanism by which the primary care doctors can be contacted by the patients and their families whenever there is a problem related to a medication. Training and empowering non-specialist health care providers would be the key here. Interventions that support clinicians in the use of assessment and treatment planning toolkits have been shown to improve clinicians' adherence to standardized geriatric assessment practices. Primary care doctors with training can take up the task of identifying and treating depression in late life. The clinician training programs should also highlight the special issues associated with pharmacological interventions in older people. Starting old age wellness clinic once in two weeks at all levels including AYUSH, which should accommodate a trained nurse/junior public health nurse/psychiatric social worker apart from the doctor is an option, as it increases awareness and can tackle social issues .

Another important task that can be undertaken by the District Mental Health Program (DMHP) is to train and support non - specialist health workers in the delivery of community based services for older people. They can be trained to identify cases and facilitate help seeking. If an older person with mental health problem cannot come to the outreach clinics, then the health workers can contact the DMHP team to initiate evaluation at home. More importantly, through their home visits, the health workers can monitor care and improve adherence and follow up care. They can function as a link between clinic based services and care at home. Our experience clearly points towards a larger role for non-specialist health care provider in scaling up dementia care.^[5,14] It is reasonable to presume that this holds true for care of older people with other disabling neuropsychiatric disorders.

Programs like DMHP should add value by making best use of the services of Health Inspectors (HIs), Public Health Nurses (PHNs) and Accredited Social Health Activists (ASHAs). Special programs to upgrade their skills and knowledge should be initiated and continued. This should be done after assigning them the task

of supporting and guiding care of older people. With brief training and seamless support from the primary care and the DMHP team, they can help to scale up services for older people with mental health problems. We can use mhGAP Intervention Guide^[15] for their training.

We do not have a well developed geriatric care service in India. Development of specialized services like psycho geriatric services is not easy. Strengthening and scaling up of mental health services for older people through DMHP is a feasible alternative. Research should inform and guide services provided by programs like the DMHP. There is a strong case for making operational research an integral part of the DMHP. Operational research needs to be embedded in national health care programs to generate data which can be used to assess the impact of these services. Service delivery research which determines the most effective and most efficient mix of psychogeriatric services for particular groups of elderly psychiatric patients are the need of the hour. The desired model for old age mental health service delivery should be comprehensive, well integrated, accessible, available, multidisciplinary and able to liaison with other services. Our suggestions are not based on formal evaluation but from the experiences in community mental health service, knowledge in geriatric medicine, pragmatism and available resources in our country.

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