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A PILOT STUDY OF MENTAL HEALTH INTERVENTION PROGRAMME IN PRIMARY HEALTH CARE IN TWO DISTRICTS OF KELANTAN

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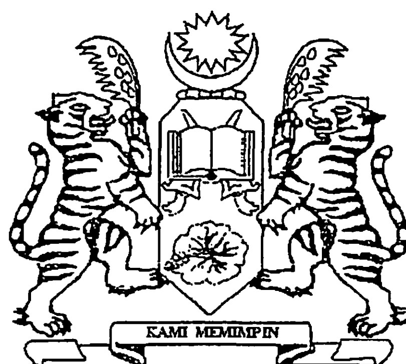

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School of Medical Sciences
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INTRODUCTION

Community, according to Le Bon [Dennis 1958], is one of those words which are 'uttered with solemnity, and as soon as they are pronounced an expression is visible on every countenance and all heads are bowed'. Some have also felt that the concept has a moral imperative [Hawks 1975], while yet others see it as a popular device to conceal various confusions and contradictions [Pinker 1982] or as a code word to embrace all good work. Titmuss [1963] expressed a similar view, seeing the 'statutory magic and comforting appellation' of community care as pulling the wool over our own and other people's eyes.

'Community' has also been employed to refer to the 'community mental hospital', which would not only provide in-patient facilities but develop out-patient services within the community it served [WHO 1953], as well as to the 'therapeutic community', consisting of a 'dynamic', non-institutional forms of psychiatric care [Hinshelwood & Manning 1979].

Finally, there is a very useful definition of community psychiatry by Sabshin [1966] - 'the utilization of the techniques, methods and theories of social-psychiatry and other behavioral sciences to investigate and meet the mental health needs of a functionally or geographically defined population over a significant period of time, and the feeding back of information to modify the central body of social psychiatric and other be-

havioural science knowledge'. This was contrasted with the public health model, particularly as advocated by Caplan [1964], which saw community psychiatry as being primarily concerned with applying techniques of prevention, at different levels, and with achieving such vague aims as 'positive mental health'. In the USA, the development of comprehensive community mental health centres was strongly influenced by Caplan's views and started with the assumption that these facilities could prevent psychiatric illness, promote health, and improve the general quality of life. Such ambitious aims were not achieved, though most outpatient care continued to be provided by private practitioners, while the centres made a disappointing contribution to the major problems of chronic psychosis and dementia.

The history of community psychiatry and of the community mental health movements has roots that go back to the 18th century,when the French psychiatrist Phillipe Pinel removed the chains from psychiatric patients,and to the 19th century, when the school of moral treatment in the United States stressed a humane and rehabilitative approach to the mentally ill. Also playing a role were Dorothea Lynde Dix, who worked to better the lot of the mentally ill in the mid-19th century, and Clifford Beers, founder of the Mental Health Association, who in 1905 published ' A Mind That Found Itself', a description of his experiences as a mental hospital patient that has become a classic text.

Community psychiatry in the late 1980's is far different

from the much publicized and much critisized community psychiatry of the 1960's. Community psychiatry of the 1960's generally neglected the chronically mentally ill and instead focussed on less sick patients,primary prevention and community activism in efforts to change basic fabric of society. This gave rise to criticisms such as that community psychiatry "has branched out well beyond mental illness into problems that it is not especially qualified to handle such as community, national and international affairs,. poverty, politics and criminality. In each areas, we have responsibilities as citizens and human beings; we have yet to demonstrate the competence of psychiatrists [Kety 1974]. Moreover, problems such as homeless mental ill have demonstrated the major problems in the way of deinstitutionalization, problems for which the community psychiatry of past decades has to share the blame. Modern day community psychiatry generally recognizes that the chronically mentally ill should be given the highest priority in public mental health efforts. Primary prevention has been brought into perspective; research is encouraged but large scale service programmes with little evidence for their efficacy have been curtailed.

'Community' is, therefore, a term which can be attached to treatment outside hospital walls, to treatment in the hospital itself, to the work of clinicians outside the hospital, to the public health approach and to prevention [Acheson 1985]. At the present time, it seems to have most meaning as a way of working in which professional, patient, and their families or other supporters from new partnerships and use those services which

anyone uses.

