

Malawi's Mental Health Service

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IN THE BEGINNING....

The traditional picture of mental illness is the very disturbed, possibly aggressive, half-naked man uprooting crops, burning houses, or walking down the white line on the road to Blantyre. Such a person would be regarded with fear and either be avoided at all costs, or strenuously restrained and handed over to the police.

Yet there have always been other presentations of mental disorder - the silent, withdrawn individual, the child running off into the bush, the adolescent who almost unnoticed begins to lose concentration and fail at his studies. Most people will also recognise mental handicap and make allowances for those who cannot learn as quickly as their normal peers.

Just as people have always recognised the most mentally disturbed in the community, so traditional treatments have been available as long as there have been traditional healers. Even those people whose mental disorder presents with physical symptoms - anxiety and depression, for example - will find not only therapy but also a ready and acceptable explanation for their illness in the traditional healer's approach.

So from the beginning there has been a limited recognition of mental disorder and an attempt by the community to deal with it. Traditional beliefs affect attitudes and so influence behaviour, and stigma affects the lives of those with a mental disability today as it has always done.

It was against this background that the mental health service of Malawi began - not in the community or in the hospital, but in the Central Prison Zomba. Staff and prisoners found that they were disturbed by a number of inmates who were clearly mentally abnormal. It was decided that it would be

much better to separate those prisoners and so Zomba Lunatic Asylum came into being in 1910 as a wing of the prison, staffed by prison warders. It remained under the prison authorities until 1951; the first psychiatrist was not appointed until 1955.

It is very interesting that the asylum was established so early. In 1910 the government spent very little indeed on health and education for Africans - most of this work was done by the missionaries. To establish an institution for the care of mentally ill people was quite remarkable.

Early on there was an attempt to enshrine in the legislation humane treatment for the mentally ill. In 1913 there was a debate on the Native Lunatics' Ordinance and the Acting Government Secretary explained that the legislation was designed to ensure that the lunatics should be properly treated during their detention . . . "with the consideration and humanity which their unhappy situation demanded". Dr. Laws spoke for the missionaries when he said that the asylum relieved the missionaries of great anxiety . . . and also provided for the safety of Europeans in cases where the patient was likely to do damage. At that time the missionaries consistently refused to accept the insane in their hospitals, even when they were physically very ill.

Dr. Laws was kind enough to express the wish that early treatment would result in the cure of a great number of lunatics. But in reality the asylum was just a wing of the prison, separating the criminally insane from normal prisoners, and no real treatment was offered until the 1930's. Most cases of mental illness continued to be treated by traditional healers.

The old reports contain much concern about diet - many of the prisoners were suffering from pellagra, or even developed it while in detention. By the 1920's physical labour and gainful employment were encouraged, along with Christian worship.

There was also an increasing concern that insanity needed treatment just as a medical illness does, and perhaps it was not right that mentally ill persons should be cared for by prison warders. The asylum wing continued to expand, and physical conditions slowly improved. In 1943 an annexe was built where quieter patients (note the change of name) lived a less confined existence and were encouraged to grow their own food as a kind of

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occupational therapy. Conditions in the old wing left much to be desired.

The new Mental Hospital was finally built in 1953, and came under the control of the Medical Department. These were exciting times in mental health services, since effective tranquillising anti-psychotic drugs became available, making it possible for the first time to halt the progression of serious mental illness such as schizophrenia and to return patients to the community.

The diet of the patients was improved and a kitchen built where the women could cook their own food, supplementing their diet with any edible plants they could find around the grounds. Occupational therapy expanded and a system of payment for work was established. An Indian trader was invited in to display a selection of his goods, and one patient set himself up as a money lender. Unfortunately he charged 100% interest on loans so his business didn't last very long.

So mental health services in Malawi as in many other countries came to be associated with the main specialist hospital - in this case Zomba Mental Hospital. Here a service has been offered for many years to help the seriously mentally ill, the mentally handicapped, disturbed children and the criminally insane. In the past it has seemed that the best thing to do with a mentally ill person is to take him away, and keep him safely inside an institution until he is fit to return to the community.

