Friday 23rd February 2007

Development of Forensic Psychiatric services: Lessons Learnt From the UK

Dr Margaret Orr. Consultant Forensic Psychiatrist. Broad Moor Hospital

Forensic Psychiatric Services cannot depend on hospital beds or forensic psychiatrists. They must be based on a comprehensive multidisciplinary team and a range of appropriate accommodation at all degrees of security from open to low secure to medium secure to high secure. These services must be culturally sensitive. They must also provide an interface with the judicial process including probation, courts and prisons.

In the UK a few low and medium secure places for the mentally abnormal offender, mainly women who had killed their children or violent people with mental disorder, had already been opened in the 18th century but it was not till Broadmoor was opened in 1863 that there was a purpose built unit for such people. This was achieved only after various high profile cases were tried and aroused such public interest that there was a groundswell of opinion to build accommodation suitable for the criminally insane.

By the 1970s the 3 Special Hospitals in England were full and prisons were overcrowded with the mentally disordered offenders. As a result of the Butler and Glancy Reports a solution of building 1800 medium secure beds was agreed. It took another 25 years before that was achieved and by then 1800 beds was a gross underestimate of the need. The private sector seized the opportunity to build medium security and a whole new forensic psychiatric business developed. Various strategies were developed to cope with the pressure in medium security such as court diversion schemes, community probation orders with conditions of psychiatric treatment, and directly employing forensic and general psychiatrists in remand and dispersal prisons.

Currently there is an upsurge in NHS facilities being built for long stay medium security and low secure units. There is a shortage of general adult psychiatrists and there are proposals to turn psychologists, nurses and social workers into supervising officers to cope with the shortfall. We have seen the evolution of Community Mental Health Teams with assertive outreach and these are now being evaluated. We have just dramatically increased the number of training psychiatrists to comply with the working hours directive of the European Community. There is a total reorganisation of training and an enormous amount of anxiety for junior doctors as they wonder if there will be any jobs in August 2007. Every SHO job in the country is being re-applied for currently.

I would like to propose to all in the medical profession in Sri Lanka, not only psychiatrists, that they can learn from the UK's mistakes and miscalculations. Instead of building a forensic psychiatric service from the top down, why not consider starting from a wide multidisciplinary base involving physicians, psychiatrists, nursing staff, psychologists, social workers, general practitioners, probation officers and prison staff ? We in the UK are only now involving patients and carers in the creation of services. Surely it would have been more sensible to involve them from the beginning, and with this group community leaders, politicians and lawyers ?

There can never be a perfect system, due to the vagaries of man, but by working together with fellow professionals, patients and the wider community, combined with mutual respect and a large amount of goodwill and enthusiasm, we may create a fine model of care for our mentally disordered patient. The qualities we shall need are those personified in our dear late friend and colleague Dr Balakrishnan Somasunderam, in whose honour and memory I hope to give this lecture in Sri Lanka on 22nd February 2007 at the Annual Academic 2nd International Conference of the Sri Lanka College of Psychiatrists.

Psychiatry in Sri Lanka – The Way Forward

Prof Samudra T. Kathriarachchi, Associate Professor and Head, Department of Psychiatry
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Sri Lanka is a beautiful island in the Indian Ocean, known as the pearl of the Indian Ocean. Expands over 62,705 square kilometer area, it has many natural resources and attractions. Sri Lankan nation shows diversity in ethnicity, culture, religion and values. Traditional Sri Lankan culture spans over 2500 years has influence from India. Later, invasion of Portuguese (1505 - 1656), Dutch (1656 -1796) and British (mid 1800's) incorporated western values to islander's minds, which is depicted in language, dress code, education, legal system, health and life style.

The diverse value systems exist in the country and existence of other systems of medicine has influenced the illness and help seeking behaviour of people. In ancient days natives of the country were more tolerant to mentally ill. Families and villages with the help of the traditional healer or the native physician looked after patients.

The current framework of mental health care services could be traced back to British rule. In 1839 "an ordinance to establish lunatic asylums" was introduced. This was a new concept to Sri Lanka. Since then, successive governments, with the help of professionals attempted to expand services, from asylum to general hospital wards, clinics, out reach clinics and community services.

Service development in this model had been hampered by various factors, which include scarcity of resources, both material and human. The few psychiatrists chose to serve the country in preference to greener pastures, face considerable hard ships in delivering a cost effective service. Specialized nurses, psychologists, psychiatric social workers, occupational therapists are scarce and they lack opportunities for professional development. However, patients are looked after with available resources. This task had been complicated by increasing incidence of minor psychiatric morbidity and emergence of psycho social problems due to adverse circumstances, both natural and man made.

The practitioners who are over burdened yet thrive to deliver a best possible service, often face criticism for not being able to deliver an island wide service in the field of mental health.

At a time much emphasis is given to mental health service development, it is prudent that psychiatrists understand their limitations in service delivery. Understanding illness behaviour and help seeking behaviour of individuals in a cultural context and recognizing the value of alternative systems of medicine and other healers would pave the way to provide a better service to many. Recognizing other systems of medicine providing care in the field of mental health need not be amalgamated with allopathic medicine. Maintaining standards of other systems and monitoring is a responsibility of respective professional group and the state. As a body, psychiatrists could assist the government to monitor activities to protect patient rights. Psychiatrists could focus on improving professional standards of the discipline of psychiatry in allopathic medicine.