DISTRICT PSYCHIATRY

Psychiatry, which ought to concern itself with whole communities rather than with individual patients alone, therefore needs to be aware of the social structures of these communities and with their environments. Those psychiatrists who have a district responsibility will have the opportunity to become very familiar with living conditions in their territory, and may well wish to intervene when overcrowding or high-rise accommodation, for instance, seem to be affecting people adversely, though there have been few instances of this happening in practice. Within each community, the pattern of social networks - a factor first clearly analysed by Bott [1957] - seems to be relevant to many psychiatric disorder, particularly non-psychotic conditions. Deficiencies in the social environment are a well established consequence of being mentally ill, while some of the increased prevalence of neurotic morbidity observed, e.g. in the lowest social class may be partly explained by deficiencies of social bonds [Henderson 1980]. However, determining which of these elements is primary, or whether a third leads to both, is a problem on which research still continues. The relationship of psychiatric disorder to social factors is extremely complex and not only may different social factors be important in different diseases, but the same social factors may operate differently in separate conditions. Jones [1988] has pointed out the illogicality whereby 'society' is blamed for being at the root of psychiatric disorders, yet when redefined as 'the community', is sup-

posed to be the healing matrix within which these problems are best managed. Furthermore, the virtues of communities were being discovered just around the time when social and cultural changes were causing them to break up and lose their cohesion in many cases - for instance; the long established working-class communities of the north of England, which were mostly bulldozed out of existance around the 1960s.

District psychiatry though, is a concept which has not developed on a theoretical basis such as that of social networks or psychodynamics, but rather through pragmatic action, and it has been mainly studied from the viewpoint of social administration. Among the professional staff involved, it has required psychiatrists particularly to step out of their traditional clinical role in certain respects, and to intervene as 'the professional in the community care context is a facilitator, coordinator, and integrator' [Mechanic 1989]. The character of district psychiatry has been strongly influenced until now by the relationship between primary medical care and specialist services within the NHS; overall, the most common reason for referral by a GP to a psychiatrist is failure of the patient to respond to the GP's initial treatment - which is usually medication. One of the commonest forms of activity developed by psychiatists in district services is that of regular visits to primary health centres, where consultations can be held with the care team and patients be seen nearer to their homes. In some cases, but by no means all, a useful dialogue develops between specialist and primary care staff as a result of this regular contact [Strathdee & Wil-

liams 1984]. However, since the most common pathway to specialist psychiatric care up to now has been referral by a GP to a psychiatrist for a medical consultation, the trend to multidisciplinary teamwork in mental health services - where initial contact might be with a member of one of several professions - will require some rethinking of these accustomed methods.

Though mental and physical health are closely related, facilities for the mentally ill throughout the world have been segregated into a separate category for as long as they have existed. This category has always been an inferior one in respect of status, resources, and the stigmatisation of its patients, whatever may be the advantages of specialisation of experience or of the more extensive space of mental compared with general hospitals. Psychiatric services everywhere have mostly been ill-co-ordinated with the overall pattern of medical and social care, and often fragmented within themselves so that, for instance, the staffs of mental hospitals have no responsibility for patients outside - a situation still to be found in many parts of Europe. One further factor that has usually distinguished psychiatric from general hospitals is some form of geographically defined responsibility, resulting from mental hospitals being provided by a level of government which did not accept any financial reponsibilities outside its political boundaries.

Related to these issues, concerning the introduction of new community-based services, is the need to ensure that treatments are targeted at those most in need, and that facilities are

located in close geographical proximity to the residential location of the target client group. This implies some knowledge of the distribution of disease within the target population, which in turn rests on the ability to identify population characteristics that either predict need or are correlated with service utilisation. It is important to distinguish between problems of given areas of the population on the one hand, and the services provided on the other, as well as obtaining independent measures of both, since they may bear only a weak correlation to one another.

