THE EXTENSION OF MENTAL HEALTH CARE IN KELANTAN

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INTRODUCTION

THE CARE OF psychiatric patients in the community is an integral part of the treatment and rehabilitation process. Unlike other illnesses where the transition from ill health to health is well recognised and the period is short, this transition in psychiatric illnesses, except in some instances, is prolonged. Psychiatric patients face a crucial period of readjustment on discharge and this readjustment (rehabilitation) is more difficult if the period in an institution has been long. Without going into these secondary handicaps well documented by Russel Barton (1960) and Erving Goffman (1961) the problems faced by psychiatric patients on discharge include those of daily living. Often they have lost their jobs and their positions in the family or village are altered, some to the point of total rejection. They have to face the social stigma and prejudice which are still present in our society.

Another handicap is the medication they receive which if not reviewed periodically contributes to drowsiness, lethargy or muscular dystonia. Psychiatric illness in most cases needs relatively prolonged follow-up and this poses problems of continuing treatment in the community, least of which is the availability of trained staff to follow them up especially in areas not served by hospitals.

In this light, psychiatrists and others have been advocating the decentralisation of services and establishment of Psychiatric Departments in General Hospitals instead of big (often with thousands of patients) institutions as in the past. These Psychiatric Departments will function to bring prompt management of psychiatric illnesses in the community where it is needed. A step beyond the Psychiatric Departments in General Hospitals has been taken in some countries to render service in rural communities without hospitals by trained medical and paramedical staff. The W.H.O. is coordinating this effort in seven countries in its Collaborative Study on the Extension of Mental Health Care. This study extends from 1975 to 1980. The scope of this Study is to determine the feasibility of introducing basic metal health care in developing countries, to select priorities for interventions, to develop methods of task orientated training for health workers, to stimulte the community's understanding of and response to problems related to mental disorders and to research on alternative and low cost methods of mental health care (W.H.O. Protocol 1978).

The efforts of the Psychiatric Department in the General Hospital, Kota Bharu from March 1977 to May 1978 is reported here.

BACKGROUND

The Psychiatric Department in Kota Bharu is also the Regional Mental Health Centre for the east coast states. There are 116 beds staffed by medical officers, social workers, nursing staff and for the majority of the period under study there were three psychiatrists of whom one was the Consultant. The effective coverage was the whole of Kelantan and the northern part of Trengganu comprising of about one million people, the majority living in rural areas. There was a twenty-bed ward in Kuala Trengganu which was visited by the Consultant. The 116 bed wards in Kota Bharu were run as an acute unit with only a few long-stay patients and since 1975, no cases had been transferred to the long-stay institution at Hospital Permai, Johore.

Overcrowding in the psychiatric wards was a constant feature and at times in the male acute ward occupancy was over 200 per cent.

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Attempts had been continuously made to discharge patients but numerous difficulties were encountered. Relatives could not be contacted or did not come to fetch patients home. Motivation for relatives to take home patients and care for them was poor as they either felt the patients were still unwell or afraid of the patients at home. Patients discharged were readmitted within a short period for reasons often of a non-clinical nature. Hence there was a revolving door process of discharges and early readmissions. More discharges led to more readmissions.

The Psychiatric Department was conducting out-patient services in five peripheral centres at Health Centres in Tumpat, Pasir Mas, Pasir Putih, Macang and Tanah Merah. These clinics were twelve to thirty-five miles distant and were held monthly or fortnightly. These were only for follow-ups and conducted by a psychiatric trained hospital assistant. The staff at the Health Centres was not involved and no case finding or management of new cases were carried out.

The purpose of these clinics was multifold. It brought follow-up care closer to the patient and ease the burden of travelling and finance. It enabled patients or relatives to save time to continue follow-up. One reason for default was that they could not afford the time to travel as they had to work. It provided a link between the Psychiatric Department and the patient and was an attempt at continuing care in the community. On these sound principles the clinics should be well attended and readmissions reduced or more widely spaced. Yet this was not so. Default of follow-up was high and readmission was high as was shown by the annual increase of readmissions.

REAPPRAISAL

A reappraisal was made into the existing service in March 1977 with the view of enhancing the effectiveness of the service. This reappraisal was made on the ward service, peripheral clinic services and the inter-relation between the two.

