A COMMUNITY CHILD AND ADOLESCENT GUIDANCE CLINIC IN MALAYSIA

W. KRAHL

S.L. QUEK

N. RAMAN

INTRODUCTION

In conjunction with the International Year of the Child, the Child and Adolescent Guidance Clinic (CAGC) was started in Ipoh in May, 1979 as an extension of the community mental health programme in Hospital Bahagia. This CAGC is probably the first of its kind in Malaysia within the community. The University Hospital in Kuala Lumpur also provides a Child and Adolescent guidance service but in a hospital setting (Woon, 1979).

The clinic was started and is being run by the staff of Hospital Bahagia, the biggest mental hospital in the country with two thousand three hundred patients. The hospital itself is situated fifteen kilometers away from Ipoh, a town of 250,000 inhabitants mainly of Chinese origin. The name of Hospital Bahagia in the small town of Tanjong Rambutan is still rather stigmatising to the patients and so the clinic was started in Ipoh. Another reason was that a place in Ipoh is more easily accessible.

The local St. John's Ambulance Society provided two rooms in its premises partitioned in such a way that they can be used for other functions as well. The clinic is run at the moment on a part time basis on two afternoons a week. The team of the CAGC consists of a consultant psychiatrist, a clinical psychologist, three psychiatric trained nurses and two social workers. The staff concerned also has other commitments within the hospital, therefore only the required staff goes to the CAGC.

Since it was the first CAGC of its kind in Malaysia a lot had to be learnt through experience. In trying to adapt to suit local conditions, development of the clinic was done slowly. The CAGC works on an appointment basis. Referrals are from different sources like hospitals, general practitioners, schools, and social welfare officers. All referrals go through Hospital Bahagia where appointments are given. In contrast to CAGCs in the West where often waiting lists may stretch up to half a year, patients are seen here within one to two weeks or immediately if necessary. Children and adolescents up to the age of nineteen years are accepted in the clinic. Due to limitation of time, staff and financial resources, so far only forty cases have been at the clinic. The clinical classification of the cases are as in Table I.

AGE AND SEX DISTRIBUTION

Roughly half the children belong to either sex. There were 22 boys and 18 girls. Eighty percent fall in the school going age between six to fifteen years (Table II).

ETHNIC DISTRIBUTION

The ethnic distribution of the children seen, roughly represents the ethnic distribution of Ipoh and its surrounding (Table III).

SOCIOECONOMIC STATUS

The classification of the socioeconomic status is based on the Registrar General, England and Wales, 1958. The distribution indicates that the CAGC in the community setting does not attract only the upper and middle classes but also a large proportion of the lower social class (Table IV).

W.Krahl, Dr. Med., Dipl. Psych.

S.L. Quek, MBBS (S'pore) DPM (Eng) MRCPsych (U.K.) M.R.A.N.Z.C.P.

N.Raman, MBBS (Mal) MPM (Mal)

Hospital Bahagia, Ulu Kinta, Perak.

TABLE I
CLINICAL CLASSIFICATION OF CASES SEEN

Normal variation	5
Neurotic disorders	
Obsessive-compulsive	1
Hysteria	2
Depression	1
School Phobia	2
Anorexia nervosa	1
Conduct disorders	
Conduct disorders	1
Mental retardation with behavioural problem	8
Psychosis	
Schizophrenia	4
Development disorders	
Food refusal	1
Enuresis	3
Miscellaneous	
Legal (post traumatic)	1
Battered child	1
Adjustment reaction	2
Epilepsy with behavioural problems	3
Psychosomatic	2
Hyperkinetic disorders	2
Total Number	40

THERAPEUTIC APPROACH

Almost all the children brought to the clinic had already been seen and treated either by general practitioners, especially those belonging to social class I and II or by native healers like sinsehs, temple mediums and bomohs. Approximately ninety percent of social classes III to V had tried to get help from traditional healers.