Whether or not community-based services promote advantages over hospital-based services, other than the prevention of 'secondary' handicaps due to 'institutionalisation', remains a moot issue, championed perhaps most eloquently by Mosher [1983], who concluded from a review of the American experience that such care is cheaper and more effective than hospital admission. He suggested that the failure of community psychiatry to command greater respect lies largely at the feet of psychiatrists, who collude with sociaty to keep patients 'out of sight' and attain greater financial rewards through inpatient care. However, Tantam [1985] has pointed to number of issues which cast doubt on these advantages as being as great as were suggested in the United States, let alone in Britain. First, in many of the studies quoted, the patients in the experimental groups (i.e. receiving community-based care) reported fewer symptoms than their hospitalised control. Prominent advantages were largely confined to the amount of time living in care or in sheltered employment and the extent

of subsequent readmissions or contact with casualty departments - an observation which may reflect the more assiduous follow-up of the experimental patients. On the whole, these studies suggest that hospital admission remains necessary for some patients, and it is likely that consumer satisfaction would be as great in these cases if attention to after-care and support on discharge was as intensive as was evident for the experimental groups. Finally, on the issue of costs, intensive community programmes may cost more in financial terms than hospitalization [Weisbrod et al 1980] and may carry some increased risk to a patient's safety [Weisbrod et al 1980, Esroff 1981], although the latter remains a moot point [Stein & Test 1980, Grad & Sainsbury 1968].

The development of effective community-based services for psychiatric disorder depends largely on the intelligent interpretation of research findings concerning the distribution and course of disorder in the general population, where such services are aimed.

Community psychiatry will continue to face an uphill task; in this struggle, it will need to base growth on sound empirical evidence, to plan and develop services for the populations and the demographic areas which most need them, and avoid, at all costs, a voluntary amputation of this far reaching limb from the body which constitutes comprehensive psychiatric care.

Caplan and Caplan(1967) proposed a number of community psychiatry "principles". These principles have proven to be

useful and valid, although only to varying degrees, and have undergone considerable rethinking and change in the succeeding decades.

Responsibility to a Population

The concept of a catchment area, that is, a community mental health centre taking responsibility for a total population in a geographic area, has great appeal. Theoretically, a community mental health centre would identify all the mental health needs of its catchment area, formulate a plan to meet these needs, and provide services based not on the staff's preferences with regard to the kind of mental health activity in which it wants to engage, but rather on the actual needs of the population. These needs would be determined by both citizens and staff and would take into account the cultural backgrounds of the population.

The catchment area concept has worked well where the catchment area includes a discrete area, both politically and geographically. There have, however, been many problems when this concept has been used in large metropolitan or sparsely populated rural areas. In metropolitan areas, the boundaries are often artificial, and where boundaries rigidly adhered to, persons moving from one part of a city to another find themselves transferred to a whole new treatment system. Thus, continuity of care is interrupted and patients and staff have to begin anew the process of getting to know each each other. Many patients, especially the chronically mentally ill, do not or cannot make his

transition and become lost to treatment. The catchment area may not reflect political boundries and natural communities and as result may have difficulty serving its population. There have been problems where federal officials have required each community mental health center to provide the whole array of services or run the risk of being denied funding (President's Commission on Mental Health 1978).

In rural areas, a minimum population of 75,000 may result in a catchment area so large geographically that great distances make the rational provision of services unwieldy.

Treatment Close to the Patient's Home

As has already been mentioned, the principle of having treatment available close to patients' homes grew out of, at least in part, the military experience. Clearly, proximity facilitates the patient's and his or her family's utilizing that treatment. Sending patients to a hospital far from home severs the patients' connections with their community and their families and discourages the families' involvement in treatment .

Rural Areas

It is now generally held that the risk of psychiatric illness are at least as great in rural places and that rural individuals tend to be exposed to a variety of stressors which can result in a need for psychiatric care (President's Commission on

Mental Health 1978). Physical isolation, low levels of education, inadequate funding, and ignorance of psychiatric problems and of techniques for addressing them further inhibit optimal psychiatric service utilization. Thus, rural populations in the United States are considered to have a substantial need for, but generally poor access to, psychiatric services (Bachrach 1983).

In terms of space, the sheer dimensions of rural service areas can be overwhelming. Most rural mental health catchment areas, for example, exceed 5,000 square miles. The largest mental health catchment area in the United States, located in Arizona, consists of 60,000 square miles. In conjunction with conditions of physical isolation, low population density, a limited tax base, and personnel shortages, space may create major barriers to providing care.

The urban bias is general in health and human services planning. Thus, Wylie (1976) states, "Social planners are urban-natured. Most live in metropolitan areas and their theoretical convictions and questions derive from a planning literature that is almost wholly drawn from the urban scene. The concept of designing mental health catchment areas consisting of 75,000 to 200,00 people is strictly an urban notion. To include populations that large in a service area in most of rural America usually means ignoring natural and social boundaries and planning for jurisdictions so large geographically that they thwart realistic programme planning.

