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ILLUSTRATIVE PRESENTATION: ANALYSIS OF CASES SEEN AT OUT-PATIENTS

by

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Most people suffer from so-called nervous symptoms, sometime during their life, and their activity is influenced in varying degrees by these symptoms (1,2,4,5,6). Of these, psychiatrists see only a small percentage. Inconveniences felt due to these symptoms, although differing from individual to individual, cause much misery, not only to the individual himself, but also to his family and community. The problem is growing more and more due to the increasing complexity of human life, through modernization, industrialization, increasing restrictions and legislation, extremes of wealth and poverty, monotony and social isolation.

In order to arrange treatment ideally fitted to the individual's needs, considerable flexibility of management and therapeutic care is required. Different systems are needed. The psychiatric out-patient (P.O.P.) clinic is one of the weapons in the human battle for sanity, security, tranquility and health. Putting into consideration the low costs, one can consider that psychiatric service programme, putting it as a back bone, is a real need for developing countries.

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In this report, it is aimed to stress the increasing importance of P.O.P. role in psychiatric service and to answer two main questions:

1. What can a traditional P.O.P. offer and how it can affect the service?
2. What are the type of patients that come to the P.O.P.?

Material

To fulfil these two questions we will present the P.O.P. attached to Cairo University Hospitals. The statistics presented will be compared to P.O.P. attached to Abbassia Mental Hospital.

The Cairo University P.O.P. started to work in 1948, through the initiative of Professor A.M. Asker. The start was rather modest, with one room attached to the R.R. for consultation and treatment, very little equipment and an old electro-convulsive apparatus. During that first year it offered help to 28 patients only. Since then much has been gained. The P.O.P. was transferred to the out-patient area, occupying 15 rooms distributed in a C shaped manner, including two consultation rooms, another for social workers, a third for clinical psychologists, others for physical therapy, including E.C.T., cerebral stimulation, electro-narcosis, a room for psychotherapy, one for filing and an E.E.G. laboratory.

For educational purposes, there is a small theatre for fifty students, separated from a demonstration cabinet by a one-way screen.

Other needed physical investigations including X-ray are at hand in the nearby laboratory of the medical out-patient.

The service is held by two teams, each working three days a week. Each team comprises four psychiatrists, two residents, four house-officers,

two clinical psychologists and three social workers. If the patient is admitted he continues to be in contact with the same team personnel.

The programme of this clinic, as it has finally evolved, is as follows: All new patients are received by a social worker and after a careful social history, are referred to the psychiatrist for examination and diagnosis. At this time, an attempt is made to evaluate the psychodynamic factors in operation, putting the social background obtained by the social worker into consideration. The initial psychiatric work may be amplified by psychological tests, physical laboratory investigations, and a social field study of the social milieu including the relatives of the patient. Then the plan of treatment is recommended, including physical therapy, psychotherapy and social therapy. The treatment programme and follow-up procedure are planned specifically for each patient so that the highest level of secondary prevention can be maintained. In the follow-up, the patient is seen twice a month for 10 - 15 minutes by a psychiatrist. The concern in these interviews is with old and recent symptoms, adjustment of medication and the evaluation of toxicity or improvement. During the interview, the patient brings up problems such as difficulties on the job or at home ...etc. which are dealt with.

Occasionally, patients need emergency hospitalization which is made readily available to them.

To demonstrate the size and variety of work in this clinic, a few tables will be presented.

From table I it is easy to observe the ascending number of patients (new or follow-ups) in the last ten years. The same observation is noticed in the number of patients frequenting the mental hospital O.P. clinic in Abbassia which started in 1960.

TABLE I

THE NUMBERS OF PATIENTS IN THE LAST TEN YEARS

Year	University O.P.			Abbassia O.P.		
	New	Follow-up	Total	New	Follow-up	Total
1963	7 793	24 973	32 766	610	3 501	4 014
1964	7 090	25 474	32 564	761	5 320	6 081
1965	7 263	26 025	33 288	866	2 572	4 438
1966	8 537	27 145	35 682	1 246	3 769	5 015
1967	8 836	31 236	40 072	2 995	6 367	9 362
1968	10 948	37 022	47 970	3 511	6 174	13 116
1969	11 904	37 304	49 208	5 701	8 982	16 403
1970	12 588	30 417	43 410	4 620	6 513	11 133
1971	11 077	41 120	52 197	4 785	6 860	11 645
1972	12 315	32 231	44 546	5 770	7 038	12 808

As regards the type of treatments used we notice the following from the figures presented in table II.