But there are considerable disadvantages to this system:

The patient is taken away from his family - In an African culture the family is perhaps the most important element in society, and someone who is separated from his family is isolated indeed. Many patients at Zomba Mental Hospital come from a long way away and it is not possible for their families to be with them.

The family does not see him recovering - Often a patient will behave very strangely when he is mentally ill. He may in some cases be violent or destructive, and family and friends may be terrified of what he is going to do. In the great majority of cases the patient settles down very well in hospital, and quickly begins to behave much more normally. But the family far away have no chance to see this happening, and so they remain uncertain and afraid of their relative. When he comes home they may keep him at a distance and half-expect him to become strange or violent again, and so his welcome is rather doubtful. This can be a great stress to the person and even cause a relapse of his illness.

He loses contact with his community - In the same way, the person leaves his village and his community at a time when he is clearly abnormal and possibly behaving in a frightening way. Friends and neighbours may find it very difficult to welcome him back.

He becomes dependent on the institution - Hospital patients lead very orderly lives. Someone tells them when to get up, get washed and get dressed. Food is brought to them, with no choice as to what they would like to eat. They are instructed to take medication, attend occupational therapy, go for social or recreational activities. If they are sitting quietly, someone is likely to come up and talk to them about their illness.

All of this may make for a well-ordered and therapeutic environment for the mentally ill. But it also takes away a person's responsibility for himself, his independence, his identity. Seemingly he becomes just another patient, who if he obeys the "rules" is more likely to be discharged. This insidious process of institutionalisation leads to serious disability in patients already handicapped by their mental problems. Some patients find it very difficult to return to normal life after leaving hospital.

He learns to behave like a mental patient - Acute wards in a mental hospital can be very disturbed. Patients may be over-excited, singing and dancing, aggressive, or showing other inappropriate behaviour. If a person is in this environment for too long, he may begin to behave this way himself. Disturbed behaviour can be infectious!

Staff may accidentally reinforce abnormal behaviour. When there are many patients to care for, staff may only be able to attend in detail to troublesome ones, with no time for those who are quiet. This may mean that patients learn to behave in a troublesome way to gain staff attention. Their behaviour may become even more abnormal than when they were admitted.

There is considerable stigma attached to psychiatric hospitals - A mental hospital by its very nature is alien to the local community and all sorts of myths and legends may arise as to what happens there. It does not fit in with traditional beliefs and practices.

Ordinary people have the idea that a mental patient is someone who behaves very abnormally and who is liable to become violent at any time. So they are suspicious and afraid of someone with a history of mental illness, and they may actively avoid them. This stigma affects the person's well being, his relationships, his potential for employment and his self esteem.

Mental hospitals become too overcrowded - For the reasons outlined above, it is often difficult for a patient to settle back into normal community life. Unless he can live happily and stay well, he is likely to relapse and be readmitted. And so the numbers go up and the hospital can become full of people who no longer belong to their communities.

Overcrowding is an especially difficult problem in a psychiatric ward. Proper assessment and treatment, a therapeutic environment and rehabilitation are impossible when there are too many patients.

Follow up is much more difficult - If the patient comes from far away, how can the mental health worker ensure that there is good follow up? If follow up is not effective, the patient is likely to relapse and may have to be readmitted.

As patients relapse and come back into the mental hospital so it becomes more overcrowded, resources are more stretched, treatment is likely to take longer and the patient's prospects for full recovery are reduced.

In response to these problems in many countries mental health services have moved out from the central mental hospitals, to try to bring services much nearer to the patient and the community.

Here in Malawi it has been both encouraging and exciting to see that it is possible to decentralise the service, strengthen district mental health care, and begin to provide community mental health services nationwide.

DEVELOPING A DISTRICT MENTAL HEALTH SERVICE

The challenge for a developing mental health service is to bring treatment, rehabilitation and mental health promotion as near as possible to the client and to the community. And this within the context of very limited resources in a speciality which has always had a place of low priority - especially when the life and death emergencies of infectious disease and maternal and child morbidity and mortality rightly take precedence.

With the philosophy that good mental health care requires integration into all health care, particularly primary health care, how could we bring this about?