Working in rural areas can present many problems for psychiatrists and other mental health professionals. They may have to provide a variety of services and thus be service generalists. They may be cultural outsiders,and that, together with the fact that they are mental health professionals, may make them suspect in the local community. They may experience professional isolation with the problems of lack of peer support and lack of ability to learn from fellow mental health professionals. Further, rural service agencies tend to be understaffed, and as a result work loads may be excessive. All of these personnel issues can combine to cause job dissatisfaction and staff burnout.

There are also advantages in rural areas. The rural sense of community may provode a potential source of support for mental health efforts that is rarely found in urban areas. Tolerance of

deviance may also be greater. There must, of course, be sensitivity to the local culture, but the rural social organization, when properly utilized, may well be an advantage in the delivery of psychiatric services (Bachrach 1983). The seriously ill psychiatric patient may have high visibility in a rural area, but this has the advantage of causing these patients to get help sooner than they might in a more anonymous urban culture. Moreover, rural psychiatrists may learn about their patients in the normal course of conversation and everyday life in a rural community.

Prevention

Proven techniques in psychiatry have been shown to be extremely effective in preventing many a psychiatric illnessess. Psychiatric complications of syphilis and vitamin deficiency are seldom seen today in developed nations. Decreased rates of birth injury and improved prenatal care have lowered the incidence of major psychiatric problems that result from congenital brain damage. Other common neuro-psychiatric disorders such as stroke and head injury have been shown to be highly preventable. Elimination of lead from house paint has reduced the number of children suffering from organic brain syndromes, and control of industrial toxins has virtually eliminated "mad hatters" and other such problems.

There are newer preventive programs that should also reduce the incidence of certain illness. For instance, counselling pros-

pective mothers not to delay pregnancy until the later childbearing years is likely to reduce the incidence of mongolism. Other programs show promise but await solid research findings demonstrating their effectiveness. Interventions directed toward abusing parents, such as Parents Anonymous, seem likely to prove effective in breaking the cycle of child abuse, which has been shown to be socially transmitted from generation to generation. Raising infants in impersonal institutions or without a consistent mother figure over a long period of time has been demonstrated to be deleterious. Programs to replace institutions for homeless children with long term, high-quality foster care or adoption should help to prevent personality disturbance. With the mounting evidence of genetic influence on the occurrence of schizophrenia and manic-depressive psychosis, the appropriate use birth control and genetic counselling should be effective in preventing the births of individuals who would be at high risk for development of these illnesses.

Attention is required, not only to basic survey information, but also to the development of systems of monitoring current therapeutic activities, and to devising quantifiable measures of the more comlex concepts of medical, social, and personal 'needs', 'demands', and ultimately 'costs'. Partly through lack of foresight, partly as a consequence of inadequate support for research monitoring of clinical activities, many of our current systems of health care remain essentially articles of faith. Unfortunately, clinical and research practices are too often viewed as inherently incompatible. The setting up of novel treat-

ments with ill-defined goals, based on inadequate scientific information and too little information about how these goals can reasonably be achieved, is surely sufficient recipe for disaster; yet if this were not enough, such innovatory schemes are threatened from other quarters as well. The failure to intergrate such new services with existing clinical practice may have contributed to the fall in popularity of community mental health centres in the USA; failures to serve the needs of the chronically ill, a selective bias towards 'less severe' disorders, and isolation from the mainstream of psychiatry have made them both unpopular with psychiatrists and ineffective in preventing admission to state hospitals or in implementing the sort of crisis intervention programmes that were the reason behind their creation [Fink & Weinstein 1979, Mollica 1980, Donovan 1980].

The amount and type of emotional disorder occuring in primary care has been a topic of increasing interest in recent years [Goldberg et al 1976]. Studies using inventories that screen for psychiatric disorders as a group have established prevalence rates ranging from 16% to 43% of practice attendees [Goldberg & Blackwell 1970]. Other studies using inventories to assess depression,the most common psychiatric condition in primary care,have found prevalence rates of 12% to 48%, with the wide range reflecting the level of depressive symptomatology chosen as significant,as well as possible differences in the practice populations [Nelson & Williams 1980;Barnes & Prosen 1984].