1. There is a diminished use of e.c.t. with an increase in drug therapy, psychotherapy, and social therapy.

TABLE II

TYPE OF TREATMENTS USED

	Physical Therapy			Psychotherapy	Socio-therapy
Year	E.C.T.	C.S.	Drug	(in sessions)	
1963	11 656	2 639	7 932	65	15
1964	11 170	3 135	9 713	29	260
1965	9 830	4 706	6 352	321	379
1966	10 531	4 460	14 504	495	405
1967	10 022	4 565	13 668	738	854
1968	11 466	8 123	17 429	1 882	712
1969	9 013	11 228	19 332	2 101	846
1970	9 720	11 830	24 998	2 135	1 074
1971	10 792	9 278	20 951	2 541	531
1972	9 246	11 416	25 630	2 379	645

2. The descent in the number of social therapy in the last two years which is attributed to the social investigation being considered a part of every patient's service.

Other types of services are demonstrated in table III, from which we can deduce the following:

1. There is a gradual increase in the number of admissions to the hospital, and in application of E.E. G. and psychometry.
2. There is a diminution in the number of patients transferred to the mental hospital.
3. There is another diminution in the number of patients transferred to other specialities denoting the importance of the O.P. as a centre for propaganda, increasing the popular awareness of psychiatric illness.

TABLE III

OTHER TYPES OF SERVICES

Year	Admission	Mental Hosp.	Other Specialities	E.E.G.	Psychometry
1963	73	456	673	30	28
1964	73	391	602	54	35
1965	93	363	594	156	32
1966	77	396	523	161	73
1967	82	315	495	229	109
1968	234	334	549	219	176
1969	311	351	596	223	465
1970	271	248	548	299	802
1971	321	271	303	288	2 787
1972	308	231	426	383	1 869

The Second question to be answered is what is the type of patient walking in the P.O.P.?

In fulfilment of the answer we matched a random sample of 10 000 patients attending the University P.O.P. to the average of the last three years patients in the Abbassia P.O.P. 15 175 patients.

TABLE IV : SEX DISTRIBUTION

	♂	♀	Total
U.-P.O.P.	53.6	46.4	100%
A.-P.O.P.	61.7	38.3	100%

a) Sex distribution

We can observe that males are more than females in both groups, a fact that can be attributed to the cultural habit of caring for the male, the bread-earner and to hide psychiatric ailment of the female as a shame,

substituting medical treatment by some sort of traditional healing for them. However, such restraining forces are less in the University P.O.P.

b) Age distribution

TABLE V

AGE DISTRIBUTION

Age in years	10⁻	10⁺	20⁺	30⁺	40⁺	50⁺	60⁺	Total
U.-P.O.P.	6.2	30.2	24.7	19.0	10.7	4.2	5	100%
A.-P.O.P.	0.2	8.3	31.5	35.3	17.6	6	1.6	100%

The patients in the U.-P.O.P. are of lower age groups than patients of A.-P.O.P. as proved by the following:

1. The peak in U.-P.O.P. is at ($10y^{+}$) while it is at ($30y^{+}$) in A.-P.O.P.
2. Most of the patients are below 30y (61.1%) in U.-P.O.P. while only 40.0% of A.-P.O.P. are below 30.
3. The average age of U.-P.O.P. is (28.1y) while in the A.-P.O.P. (33.7y). Yet we can notice a higher percentage in the U.-P.O.P. in the age group 60^{+}.

A third observation is that some child psychiatric patients are not included in the figures of the U.-P.O.P. as they go to the paediatric psychiatric clinic.

c) Education level

In table VI, we compared the group of U.-P.O.P. with a random sample of 100 medical cases coming to the chest clinic in the same hospital. We can conclude that although the illiterate groups are comparable there is a higher percentage in the psychiatric O.P. in the groups of higher education.

TABLE VI

EDUCATION LEVEL

	Ill	Prim.	Prep.	Second.	Univer.	Post-grad.	Total
Psychiatry O.P.	43.8	26.2	17.1	8.6	4.1	.2	100%
Medical O.P.	46	42	6	6	-	-	100%

d. Occupation

Nearly 3/4 of the females were housewives. Of the rest, students came to the top followed by the unskilled worker group. Whereas the larger number of the male patients were skilled workers followed by unskilled workers then the students (table VII).