However psychiatrist's responsibilities to patients who do not have capacity still remain. In this respect bringing them to the care facility need to be addressed by another agency, as the number of psychiatrists (30) that serves the country is unlikely to increase in significant amount in the near future, to cater to this need.

Collective effort on educating the policy makers on these delicate issues is the prime task of psychiatrists today.

Development of Mental Health Services of the Southern Province of Sri Lanka

Dr [illegible] Department of Psychiatry, Faculty of Medicine, University of Ruhuna

Development and improvement of the mental health services of Southern Sri Lanka was a long felt but [illegible] needs. Attention to this was noted to be rising after the 2004 tsunami, with anticipated increase of psychiatric morbidity as all three districts of the Southern Province were severely affected.

Out of the three districts of the Southern Province, Galle is the most resourced with regards to mental health services. Galle privileged with the services of a Consultant Psychiatrist of Ministry of Health (MOH) and a team of Psychiatrists of the University Psychiatry Department, is the only hospital with a closed psychiatric inpatient ward, which provides services to all three districts, though the facilities are inadequate. The medium stay unit and drug rehabilitation service at Unawatuna hospital compliments the services of Galle hospital. The Child & Adolescent Psychiatric [illegible] conducted at Galle Hospital is the only service for young patients of the province. [illegible] small hospitals, one has a Medical Officers of Mental Health (MO/MH) providing in-patient services.
Matara district has out patient service and liaison services at the General Hospital. There are MO/MHs working in two peripheral hospitals. Hambantota district major hospital out-patient mental health services is provided by a MO/MH and MO/MH's at two peripheral hospitals also provide mental health services. Long stay unit at Ridiyagama provides rehabilitation services in an [illegible] setting. In all three districts several NGO's have been providing community based [illegible] services.

Since the [illegible] resources were directed to improve mental health services. Immediately after the [illegible] College of Psychiatrists mobilized clinicians to needy areas of south with an [illegible] management of disaster related mental health services. This was complimented by 100 [illegible] trained in disaster related psycho-social support. As this was a short-term measure [illegible] services in mental health, several community based programs were implemented [illegible] the establishment of Provincial and District Mental Health Committees, [illegible] of the services of state sector and NGO's.
Still the [illegible] resources required in mental health, especially the leadership is lacking. At present [illegible] consultant psychiatrists are available only in Galle district. Hambantota is getting services of visiting psychiatrists from Mental Hospital Angoda as a relief measure. Matara [illegible] before tsunami, with further deterioration of the available human resources. [illegible] improvements of the existing services. But taking the services to the grass-root level [illegible] and to increase the accessibility of services to many, has to be improved. [illegible] workers of some areas are given training in mental health, referral system and supervision in place. Lot more work is required to make at least basic mental health [illegible] to people of rural and remote areas and for this I personally believe most important requirement is enthusiastic leadership.

Modernization of an asylum

Dr [illegible] Director, Institute of Mental Health, Angoda, Sri Lanka

[illegible] Hospital Angoda goes back as far as 80 years. Until recently the operated like [illegible] without much difference from its inception. The facilities available were not [illegible] the hospital environment was not very pleasant for the patients or their families. The [illegible] motivation of the staff to provide services for psychiatrically ill patients were not satisfactory.
The author was appointed as the acting director of the hospital following a dispute between [illegible] the newly assigned director.
There are significant changes that have been introduced to improve the patient care such as human resource development, structural changes, administrative changes and continuous training [illegible] for all grades of staff of the hospital.
The attitudinal change is expected to follow with these changes.

With these new developments the hospital could develop into oe of the best psychiatric hospitals in the South East Asia
In accordance with the new Mental Health Policy further plans of hospital development for next 10 years is discussed

Need for the Psychiatrists to give Leadership

Prof. Nalaka Mendis, Professor of Psychiatry, Faculty of Medicine, University of Colombo, Sri Lanka

The development of psychiatric services in Sri Lanka has been modest compared to the general health services. In some areas the services have changed very little over the last thirty years. Some of the past developments have been initiated by the psychiatrists. Traditionally psychiatrists have been involved in patient focused services in the institutions. Increasingly there is a need for the development of population focused services which will benefit the entire communities. Recently however there had been a number of new initiatives by psychiatrists which have been adopted by the government or the institutions for the benefit of the larger community. In order to develop population based services psychiatrists need to acquire new competencies. The paper discusses these aspects.

Is Research and Audit in Psychiatry a necessary luxury in Lower and Middle Income (LAMI) Countries?

Dr. Sherva Elizabeth Cooray, Consultant in Psychiatry of Learning Disability, Central & North-West London

Countries categorized as low- and middle-income. (LAMI) by the World Bank constitute Eighty Five % of the world's population. Despite this, they contribute minimally to high quality research based mental health literature, which is dominated by high-income countries. In view of the inherently complex nature of mental disorder where culture and ethnicity play a significant role, extrapolation of research findings from the high income countries to LAMI countries may often be inappropriate. The social and economic cost of unmet mental health need in these countries is significant and capacity building is paramount
Clinical Audit is the continual evaluation, measurement and improvement by health professionals of their work and the standards they are achieving. It is an integral key component of Clinical Governance. In conjunction with research based evidence, Clinical Audit underpins the delivery of high quality mental healthcare.
The substantial barriers that impede relevant research and audit in LAMI countries as well as Strategies that could potentially address the issues will be explored.