Relatively few studies have examined the prevalence of specific disorders in primary care. Before the 1970's the unreliability of psychiatric diagnosis and the absence of systematic assessment methods were formidable obstacles to obtaining such a data in a meaningful fashion. With the development of psychiatric classification system with established reliability for individual disorders,such as the ResearcH Diagnostic Criteria [Sptizer et al 1975], DSM-III [APA 1980] and ICD-10 [WHO 1992] accurate determination of the amount and type of specific disorders became possible. Prevalence rates for individual disorders were obtained ranging from 5.8% for major depression and phobic disorders to 1.6% for generalized anxiety disorder. The established prevalence for all RDC disorders was 26.7% fo practice attenders [Hoeper et al 1979]. Other common disorders were alcohol abuse 8.2%; other substance abuse,7.1%; and phobic disorders,6.8%. For a Baltimore teaching hospital out-patient clinic Von Korff et al [1987] using a two stage assessment,determined the prevalence of specific disorders using the DIS to be 8.5% for any anxiety or depressive disorder and 25.0% for any psychiatric disorder. These studies are the only ones in print that have reported prevalence data for specific disorders for a representative sample of primary care attendees.

Recent studies have demonstrated a high prevalence of mental disorders among patients of primary care providers in the United States. Earlier studies estimated that between 15% and 20% of primary care patients have a diagnosable disorder,and more recent work suggests that approximately 30% of primary care patients

using services within a year have a diagnosable psychaitric disorder,most of which are mainly affective,such as the depressive disorders [Goldsberg 1979]. It has also been demonstrated that primary care practioners in the US are exposed to the full spectrum of psychiatric disorders, acute as well as chronic disorders, severe cases as well as mild. These studies and others [Hoeper et al 1979; Shepherd et al 1966; Stumbo et al 1982] have shown that general medical practitioners generally under-report such illnessess. Of what consequences in this ? If those illnessess are predominantly minor and transient in nature, it might seem less critical than if physicans were neglecting to record major disorders. To address this issue, studies following up patients over time with multiple assessments are necessary.

There is much evidence to show that only a proportion of patients with significant psychiatric disorder who present themselves to their general practitioner are recognized as such: the 'hidden psychiatric morbidity' [Goldberg & Blackwell 1970]. Goldberg and his colleagues [1982] have shown that this misidentification, or misclassification, can be thought of as consisting in two components: bias (an individual doctors consistent tendency to make or avoid making a psychiatric diagnosis); and accuracy (the extent to which the GP's assessment of psychiatric disorder concurs either with the patient's own assessment or with an independent psychiatric assessment). There is evidence that bias is largely determined by factors such as the personality, attitudes and experience of the GP, whereas accuracy correlates with his behaviour during the consultation [Goldberg & Huxley

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1980]. Among the issues discussed, two concerns seem to be most pressing: first,too many individuals with mental disorders do not seek treatment,and; secondly of those that do seek treatment, a majority do not procure services from mental health professionals. Regier[1982] noted that about 20% of the estimated 32 million persons with mental disorders do not obtain any care, another 60% seek help from primary health professionals. In the Epidemiological Catchment Area study, Shapiro et al [1984] found that only between 24% and 38% of all ambulatory visits by persons with Diagnostic Interview Schedule disorders were to mental health professionals.

Finally, there is as yet no easy solution - such as primary prevention - to solve the problems that face professionals who serve the mentally ill. Our difficult patients will not magically go away. We will have to struggle with the discouraging and often overwhelming obstacles to overcoming mental illness and resist the temptation of uncritically embracing simple solutions offered to us.

A BRIEF HISTORY OF MALAYSIAN PSYCHIATRIC SERVICES

The earliest recorded evidence of a psychiatric facility was the existence of a lunatic asylum in the area of what is today the general hospital grounds in Penang, for the East India Company in the late 18th century. The next record is the building of the Central Mental Hospital in Tanjong Rambutan,Perak in 1911 to house the mentally ill,presumably of the whole coun-

try. It was built on such a large scale with over seventy wards in over 600 acres that it must have been conceived as a centralized hospital for the mentally ill patients. In 1933,another large hospital of almost the same size was built in the south of the peninsular at Tampoi. Around the same period,a 300-bedded hospital for mental patients was built in Kucing,Sarawak. In the 1920's,a small 100-bedded psychiatric hospital was built in Sandakan at Buli Simsim.