One problem affecting both services was the lack of hospital transport for the Social Worker and peripheral clinic staff. A Social Worker's effectiveness is seriously curtailed if he is unable to visit patients' homes and relatives. The wards were overcrowded and put severe strain on physical and rehabilitative facilities and taxed the nursing capacity of the staff. Less obvious difficulties were staff morale and training and effective team-work. This was not due to lack of willingness to contribute and cooperate but due to overcrowded wards and frequent changes of staff.

The peripheral clinics were continuing medication for discharged patients but there was no attempt in meaningful involvement of the family in the patient's care or treatment of fresh cases. This was strongly felt in the area of the rapport established between staff in the hospital and relatives of patients. This rapport and trust in the staff could be established at the peripheral clinic but was not possible because of the widely-spaced visits of the hospital assistant.

The peripheral clinics were functioning as an extension of the Psychiatric Department deploying staff from the department. The Health Centre staff was not an integral part of the system. In this respect the attempt at decentralisation of service utlising local staff was ineffective. The advantages of local staff treating and managing cases are many. They live in and are part of the community. They are available to provide care daily instead of periodically. They could give immediate care for acute cases or relapses instead of the patients having to travel for miles. The establishment of rapport and trust in the ability of local staff will enhance the acceptance of mental health care locally.

INTERVENTIONS

A series of interventions were planned and carried out in stages. The interventions were closer cooperation of Department staff in patient care through weekly conjoint staff meetings, active occupational and recreational therapy as part of social rehabilitation, wider and more intensive utilisation of the social workers and involvement of them in patient care, closer initial supervision of peripheral clinics by the psychiatrists, to solve transport problem, staff training for the Department and peripheral clinics (Health Centre staff), the shift of discharged patient care from the Department to Health Centre doctors after training.

Conjoint staff meetings were initiated and held weekly to discuss all cases for discharge and

"problem cases". These were attended by doctors, nursing staff, occupational therapist, social workers and the peripheral clinic hospital assistant. A team approach was used towards patient care from contributions from all categories of staff. The social workers' reports were now available to all staff instead of the doctors only. The social workers in turn were able to share the experience of the nurses on patient behaviour and interaction in the wards. This team approach gave a clearer understanding of management procedures and of interdependent staff roles.

Simultaneously, a more active occupational and rehabilitative programme was instituted and the time the patient spent doing nothing was reduced. Auxillary staff was increased in this area.

The social workers were more extensively utilised as the transport problem was solved with the coooperation from the Medical Superintendent of the General Hospital. Home visits to contact relatives, to prepare social case reports, to send discharged patients home and to follow-up defaulting patients were intensified. There was more contact between doctors and relatives as a result. Doctors now had an opportunity to discuss with the relatives the patients' illnesses and plans for rehabilitation. A conscious attempt was made to impress on the relatives the continuity of care by the peripheral clinics. Particular attention was directed towards changing attitudes of relatives of patients towards mental health in general and attempts were made to clarify their doubts and fears.

Staff training was vital if they were to be involved more extensively. For some staff, the training was a refresher, for others it was a new experience. Lectures were held after office hours and attendence was voluntary. A systematic training programme for doctors from Health Centres was held to train them in community aspects of psychiatry and in early diagnosis, treatment and for follow-up. A two week course was held for doctors from the three East Coast States including Kelantan. This course was held twice within the year. In all fourteen doctors were trained.

In the beginning of this study period the psychiatrists started more frequent supervision of follow-up in the peripheral clinics. This frequency of supervision was reduced when the Department trained doctors took over in running these clinics. The scope of care was widened to include treatment of fresh cases in the clinics without referral to the Department. Towards the final stage of the study, the doctors at these Health Centres were operating independently in management of psychiatric cases but with opportunity for referral and discussion of difficult cases with the Department.

RESULTS

One outcome of these interventions was the reduced rate of daily occupancy of the wards (Figures 1 and 2). Readmissions which used to occur within weeks or even days of discharge were spaced out. Unlike past experience increased discharges did not bring about increased immediate readmissions after the interventions. The noisy and hectic environment in the wards was improved and the need for early quick discharges was eleviated. One pre-discharge ward could even be converted to a drug detoxification ward without any overcrowding in other wards. Working condition was improved with less patients.