Old age psychiatry-Transcultural aspects

Professor T Elliott FRCPsych MSoc Sci Programme Director Centre for Ageing and Mental Health Staffordshire University UK

Psychiatric Disorders in Old Age are influenced by Cultural Factors. Professor Elliott will illustrate this by presenting case studies from Sri Lanka and UK. This work has been part of an educational initiative between himself and colleagues in Sri Lanka. Professor Elliott will also outline potential future opportunities for ongoing training and educational initiatives in Old Age Psychiatry between Sri Lanka and UK

Improving research capacities in LAMI countries: is the evidence skewed ?

Peter Tyrer, Professor of Community Psychiatry, Department of Psychological Medicine, Imperial College , St Dunstan's Road, London W6 8RP , UK

There is a well-known rule that international organizations are very fond of repeating: it is called 'the 10/90 divide' and describes the fact that 90% of scientific activity and published work comes from 10% of the countries of the world. In the case of mental health a recent paper showed that 'high-income countries, with 15% of the world's population, contributed 94%; low- and middle-income countries, with more than 85% of the world's population, contributed 6% to internationally accessible mental health literature' Saxena et al, 2006). This is, to say the least, highly unsatisfactory, and the notion that the research in high income countries will percolate through to poorer countries, the 'trickle-down effect', is also not borne out in practice. What is to be done about this? Solutions include the development of new journals, better international collaborative links, development of research institutes of excellence, and greater flow of professionals across country boundaries. The ratio tables are beginning to turn but they are exceeding slow. Ways of speeding up the process will be discussed.

Saxena, S., Paraje, G., Sharan, P., *et al* (2006) The 10/90 divide in mental health research: trends over a 10-year period. *British Journal of Psychiatry*, 188, 81 –82

Domestic violence

Prof. K. A. L. A Kumpuarachchi, Professor of Psychiatry, Faculty of Medicine, Ragama, Sri Lanka

Domestic violence can be defined as a pattern of abusive behaviour directed at the spouse or the partner. The abuser resorts to use intimidation or fear to gain the power and control over the victim of domestic violence. The abuse may be physical, emotional, sexual , economic deprivation or a combination of many of those.

This is also called intimate partner violence. This is a universal phenomena, involving both developed and developing countries. The available data in the developing countries too suggest that domestic violence is a major concern.

In Sri Lanka it is estimated that about 60% of women are faced with domestic violence. A study done in the North Colombo General Hospital with regard to domestic violence showed that 40.5% of the participants have faced some form of abuse by the partner. It was interesting to note that about 79% of those abused were abused in the relationship for more than 10 years. The majority felt that the violence by the spouse has to be tolerated.

The reason for the domestic violence may be many, eg. personal difficulties, abuse mentality, extreme possessiveness, jealousy and alcohol / substance misuse of the partner, underlying psychiatric disorders, and poor anger control. Factors like disrupted family structures, poor education may play a role. Lack of respect for the others' views, deterioration of religious spiritual and moral aspect of the life may also contribute.

The consequences include psychiatric morbidity in the partner, sustaining physical injuries and homicide. The children who witness violent activities also have problems in their personality development. In children vulnerability factors are multiple and additive. In those families where domestic violence is seen, other vulnerability factors such as poor relationships, substance misuse, social deprivation, separation are common. Hence the children grown up in these families are more vulnerable to develop psychopathology. Children who witness violence, have a higher risk of being in a violent relationship as adults. In the management it is important for the victims and the families to learn how to safe guard. They should be educated with regard to the consequences of domestic violence, including psychological effects in their children. The families need guidance and counseling and legal help. It is mandatory to improve coping strategies and improve the spiritual wellbeing and moral values.

Alcohol and violence

Dr. Ranil Abeysinghe, Senior Lecturer, Department of Psychiatry, Faculty of Medicine, Peradeniya, Sri Lanka

Common experience suggests that alcohol and violence are related. Facts seem to bear this out for all forms of violence.

1. 75% of homicides in Russia were associated with alcohol and in Norway 53% of physical violence was related to alcohol.
2. In UK study of 100 battered women 52 had frequently drunk and 22 had episodically drunk partners.
3. In the UK58% of men convicted for rape reported abusing alcohol prior to rape

However this well known association does not spell out the nature of the association. The nature of this association has been shown to exist in the following areas:

1. Alcohol brings out the latent aggression in normal individuals by restricting their level of consciousness. This helps individuals focus on slights and minor threats and react them with aggression. There is a dose response relationship in this.
2. Individuals with aggressive personality traits are more likely to drink larger amounts and become more violent.
3. Uncomfortable poorly managed drinking situations have been shown to lead to more violence.
4. There is a major role of cultural and sub cultural expectation of violence after alcohol. Where violence is expected in a given culture, individuals who drink are more likely to show violence.

Implications for prevention

1. There is a need to adopt society wide firm disapproval of alcohol related violence at any level.
2. Binge drinking and drinking in unsuitable settings must be reduced.
3. Set up treatment centres for alcohol related problems.
4. Public education of sensible drinking.