During the Second World War,the mental hospitals throughout the country were emptied of patients for the most part to house the Japanese troops and the psychiatric population was dissipated throughout the country. The end of the war brought the hospitals rapidly to overwhelming so that by 1957,just twelve years after the end of the war,there were serious allegations of security breaches,corruption and ill treatment in the country's largest psychiatric hospital at Tanjong Rambutan. Then the lenghty and often times intruiging inquiry brought to light the many drawbacks of institutional psychiatry,that held sway over the mentally ill in the 1950's. The visit by an Australian WHO adviser,Dr Cunnungham Dax in 1960 and his subsequent report on the psychiatric services in Malaya and the recommendations he made for decentralization,a better training programme were very timely. Since then several other WHO reports have alluded to the need for deinstitutionalization and better staffing. Today despite the psychiatrist population ratio of about 1:350 000 in Malaysia which is far below recommended levels for developing countries,there have been steady advances in the state of psychi-

atry with deinstitutionalization and improved quality of care, in and outside hospitals. A number of community agencies and over eighty outlying clinics have also cropped up.

The situation with regards to facilities for mental health care, however, has not kept pace with the improvement in the number of psychiatrists in the country. Overcrowding of the psychiatric wards; especially in the urban areas, is a severe problem still, with quite a few psychiatric patients being made to sleep on mattressess on the floor. One obvious reason for this is that the increase in the number of psychiatric beds has not kept pace with the increase in the population. Moreover, in some places the locks and the iron grills and bars have become part of the fixture so much so that some of our doctors cannot imagine that you can actually have psychiatric wards without locks or bars or grills. Mechanical restraints are still frequently used and appears to be more preferred than chemical restraints, even to the extent of causing severe lacereations sometimes. However, nowadays patient abuse has become an uncommon event and this is something one can really be proud of, considering the patient load they have ot look after.

Another important change that has occured is the substantial reduction in the number of beds in the psychiatric hospitals and the increased emphasis that has been given to community based mental health care. Similar changes have occured throughout the world, resulting in the premature closure of many a psychiatric hospitals. The motive behind this policy of deinstitutionaliza-

tion is praiseworthy; it is in its implementation that the problem arises. And the problem arises because the reduction in the beds has not been matched by the concommitant in the infrastructural facilities to support the chronic schizophrenics and families in the community - facilities such as halfway homes,psychiatric hostels,day care centres or sheltered workshops. It is not an uncommon sight to see chronic schizophrenics discharged from the hospitals rummaging in the dustbins behind restraunts for food or smiling and gesticulating by himself in the city streets. Rightly or wrongly one gets the impression that these chronic schizophrenics are simply dumped into the streets or to the unprepared family, with no support given to them or the community to help them cope with these chronic patients, much less to rehabilitate them.

Another aspect of the mental health care is the community's perceptions,attitudes,beliefs and health seeking practices. The society copes up with the mental illnessess and the mentally ill in particular ways, which are many times undesirable because of the differences between mental and the physical illnessess. In general,the mental illnessess are not recognized easily, their causes are poorly understood and often misinterpreted by magico-religious explanations and their treatment requires other adjustments besides medication over longer periods. The public stigma attached to the use of psychiatric treatment interferes with the willingness of individuals to seek specialised services. In addition many lack confidence in the effectiveness of psychiatric treatment while others find it too expenive.

Yet, another problem facing Malaysia is that it is not uncommon to find a person with mental illness untreated for several years in a Malay village (Tan Eng & Wagner 1971). It is observed that most (90%) patients with mental illness brought to the hospital have previously visited a traditional healer, bomoh, or sinseh or a bobo hizan. It is only when these efforts fail that the person is brought to the modern medical facility. This indicates that magico-religious beliefs about the causation are still pervasive in the Malaysian Society and directly influence health seeking behaviour. In Malaysia the delay in hospitalization after the onset of illness beyond 6 months is significantly more frequent in those who had consulted bomohs. It is often feared that consultation of the traditional healers prevents institution from early treatment with modern medicine.

Thus we see that in Malaysia still the community mental health services are lacking in the following areas;

1. There is still no treatment close to the patient, instead the patients has to come to the hospitals far away from their homes.
2. Comprehensive psychiatric services are not available, such as half way homes, day care facilities and other rehabilitation programmes.
3. Multidisciplinary team approach is lacking. Very few places have teams comprising of psychiatrist, psychologist, psychia