TABLE II
AGE DISTRIBUTION

Age in years	No.	%
0 — 5	1	2.5
6 — 10	16	40.0
11 — 15	16	40.0
16 — 20	7	17.5
Total	40	100

TABLE III
ETHNIC DISTRIBUTION

Ethnic Group	No	%
Chinese	23	57.5
Malays	11	27.5
Indians	6	15.0
Total	40	100

The therapeutic approach here is eclectic using different clinical techniques if required (Wong, 1979). Behaviourally oriented techniques have often been adopted. Since the child is with the parents for 168 hours a week whereas he spends at the most one to two hours at the clinic, and since the parents' behaviour is often the source of the child's problem, the parents are considered to be an important factor in therapy (Spiel, 1976). Depending on the problem, attempts are made to work more with the parents to create an insight in them as to why the child is showing a certain behaviour, how they should react and if possible to train them as therapists. It becomes a necessity when parents are so poor that they cannot afford to come to the clinic once a week.Psychotherapy is offered in the form of play therapy. Medication is used only in a few indicated cases. Placebos were used in some cases because the parents expected some kind of medication and were willing to come to the clinic only if medication was provided. In general close work is done with the children's school and teachers and if necessary the teacher is also involved in the therapy. It is a problem if a child needs admission because the Children's Ward in Hospital Bahagia is meant for the grossly retarded children and not for school children with psychiatric problems. If admission is unavoidable, the child is sent to a ward in Hospital Bahagia where the staff patient ratio is the best. An activity club is available one morning a week for male adolescents. The boys in this group mostly comprise those with schizophrenic symptoms. So far the results of the activity club have been encouraging. The treatment of each child is reviewed in team meetings and if necessary changed.

Some psychological tests used if necessary are Vineland social maturity scale, Raven's colored and advanced progressive matrices, Goodenough draw-a-man test, sentence completion test and Wechsler Intelligence scale for children.

TABLE IV
SOCIOECONOMIC STATUS

Social class	No:	%
I Professional (doctors, lawyers, engineers)	6	15
II Managerial (teachers, owners of small business)	4	10
III Skilled workers (foreman, clerks, sales workers)	14	35
IV Semiskilled workers (factory operatives, agricultural workers)	11	27.5
V Unskilled workers (domestic servants, casual workers)	5	12.5
Total	40	100

PROBLEMS ENCOUNTERED

Language

Malaysia being a multiracial country has three main languages and within a language like Chinese, there are a number of dialects. Although this problem is overcome with a multiracial team, the problem is encountered during the play therapy and during the activity club where there are problems of verbal communication between the children.

Lack of a proper place

The St. John's Ambulance premises are given free and sometimes programmes of their own interfere with ours. Furthermore, modification of the place cannot be made on premises. We are in the process of getting a more ideal setting in the municipal child and health clinic which is also based in a community setting.

Lack of full-time staff for the CAGC

This is a problem faced by all developing countries and efforts are being made for training the various categories of staff.

Poor socioeconomic status of some parents that affects optimum mental health care for children

Although the clinic is in a community setting, yet we see some parents who are too poor to come as often as would be needed. Many parents being daily rated workers find it difficult to attend clinics regularly without having to take leave and thus lose a days wage. For others even the bus fare is a financial burden. We find it difficult to solve this problem.

Stigma attached to mental illness and associated psychological problems

The stigma attached to mental illness is still very strong. But this is partly resolved by having the clinic in a community setting.

Expectations of instantaneous recovery

This is especially so with the lower social class, where instantaneous cure is expected with pills, "machines" or operations. For this reason our first line of management is sometimes symptom orientated. For example, Tofranil or Bell and Pad are used for enuresis while the attendant psychological problems are worked through. Some parents also do not see play and counselling as means of therapy.

Shortage of referral agencies

Until now it had been a problem for us to refer to remedial classes or special schools but recently the Ministry of Education has started to set up such schools. The problem of foster homes is still unsolved but hopefully with further community involvement this problem can be overcome.

Our future plans are to move into new premises and to work in close association with the Ministries of Health, Welfare and Education to provide services in a more ideal setting.

ACKNOWLEDGEMENT

We would like to thank Haji Dr. Abdul Talib b. Latiff, Director General of Health, for his kind permission to publish this article. Our thanks are also due to Miss Lalitha Kandiah for typing the script.

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