Ethnicity and Psychiatry

Dr Neel Tambimuttu, MBBS, MRCPsych(UK), DPM(UK), Consultant Psychiatrist & Lead Clinician Transcultural Psychiatry- Coventry ,UK.

The term Common Mental Health Disorders (CMHD) came into common use in the early 1990's.The prevalence of CMHD's varies across population groups; ethnicity is one among several factors influencing that variability. This short talk concentrates on the prevalence and the ethnic differences in CMHD's in ethnic minority groups in the UK. It highlights the differences in the perceived value of consulting for emotional problems across cultural groups. It also emphasizes the complex interactions between ethnicity, socioeconomic status, social inclusion, age and sex.. Ethnicity is thus one of several explanatory models.

Interpersonal psychotherapy – an overview

Dr Raveen Hanwella - MBBS(Col), MD(Psy), MRCPsych
Senior Lecturer in Psychiatry, Faculty of Medicine, Colombo, Sri Lanka

Interpersonal psychotherapy (IPT) is time limited, dynamically informed psychotherapy which aims to alleviate patient'suffering and improve thier interpersonal functioning. ITP focuses specifically on interpersonal relationships as a means of bringing about change. In addition it also assist patients to improve their social support networks. The presentation would outline the charachteristics of IPT,the theories on which it is based and its clinical applications.

Schedule of Oral Presentations

Free paper session 1 – Friday 23rd February – 1400 - 1500
Chairpersons : Dr. Thilak Ratnayaka, Dr. Upali Peris

PICU : Institute of Psychiatry, Angoda – Descriptive survey
B J Medis, A M S K Attanayake, A Ellepola
Institute of Psychiatry, Angoda

Response of Police Officers to Domestic Violence victims and their complaints – a descriptive study
S T Kathriarachchi, E. M. K. A. Senakumara, P. B. Wickrama, D Alponso
University Psychiatry Unit, Colombo Sounth Teaching Hospital, Kalubowila

A case of kerosene dependence in a child
R Abeyasinghe, R Malwanna, S Arambepola
University Psychiatry Unit. Teaching Hospital, Peradeniya .

Denial of Pregnancy and Mother infant relationship disorder – a case report
S T Kathiarachchi , P B Wickrama
University Psychiatry Unit, Colombo South Teaching Hospital, Kalubowila

Free paper session 2 – Saturday 24th February – 1400 - 1500
Chairpersons : Dr. Victor Wimalasinghe, Dr. Usha Gunawardene

A study on Near Death Experiences (NDE) amongst suicidal attempters.
K A L A Kuruppuarachchi , G Padmasekera, H Gambheera, M H Perera

Adolescents' perception of adolescent-parent connectedness and some associated factors in Divulapitiya MOH area
D G M H Gamage

Audit on concordance with Lancashire Care Trust(LCT) Protocol for Lithium Therapy
S Narayan. . N Dolage . .P Kundi . L Mellor.

Violence faced by Psychiatric Tainees
K A L A Kuruppuarachchi, L T Wijeratne, T S Lawrence
Department of Psychiatry, Faculty of Medicine, Ragama

Abstracts of Oral Presentations

PICU ; Institute of Psychiatry, Angoda - Descriptive Survey

B J Mendis, A M S K Attanayake, A Ellepola
Institute of Psychiatry, Angoda

Introduction
Violence and aggression have become an increasing problem in psychiatric institutions. Such incidents can be reduced by having a Psychiatric Intensive Care unit. It also increases the acceptance of treatment by patients and their families while combating stigma. PICU s are not well developed in this part of the world
PICU at Angoda was started in May 2006. It is a 4 bedded unit with 2 nurses working at a time from 7 am to 7pm. With the intention of extending it to a 24 hour service.
Objective
To describe the demographic and clinical characteristics of the patients managed at PICU.
Method
All the patients admitted to PICU from 1st of July 2006 to 31st of December 2006, were evaluated retrospectively using PICU assessment forms, case files and the register in PICU.
Results
A total of 380 patients were admitted.
The highest number of patients were from 40 -49 age group. 11 teenagers and 17 elderly were among them. Male: Female ratio was 5: 4 . Majority (74%) were from western province. Mean duration of stay was 47 minutes.
Schizophrenia and other Psychotic disorders accounted for 61.4%. 26% had Affective disorders. 6.1% Substance abuse and 3.6% Organic disorders
Rapid tranquilization was not used in 18% of patients. 0.7% were given Haloperidol 5 mg IM only. 5.5% were given Haloperidol 10 mg IM
Midazolam 5 mg IM and 10 mg IM were used in 1.3% and 3.4% respectively. Combination of Haloperidol 10 mg IM and Midazolam 5 mg IM was given to majority 57% .
BP, Pulse respiration and general condition were monitored. 4 patients were found to have postural drop
6 patients were transferred to NHSL for suspected organic problems. 7 were sent home. 367 were admitted to the relevant wards of Institute of Psychiatry .
Discussion
18.6% of patients were de-escalated without Parenteral medications .Serious complications were not reported.

