NEVER TREATED SCHIZOPHRENIA IN DEVELOPING COUNTRIES

Saeed Farooq

One of the most significant recent developments in treatment of schizophrenia has been the early intervention for psychosis. Unacceptably long duration of untreated psychosis (DUP) has been considered as a major challenge for psychiatric services. The studies from developing countries report a DUP almost twice as long as that in developed countries; thus necessitating an action for early intervention[1]. An even more alarming trend reported in many studies is large number of cases which remain untreated for many years, often in inhuman condition. Malik and Bokharey[2] reported what they described as 'human zoo' for a group of patients which according to authors provided 'cure' for patients suffering from schizophrenia " chained to the trees in the open spaces around the shrine— through the chilly winter nights and the blazing heat of summers for days, months and at times for years".

Souza et al[3] identified 49 patients only in two months period in Darfur region of Sudan by active case findings. Some patients were in such dramatic situations as being chained to their beds. Srinavasan et al[4] describe a cohort of 72 never-treated chronic schizophrenia patents in Chennai, India. Similar untreated cohorts are rported from china and number of other devloping countries.

Almost all these studies report serious effects in term of psychological, physical and social outcomes. A common problem is high mortality. In rural China where very few patients received adequate treatment, untreated patients were found to have marked social and occupational disability and a fourfold increase in mortality[5,6].The high mortality reported in these studies is not due to suicide, the commonest cause of higher mortality in schizophrenia but due to malnutrition, infectious disease and other physical causes.

Ironically, number of these studies have focused on these patients as 'interesting' cases, in which details and manifestations of a chronic mental illness are examined in microscopic details without much attention to the challenges these cases pose for the service provision. Few isolated programmes have tried to address the need for provision of some treatment for these patients[2]. However there is need for more systematic and coherent approach in addressing the large gap in treatment these populations pose.

Lack of treatment for many years in patients suffering from Schizophrenia is related to many factors and there is little evidence for effective interventions to address this issue. Srinivasan et al[4] found that unemployed status of male patients, living in a joint family setting and families initially unaware of the psychiatric nature of the problem were the factors that related to failure to seek treatment. Patient's sex, age, education, marital status, economic status, age at onset and duration of illness, degree of disability and clinical symptoms (except self-neglect) were not related to taking treatment.

Cost of treatment is an important barrier. Medicines account for 20–60% of health spending in developing and transitional countries,[7] compared with 18% in countries of the Organisation for Economic Co-operation and Development[8]. Up to 90% of the population in developing countries purchase medicines through out-of-pocket payments,3 making medicines the largest family expenditure item after food. People with severe mental illness who have increased difficulty obtaining food, shelter and medical care[9]. are most vulnerable to these effects.

There is urgent need to devise effective public health interventions to improve the access to the pharmacological treatment for those suffering from Schizophrenia in developing countries. Isolated programmes in many countries have shown that it is possible to provide standardized regimen of antipsychotic treatment. However these programmes have rarely been replicated outside model programmes. An article in this issue[10] describes such an approach. It is interesting to note that the approach described in this article is based on principles of DOTS, an intervention originally proposed for Tuberculosis. Although TB has nothing in common with schizophrenia two disorders share some rather interesting historic facts. Tuberculosis is perhaps the only physical disorder which needed treatment in institutions like schizophrenia .The stigma associated with TB has

Correspondence:

Dr. Saeed Farooq, MCPS, FCPS. Associate Professor and Head Department of Psychiatry, PGMI, Lady Reading Hospital, Peshawar, Pakistan.
E-mail: sfarooqlrh@yahoo.com

been bad as we have today for Schizophrenia. However, implementation of an effective treatment at public health level changed the situation dramatically for Tuberculosis. The success story of Tuberculosis demonstrates that an effective interventions applied optimally at the public health level is the most effective way of reducing the stigma. Interestingly, since DOTS like treatment approach was suggested for Schizophrenia, it has been advocated for other Non Communicable Disease as well to overcome the problem of poor access to the treatment. At present it seems that any intervention for psychosis is the early intervention for this serious disorder in Low and Middle Income Countries (LAMIC). It is now time that early intervention for psychosis is considered as major public health priority in developing countries.

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