TABLE VII

OCCUPATION DISTRIBUTION

	H.W.	P.	U.W.	SW	Cl.	Pr.	T	S	U	C	Total
Males %		6.2	19.2	30.6	5.4	4.1	4.7	19.0	9.0	1.7	100
Females%	73.4	-	6.0	2.4	2.0	2.0	-	12.9	-	.6	100
Total %	34.1	3.3	13.1	17.6	3.9	3.2	2.5	16.2	4.9	1.2	100

H.W. = Housewife P = Peasant U.W. = Unskilled worker

S.W. = Skilled worker Pr. = Professional T = Tradesman

S = Student U = Unemployed C = Child Cl = Clerical work

e. Civil Status

The married and single groups are comparable 47.6% and 45.1% respectively followed by the widow, then the divorced and separated groups (table VIII). However, the groups with children are greater than those without.

TABLE VIII

DISTRIBUTION OF CIVIL STATUS

	Married		Divorced		Widow		Separated		Single
	+	-	+	-	+	-	+	-	
%	38	9.6	1.0	0.2	4.8	0.5	0.6	0.2	45.1

+ = with Children
- = without Children

f) <u>Diagnostic Differentiation</u>

From table IX we can conclude that schizophrenics, epileptics, and anxiety patients are more in the mental hospital O.P., while those with organic brain syndrome, hysteria and other categories present to the U.-P.O.P. more. Comparing these results with those obtained from Ras-El-Teen O.P. in Alexandria Province , we notice that Ras-El-Teen recorded the highest incidence in mania, hysteria, and senile dementia and the lowest in depression, mental subnormality and obsessions. Can these differences be attributed to cultural difference is a question that needs further investigations before being settled.

TABLE IX

DIAGNOSTIC CATEGORIES

Diagnosis	U.-P.O.P.	A.-P.O.P.	R.-P.O.P.
Psychoneuroses			
Anxiety	14	24.1	13.9
Hysteria	12.1	4	26.2
Obsessions	0.9	0.6	0.4

TABLE IX

DIAGNOSTIC CATEGORIES
(continued)

Diagnosis	U.-P.O.P.	A.-P.O.P.	R.-P.O.P.
Functional Psychoses			
Schizophrenia	8.8	32.5	23.6
Mania	1.5	1.0	1.2
Depression	26.8	22.3	5.7
Organic Brain Synd.	5.7	0.8	3.9
Senile dementia	1.3	0.1	4.3
Drug addiction	0.7	0.5	0.5
Epilepsy	5.4	6.5	8.4
Mental Subnormality	6.3	5.0	4.2
Psychopathy	0.8	0.8	0.6
Psychosomatic Dis.	6.5		3.1
Other Diagnostic Cat.	9.2	1.8	4.0

How the O.P. service modified the service in the mental hospital?

The answer to this question may be found by observing the relation between the out-patient services and in-patient (Table X).

TABLE X

COMPARISON BETWEEN ADMISSION TO HOSPITAL AND ATTENDANCE TO OUT-PATIENT

Year	Mental Hospital				University Clinic	
	O.P.	I.P.			O.P.	I.P.
1963	610	3 132			7 793	73
1964	761	3 151			7 090	73
1965	866	3 370			7 263	93
1966	1 246	3 563			8 537	77

TABLE X

COMPARISON BETWEEN ADMISSION TO HOSPITAL AND ATTENDANCE TO OUT-PATIENT

(continued)

Year	Mental Hospital				University Clinic	
	O.P.	I.P.			O.P.	I.P.
1967	2 995	3 240			8 836	82
1968	3 511	3 320			10 948	234(*)
1969	5 761	3 699			11 904	311
1970	4 620	3 577			12 588	271
1971	4 785	3 496			11 077	321
1972	5 776	3 436			12 315	308

(*) a new section with more beds was added

It can be observed how the services increase in the O.P. gradually in both clinics, to overshoot the numbers of admissions.