Response of police officers to domestic violence victims and their complaints – a descriptive study

S T Kathriarachchi, F M K A Senakumara., P B Wickrama., D Alponso
University Psychiatry Unit, Colombo South Teaching Hospital

Background
It is estimated that around 60% of adult women in Sri Lanka are subjected to domestic violence. Of these only 0.05 %(2155) were reported to the police in 2000. We attempt to describe the perception of first contact police officers who recorded some of these complaints
Objective
To describe the perception of police officers of the complaints of domestic violence they received
Method
A descriptive cross sectional study was carried out using a self administered study specific questionnaire that had been pretested. 51 police officers who dealt with complaints of domestic violence in the North Western province were sampled.
Results

The sample comprised of 27 (53%) males and 24 (47%) females, with experience ranging from 3 to 37 years. 29 (57%) claimed that complaints were stressful for them. 60% stated they could definitely help victims
A fifth of the sample stated that they would send the victim home without documentation of the complaint. Responses did not significantly differ according to sex or experience.
With regard to prevention, the majority proposed that community education, reduction in alcohol use and settling marital conflicts will be useful. Only eight participants proposed recourse to legal aid for the victims.
Discussion
This study shows the importance of identifying stress related to these complaints among police officers. It is also useful to educate police officers regarding their role in helping victims within the legal framework

A case of kerosene dependence in a child

R Abeyasinghe, R Malwanna, S Arambepola
University Psychiatry Unit, Teaching Hospital, Peradeniya .

Kerosene abuse by adolescents was described in Indian adolescents by Das et al. and Shah et al. No reports of kerosene abuse by children exist. We describe the case of an 8 year old child who is dependent on kerosene.
Lahiru, an 8 year old boy presented with drinking kerosene oil habitually since 6 1/2 years of age. He started sniffing kerosene which habit developed into drinking a half bottle daily. He would seek kerosene oil and even steal kerosene from neighbours. He always slept after drinking. He also abused other oils, syrups, tablets, stationery material and charcoal.
Lahiru was restless, impulsive, reckless and has difficulty in controlling anger from the age of 5. He cut him self and enjoyed the sight of blood. He injured children, lied and played truant.
His mother suffered from depression during the pregnancy and 1 1/2 years in to the post partum period. This affected bonding between Lahiru and his mother.
Lahiru acquired motor milestones at proper age but his speech development and school performance were poor.
On examination, Lahiru was of adequate built for his age. He was hyperactive and impulsive. Physical examination was normal apart from the scars due to self inflicted cut injuries.
Blood biochemistry including liver function tests did not reveal any abnormalities.
The multi axial diagnosis of this child and implications for treatment will be discussed.
References
Das, P S Kersone Abuse by inhalation and ingestion: The American journal of psychiatry, 1990; Vol 149 May
Rakesh Shah, G K Vankar, Himanshu P Upadhyaya: Phenomenology of Gasoline Intoxication and Withdrawal Symptoms Among Adolescents in India: A Case Series. American Journal of Addiction, 1999;8:254-257)

Denial of Pregnancy and Mother Infant Relationship Disorder – A case report

S T Kathriarachchi, P B Wickrama
University Psychiatry Unit, Colombo South Teaching Hospital

Introduction
Though pregnancy is a celebratory event for most women, a minority fears it and conceals the pregnancy resulting in impaired bonding. Frequency of failure to recognize pregnancy by the mother is about one in 400, and is a risk factor for infanticide
Case Presentation
Ms S, a 33 year old housewife living with her carpenter husband amidst many financial difficulties, was referred for alleged attempt to strangulate her baby during delivery. She claims she was unaware of her

pregnancy till being admitted in labour. She avoided medical consultation despite being advised to do so by relatives. Premorbidly she was stubborn.

Management

Following multidisciplinary case conference. the baby was handed over to the father on his request. with supervision of a probationary officer. through a court order.

A week later Mrs S was readmitted depressed, but refused medication and left against medical advice.

Currently her bonding with the baby has improved and she is well at home.

Discussion

Denial of pregnancy and mother infant relationship disorders are well recognized. Treatment would aim at improving bonding. treating any underlying depression and dealing with issues relating to guardianship.

A study on Near Death Experiences (NDE) amongst suicidal attempters.

K. A. L. A. Kuruppuarachchi . G Padmasekera. H Gambheera. M H Perera

Introduction

Near death experiences (NDE) had been reported by people after having experienced life threatening situations. where they have come close to dying. Main features are a feeling of peace and quiet feeling like traveling in a dark tunnel. out of body experience. life review. meeting religious or other people. coming to a border or a limit and the decision to come back NDE has been reported amongst people with cardiac arrest. shock. electrocution. coma, near drowning. intra cerebral haemorrhage. asphyxia. trauma and amongst suicidal attempters. Even though it has been described among suicidal attempters this group has been less rigorously studies compared to other groups such as cardiac arrest

It has been reported that NDE is not uncommon and the medical profession must be aware of this important area

Methodology

We aimed to assess the prevalence of NDE and demonstrate features amongst suicidal attempters The duration of more than 24 hours inpatient admission was regarded as a serious suicidal attempt

All the consecutive people admitted over a eight month period (N = 77) to the North Colombo Teaching Hospital. were included in the study.

A modified Sinhalese translation of the Bruce Greyson NDE scale and a questionnaire to gather the demographic. medical. psychological and pharmacological data were administered.

NDE was defined as 2 or more elements present on the scale.

Results

The majority of the population was 18 – 25 years (mean age 30 – 54 years) 7% had loss of consciousness and the majority attempted suicide my overdosing.