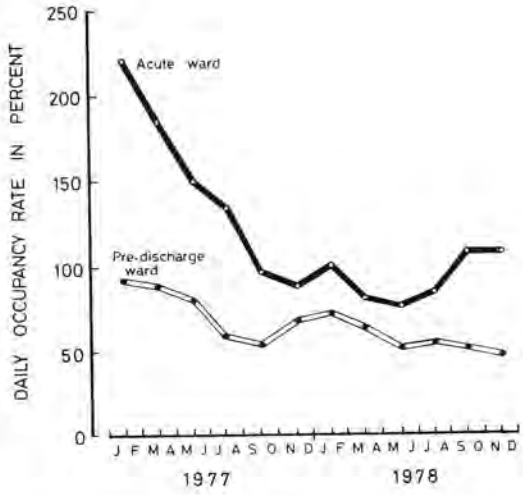

Fig. 1. Bi-monthly average daily occupancy rate of the acute and pre-discharge male wards from 1977 to 1978.

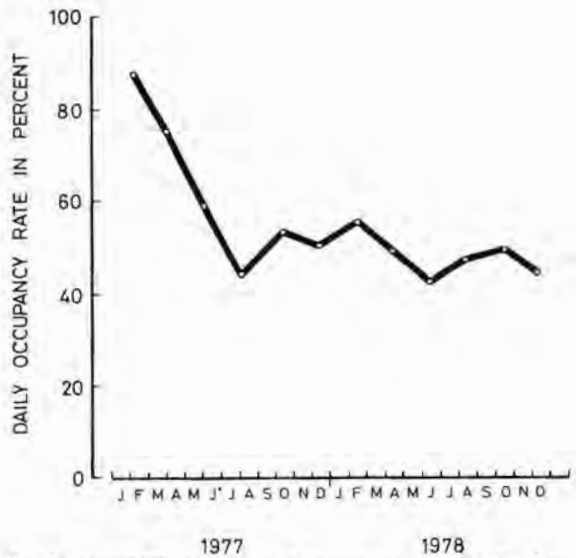

Fig. 2. Bi-monthly average daily occupancy rate of the female ward from 1977 to 1978.

The peripheral clinics took on an identity and function of their own in being independent units for early diagnosis, treatment and prevention. The number of patients treated and number of visits increased (Table I). Though no study was made of pre-intervention as against post-intervention morbidity, it could be expected that the districts covered by these clinics would eventually have reduced morbidity. More fresh cases which had previously remained untreated were detected.

Table 1
Number of cases treated at peripheral psychiatric clinics in Kelantan

	1976	1977	1978
Machang	592	795	829
Pasir Mas	565	757	871
Pasir Puteh	479	614	710
Tanah Merah	240	407	520
Tumpat	176	273	312
Total	2,052	2,846	3,242

DISCUSSION

This study was a planned course of extension of psychiatric care into the rural areas by utilising doctors in the Health Centres and with coordination with the Psychiatric Department in the General Hospital. It was also a study of social rehabilitation in the inpatient wards.

The Expert Committee on the Organisation of Mental Health Services in Developing Countries (W.H.O. 1975) had advocated the need for planned decentralisation of psychiatric services and the advocation of circumscribed training of paramedicals in the treatment of psychiatric illnesses. In India Murthy and Wig (1978) and in Columbia Climent *et al.* (1978) showed the feasibility of training paramedical staff in rural areas to treat psychiatric illness with a limited range of drugs. In this study the doctors were trained instead as it was felt that as under the present system of care they were already treating all illnesses, they should be managing psychiatric illnesses as well, as this would fit in line with their functions. The need for training of paramedical staff at sub-health centres, where there are no resident doctors, could be assessed.

This study attempts to show that with concerted efforts and a planned course of interventions, patients could be effectually maintained in the comunity with treatment continued by trained local medical staff with coordination from Psychiatric Department of a General Hospital. Discharges have to be planned and coordinated as unplanned discharges brought on increased readmissions and morbidity, not only to patients, but their relatives too. Social rehabilitation in the wards have been shown to increase staff morale and patients' motivation for discharges (Brown and Wing 1970). The increase of fresh cases coming for treatment could be interpreted as the acceptance of psychiatric care by the community which had previously depended on traditional healers. The extension of mental health care to the rural areas is feasible but needs coordinated planning with administrators, social scientists and other professionals if it is to be implemented on a large scale effectively.

SUMMARY

A series of systematic interventions in the Psychiatric Department, General Hospital, Kota Bharu and the extension and improvement of provision for mental health care in the Districts were carried out. As part of the extension programme, medical officers in the Districts were trained in the Department to provide care in the

Districts. These interventions and extension of care contributed to the maintenance of discharged psychiatric patients in the community, the reduction in the frequency of readmissions and the reduction in the daily occupancy rates of the psychiatric wards. Early detection and treatment of cases in the community resulted in the increase of new cases.

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