It can also be noticed that this increase stabilized more or less the number of admissions which is below the expected rise with the increase in the population in the last ten years. If we put into consideration that more beds are allowed in the later years and the turnover is more rapid, we can conclude that the O.P. service has helped a lot in improving the service in the mental hospital, allowing a lower number of patients and thus raising the standard of the expected service.

Another point is that the presence of capable O.P. has secured the psychiatrist when considering early discharge of the patients being sure that his patient will be taken care of, while leading his ordinary life. This fact can be deduced by observing table XI which shows the period of stay in the mental hospital.

TABLE XI

DURATION OF STAY IN MENTAL HOSPITAL

Year	Female			Male		
	6 weeks -	12 w -	12 w +	6 weeks -	12 w -	12 w +
1963	32.3	19.9	45.4	28.8	25.4	41.7
1964	34.3	18.4	44.1	32.3	20.8	43.6
1965	35.4	15.2	46.9	35.9	21.4	38.3
1966	61	8	28.7	40.5	30.8	25.2
1967	63	3.3	32.2	42	28.4	26.1
1968	69.9	5.2	22.5	40.5	37.4	18.6
1969	54.8	16	27.1	46	33.5	17.1
1970	46.4	25.3	26.8	64.7	20.6	12.1
1971	57.3	32.6	9.1	65.3	19.6	14.9
1972	59.8	31.8	7.7	66.8	18.5	11.6

The rest of patients to complete 100% is that of deaths and accidents.

The short stay (less than 6 weeks) is increasing in frequency in both sexes, while the long stay (more than 12 weeks) is diminishing. This signifies a diminished tendency to use mental hospitals with the availability of P.O.P. services. However, we must take into consideration that the use of tranquilizers was generalized in the same period with more consolidation of the improvement reached.

Discussion

It is evident from the above-mentioned data, how important and variable is the service offered in the P.O.P., how much the work is increasing to surmount the magnitude of work in the mental hospital.

However, this does not mean that the P.O.P. service will substitute the in-patient service completely. The key to the system of community mental health centres is the integration of these varied services including I-P, O-P, emergency centre, walk-in centre, and day and night hospitals. The essential quality of that is that these services are so organized as to form a coordinated system of care. So the P.O.P. can act as complementary and preventive medium. It can be of great help in alleviating family anxiety, especially with regard to the stigmatizing reputation of hospitalization. Patients attached to the P.O.P. live in their home settings where they continue to relate to family members and friends while engaged in intensive treatment. Such a programme offers effective treatment for patients suffering even from depressive and schizophrenic reactions, especially those whose personality traits or family relations accommodate for cooperation with medical personnel.

There are many questions that arose when the U.P.O.P. was first started. These are:

1. How often must patients be seen for evaluation and adjustment of medication?
2. Would psychiatric hospital care be required frequently for those patients?

3. What frequency of clinic appointments would be best for the patient and at the same time permit the clinic to handle an adequate volume of patients?
4. Would an out-patient visit of 10 to 15 minutes duration be sufficient to allow careful re-evaluation of the psychiatric status of each patient?
5. What psychiatric medications would be most desirable for what patients?
6. What type of procedure for the termination of these patients could be employed?
7. What are the medicolegal problems in this type of programme and how can it be solved?
8. Can this type of clinic be staffed with resident physicians working under the supervision of senior psychiatrists?
9. Being attached to a university, can it be a field for research?

Some of these questions have been answered during practice and some will find the answer only through trial and error.

I must stress now, that not all the problems are defined or solved, as some are problems of evolution. An example is the problem of relatedness of the P.O.P. with its complicated and growing structure to the general hospital. Again a related question is whether the P.O.P. can be distributed all over the country independently according to a certain system directed by the society's needs. Both, dependence and independence can work. In Egypt we use only the dependence programme, in constructing

new P.O.P.s (we have nine P.O.P.s in Cairo and twenty distributed all over the country) attaching to the P.O.P. few beds whenever possible for emergency needs. In the Soviet Union the P.O.P. acts more independently under the name of dispensary.

Another problem that has ushered was the possibility of psychotherapy use. Unfortunately, in a large public clinic the requests for assistance far exceed the capacity of the staff to administer psychotherapy individually. However, a type of compromise was reached in our clinic by administering supportive superficial, and group therapy reserving insight psychotherapy to few selected cases.

Even drug therapy introduced the problem of financial support and till now such problem is not yet solved.

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