None of the patients with attempted suicide reported NDE.

Conclusion / Discussion

None of the subjects in our sample showed NDE. Reasons may be that the attempts were not severe enough to induce NDE

Adolescents' perceptions of adolescent-parent connectedness and some associated factors in Divulapitiya MOH area.

D G M H Gamage

The study was conducted to describe adolescents' perceptions of adolescent-parent connectedness and selected associated factors among 13-17 years aged schooling adolescents in Divulapitiya MOH area. The survey included 640 schooling adolescents out of 16 clusters from the schools in Divulapitiya MOH area.

A questionnaire was developed for the assessment of the parent adolescent connectedness. as perceived by the adolescents. with the help of a process similar to Delphi process ensuring validity and cultural acceptability. The parent child connectedness was studied in association

with selected associated factors using a self administered questionnaire.

Majority of the adolescents reported very satisfactory relationships with their parents from the point of view of attachment to the parents. warmth. cohesion. support. communication and autonomy granting. However 75% of the adolescents reported that their parents selected punishments as a measure of control. Considerable proportion of adolescents reported overprotection and always setting limits by their parents.

The parent adolescent connectedness was studied for selected associations. Age. sex. or religion was not significantly associated with adolescent parent connectedness according to this study. However some parental factors. family configuration. peer relationships. social class and neighbourhood was significantly associated with parent adolescent connectedness.

This study being the first attempt in Sri Lanka to assess parent adolescent connectedness, it has been understood that further studies is needed to uncover most of the areas related to this subject

It is expected that this effort would lay foundation to study and intervene the crucial dynamics between parents and adolescents for the sake of the future of the nation.

Audit on concordance with Lancashire Care Trust(LCT) Protocol for Lithium Therapy

S Narayan . N Dolage P Kundi . L Mellor.

Introduction

For patients safety when initiating Lithium therapy LCT Protocol should be adhered . However. it was noted that in Skelmersdale sector the Lithium monitoring is not done according to the LCT protocol. This has lead to several practical difficulties and risk situations.

Standard

LCT Lithium protocol gives details of indications. therapeutic level of serum lithium . hospital responsibilities. shared care arrangements between primary care and secondary care and GP responsibilities .

Objectives

To assess the concordance of current practices in skelmersdale area with the LCT protocol on Lithium

Methodology

All patients on Lithium in Sklermersdale area were selected for the audit.

Results

17 Patients in skelmersdale sector were on lithium. 3 were not included due to improper documentation in the audit tool. *Baseline investigations prior to initiation of Lithium*: Urine. electrolyte and Thyroid function test was done in 12/14 (86%), ECG 10/14 (71%) Weight 2/14(14%). *3 months monitoring* : only 4/14(29%) case notes show documentation of serum lithium no case notes indicated the timing of serum lithium,5/14 (36%) had urine and electrolyte checked 2/14 (14%) had thyroid function test and weight documented. *Communication regarding Lithium*: Lithium card was given only to 2/14(14%). None of the patients had received a lithium leaflet 9/14 (64%) of patients were given verbal information about lithium.11/14 (79%) of patient records showed that a letter was sent to the GP however none had therapeutic level indicated. only 1/14 (7%) of records show that GP had faxed the results to the secondary care

Recommendations:

1. To disseminate the copies of LCT protocol on Lithium to ward staff. Community Mental Health Teams . Pharmacy and primary care so that standards can be improved.
2. Improve the blood forms for serum lithium where timing is made mandatory.
3. To have clear guidelines in the Lithium protocol regarding the responsibilities of issuing Lithium card and leaflet.
4. To draft a standard letter to GP when patients are initiated on lithium according to the protocol
5. Draft a leaflet about Mood stabilizer for LCT and sent to clinical governance

Violence faced by psychiatric trainees

I T Wijeratne, T S Lawrence, K A L A Kuruppuarachchi

Introduction

Studies carried out in many countries show that the risk of being confronted with patient violence is more than twice as high among psychiatric trainees than among trainees of other medical disciplines. Between 36% to 56% of psychiatric trainees have faced physical abuse. Violence faced by psychiatric trainees has not been studied in Sri Lanka.

Objectives

To determine the percentage of trainees who have encountered violence from their patients, the trainees' reaction to violence and the level of confidence in the trainees regarding handling violent patients.

Method

A pre-tested self administered questionnaire was distributed among registrars and senior registrars in the training programme for MD in psychiatry. Confidentiality was assured and those who did not consent to take part were excluded from the study.

Results

97% of the participants claimed that they have faced violence by their patients at least once during their period of training. Verbal abuse was commoner than physical abuse. The commonest from of abuse experienced was the use of abusive language by the patient. This was experienced by 60% of the participants. 10% have been pushed and 16.7% slapped and had an object thrown at them. 10% have sustained minor injuries. None of the participants sustained injuries that needed treatment.

57% of the trainees who experienced violence said that they were emotionally affected by the incident. 27% of the violent incidents occurred in the ward and 72% of the participants have been alone when they experienced violence. Only 27% of the trainees felt they had adequate supportive staff to handle violence from patients. 6 % stated that an escape route is available in the ward.

Only 50% reported the incident to the seniors.

57% of the participants felt their knowledge on how to handle a violent patients was inadequate.

Conclusion

A significant proportion of psychiatric trainees have experienced violence from their patients. The commonest form of violence was verbal abuse. A large proportion said they were emotionally affected by the violent incident. Facilities available in the ward to handle violent patients is not satisfactory. It is recommended that training on how to handle violent patients should be made an integral part of the training programme. Facilities to handle violent patients in the wards too need improvement.

Abstracts of Poster Presentations

A case report of Neuroleptic Malignant Syndrome following Clozapine

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Miss. X was a 43 year old single unemployed woman with a history of learning disability. She was diagnosed to have schizophrenia since the age of 15 years and stabilized on clozapine 300 mg nocte for the past 5 years.

She presented with gradual onset of lack of speech and psychomotor retardation followed by difficulty in swallowing, fever with productive cough and hyper salivation of 5 days. She showed an abnormal posturing for the last 2 days. On presentation she was mute for one day.

On admission she was profoundly ill. She was febrile, dehydrated and mildly dyspnoeic. She was found to have dystonic posturing with opisthatonus, frightened facial expression and intense effort to speak but inability to do so. Her muscle tone was increased.

She required immediate hospitalization and intensive care initiated with discontinuation of clozapine. Intravenous hydration, nasogastric feeds and intravenous antibiotics (Cefotaxime, Metronidazole) were started. One procyclidine injection was administered intramuscularly on day 1.

Her creatinine phosphokinase peaked at 3432 u/l on day 3. Leucocytosis was noted with picket fence pattern of fever spikes.

With intense treatment she became afebrile from day 3. She began to respond to command in 7 days. She resumed communication within 3 weeks.

Patient recovered 4 weeks after stopping clozapine without residual weakness.

Discussion

Miss X met all criteria for Neuroleptic Malignant Syndrome(NMS).

It is a rare case of NMS which developed after prolong treatment with clozapine even without recent dose change in a patient with multiple predisposing factors.

However if profound dopamine D2 receptor blockade may be postulated as a possible cause of NMS, then it may be equally possible that some individuals develop concomitant and profound muscarinic cholinergic receptor blockade which will help to explain why clozapine when used alone may cause NMS.

A case of Serotonin syndrome with Sertraline

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A 74 year old man on Lithium 750 mg/day for bipolar affective disorder, was started on Sertraline 50mg for a depressive episode. He presented with tremors, muscular rigidity and abnormality in mental status of four days duration.

On examination he was agitated, tremulous and sweaty. His pulse rate was 88 beats per minute, blood pressure was 160/100, which 4 hours later was 130/90. His muscle tone was increased with exaggerated reflexes, more marked in the lower limbs. His mental state was fluctuant, at times he was confused and at other times he was well orientated.

The symptoms persisted in spite of stopping Lithium. His serum Li level was 0.75meq/ L and his Creatinine phosphokinase level was -65u/l, The blood urea, serum electrolytes, blood sugar, full blood count and ECG were normal.

A diagnosis of Serotonin syndrome was made and the other potential causes were excluded. He had hyperserotonergic symptoms and had more than 3 of the symptoms in the Sternbach's diagnostic criteria.

(Sternbach H 1991) including agitation, sweating, hyperreflexia, shivering, tremor and mental state changes. There were no concurrent antipsychotic dose changes prior to the onset of symptoms.

The management was mainly supportive. He improved within one day of discontinuation of Sertraline. This case highlights the importance of considering Serotonin syndrome which often can occur even with therapeutic or sub therapeutic doses of drugs.

Hyperactivity is not always ADHD (Attention deficit hyperactive disorder)

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Lady Ridgeway Hospital for Children

A nine year old girl was referred to the child guidance clinic by a general practitioner with a history of hyperactive behaviour of five months duration. She was always on the go and did not stay at one place for long. She was not sent to school for three weeks because of her hyperactive behaviour was uncontrollable. On close questioning parents revealed that in addition to hyperactivity the child had been having excessive sleepiness, bed wetting at night and day time. In addition she has had early morning headaches with vomiting in addition to loss of appetite and has lost considerable amount of weight. There was no history of any febrile illness or significant psychological precipitant prior to the onset.
She was of average build and was extremely hyperactive and was running around in the clinic room. She was disinhibited, over familiar and at times was aggressive towards her parents. She talked in a childish way and sometimes used obscene language. She was irritable at times. She was oriented in time, place and person. Intelligence was normal.
Since there were symptoms other than those of hyperactivity, an organic cerebral pathology was suspected and was referred to a pediatrician. Her physical examination was unremarkable except for marked papilloedema and a CT examination done at this stage revealed a large neoplasm in the anterior cranial fossa, most likely to be a meningioma.
This case highlights the importance of considering an organic pathology in all children presenting with hyperactivity and behavioral disturbance.

Clozapine induced Hypertension – A Case History

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Twenty-four year old female, a diagnosed patient with schizophrenia presented with suspiciousness and aggressive behaviour towards her relatives for a period of one-month. On mental state examination she was found to have delusions of control, thought broadcasting and second person auditory hallucinations.
She had the illness for ... years. She had shown poor response to adequate doses of Trifluoperazine and Olanzapine, each given for more than two months.
Therefore she was considered as having resistant Schizophrenia and consent was obtained from the patient for the initiation of Clozapine.

Her physical examination and baseline laboratory investigations were within normal limits. She was started on clozapine and the dose was increased by twenty-five milligrams every two days. Her pulse rate, blood pressure and temperature were measured three times daily and her weight was measured weekly.

She developed sinus tachycardia on day thirteen while on a daily dose of hundred and fifty milligrams. As the tachycardia was persisting, the dose of clozapine was increased more gradually and the pulse rate returned to normal limits.
She was found to have developed persistent high blood pressure during the third week of clozapine therapy while on a dose of two hundred milligrams of Clozapine. (Maximum systolic blood pressure- 180mmhg, maximum diastolic blood pressure - 110 mmgh.)

We performed an Electrocardiogram, two dimensional echocardiography and twenty four-hour urinary VMA measurement. An ultrasound of the abdomen was performed on her in order to exclude any other organic abnormality. All investigations were normal.
She was commenced on Losarten twelve point five milligrams as her blood pressure was persistantly high. One week later her blood pressure returned to normal with adjustment of the dose of Clozapine to twenty-five milligrams.
Subsequently we have increased the dose of Clozapine to two hundred and fifty milligrams and the patient is currently non-psychotic.
Most reported cases are of Clozapine induced hypotension. This case highlights hypertension in a patient on Clozapine.

A clinical audit on antipsychotic prescribing and polypharmacy. Is it justifiable to use polypharmacy?

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Introduction
Our understanding of the clinically relevant pharmacodynamics and pharmacokinetics of psychotropic medications has been developed over the last 40 years. Despite extensive research and recommendations as to the rational prescription of antipsychotics, polypharmacy is still widely prevalent in clinical practice world wide. Asian counties are well known to use polypharmacy. Each drug that is added to the patient's regimen increases the likelihood of an adverse outcome and the expense of the treatment. In this audit we aimed at identifying the patient and the associated factors of polypharmacy.

Objectives
1. To estimate the percentage of polypharmacy among the patients with Schizophrenia
2. To identify the patient factors associated with polypharmacy
3. To study the relationship with polypharmacy and adverse effects

Method
The study sample was selected from the patients with a diagnosis of Schizophrenia who are in remission, attending to the Clinic Psychiatry Clinic in the National Hospital Sri Lanka on third Wednesday. (A one day census in the Schizophrenia clinic) Data was collected by using a semi-structured format and available clinic notes.

Results
In this audit, prescription of more than one antipsychotic was found in 47.83% of patients with a diagnosis of Schizoprenia in remission. In addition we discovered that this type of prescribing was prevalent (86.36%) in early years, that is before year 2000. We also found that in addition to multiple antipsychotics 31.82% patients were prescribed benzodiazepines for a length of time than recommended in the B.N.F (ie. 4/52). Majority (81.82%) of patients had experienced extrapyramidal side effects due to antipsychotic use and from them 16.67% of patients were having clinical tardive dyskinesia and 22.22% of patients were experiencing sexual side effects.

Conclusion
Knowledge and practices on polypharmacy among medical officers needs to be improved. As far as possible attempts should be taken to use monotherapy. Otherwise rational polypharmacy should be instituted.

A Study of deaths, In the Institute of Psychiatry, Angoda Sri Lanka, in 2006

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Introduction
Deaths in a Mental Hospital, carry some extra-significance.
This study was done to analyze the various factors related to the deaths in a Sri Lankan Mental Hospital.
Objectives
1. To illustrate the demographic characteristics, relative frequency of psychiatric diagnoses, medical comorbidities and causes of deaths in these patients.
2. To identify factors related to medication used and the quality of care received by these patients.

Design
A retrospective descriptive study.
Setting
Institute of Psychiatry, Angoda, Sri Lanka.
Method
A total of 55 patients died [illegible] admissions, to Institute of Psychiatry, Angoda Sri Lanka from 01.01.2006 to 31.12.2006 were studied through case file review.
Patients were categorized according to demographic variables and institutional characteristics.
The leading causes of death, psychiatric diagnoses and medical comorbidities were calculated for this population.
Information regarding types and doses of medication and the frequency of medical review was collected.
Results
51% of the deceased were less than 60 years of age.
20% of deaths were direct admissions to geriatric unit (11). 29% these old age people died within 10 days of admission.
In 57% of the deceased, the main psychiatric diagnosis was schizophrenia, duration ranging from 5-50 years (mean 17.7yrs). 86% of them were ill for >10yrs.
62% of patients had one or more medical co morbidities. Diabetes Mellitus was the most frequent medical illness (22%). Epilepsy and Hypertension (16%).
92% of patients had been continuing antipsychotics, the duration ranging from 4 days to 49 years (60% typicals, 40% atypicals). None of them had been prescribed above the recommended dosage.
The leading cause of death was Ischemic Heart Disease (40%). Pneumonia was next (20%). The incidence of deaths from unnatural causes was 3.8%.
There was one suicide on the ward (1.9%).
90% of patients had been seen by the medical officer or registrar within 24 hours prior to the acute stage or the time of transfer.
The last date of review by the consultant psychiatrist or consultant physician was ranging from 1day to 10 days in 88%. (Mean, 4 days)
Conclusions
This study demonstrates excess mortality among patients with medical co morbidities.
Increased emphasis on medical care and routine screening for common medical illnesses is important.

Invited Speakers

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