In order to develop an appropriate and cost effective service we first looked at our existing resources. The great strength of the service lies in its specialist nurses. Many enrolled psychiatric nurses had been trained, and some were posted to district hospitals: but few were using their skills in

the most effective way, nor were district hospital managers very sure how to achieve good service delivery.

But there was in existence the system whereby District Health Officers and their teams regularly visited all the health centres in the district, giving support to primary health care activities and providing an immediate referral opportunity for cases of TB, dental problems, orthopaedic problems and so on. Why not mental problems too?

And so psychiatric nurses were encouraged to look at the possibility of joining the team on the health centre visits. We began a pilot project in Zomba district to show that it could be done; psychiatric nurses accompanied the DHO from Zomba General Hospital and mental health clinics were quickly established in all the health centres of the district. The project was so successful that we felt confident enough to encourage other districts to pursue a similar system. Today almost every district provides a mental health service to many or even all of its health centres every month.

We discovered that publicity is vital to the success of this service. The objective is to identify clients with mental disorder and to maintain them on effective treatment so that they stay well. If the client, his family, or the community are not aware of the service, they cannot be helped. So a good service often begins in a blaze of publicity, with local leaders and villagers invited to a meeting, performances from health education bands and drama groups, and the psychiatric nurse explaining the purpose of the service. All health workers at the centre also need to know when the clinic is to be held, and they need encouragement to discover potential clients in the community.

So has this immensely exciting development left the specialist team from Zomba Mental Hospital unemployed? *On the contrary.* We regularly visit the regions, and discuss service development with the DHO and matron at each district hospital. We give encouragement to the nurse and where necessary help with difficult clinical cases. We can offer teaching sessions for all staff, perhaps discussing one of the patients, or giving a tutorial on a mental health topic. In this way the specialist service comes out to the district, rather than all those patients being sent away to Zomba.

We are very happy too to respond to situations of special need. For example, several districts have noted a lack of knowledge and skills in mental health amongst general health workers, and we have been able to provide seminars to cover the relevant topics. It has been most encouraging to see a real turn around in the attitudes and practice of many health workers who now take a full share in the care of the mentally ill.

Our specialist visits have taught us that a district mental health service can be developed even with very limited resources, provided that the DHO is committed to providing the service, that the nursing management can be ingenious in their deployment of manpower (or, more often, womanpower) and that the psychiatric nurse is able and willing to use her skills.

The community can care

Almost every district hospital now has a psychiatric nurse. She is able to care for mentally ill patients in the hospital, and can often do a very good job without needing to refer them to the mental hospital.

Treatment locally means that:

- a. the person stays near his family and they can be involved in his care.
- b. the family see him getting better.
- c. the family have the chance to learn about the nature of mental illness and how it can be avoided and treated.
- d. the person is treated like any other patient; there is no stigma attached to district hospitals; he does not depend on the hospital in the same way as at the mental hospital.

The nurse is now much better able to follow up her patients. In most districts the nurse holds clinics at the district hospital and the outlying health centres. Many patients will do very well if kept on a small dose of medication. The tendency to relapse is controlled, and early signs of illness can be quickly spotted and treated energetically. For a community mental health service to work well, there needs to be a good system for following up defaulters.

It is vital that if the psychiatric nurse cannot be released to do home visits, then another member of the team can help - the community nurse, public health nurse, health assistant and so on.

Being in touch with a local community means that the nurse can address real problems. She can discuss with local leaders, teachers, village headmen, traditional healers and ensure an adequate understanding of how western medicine can help in certain mental illnesses.

As the community learns about mental illness and how it can be treated, so the mentally ill should be identified earlier, treated more humanely and given appropriate medicine.

Integration, not isolation

Mental health problems of a community do not only mean mental illness. Alcohol, as well as drugs such as chamba, cause many physical and mental problems. Serious illness like cerebral malaria,

meningitis, measles can damage the brain and lead to permanent mental disability.

Integrating mental health with primary health care means that these problems can be tackled. Bringing mental health services to the community means not only **treating the mentally ill** but also **preventing mental illness and retardation and minimising disability** as far as possible.

STRATEGIES FOR A SPECIALIST SERVICE

And so the numbers of patients at the mental hospital are going down very significantly. Patients can stay a much shorter time than previously. Many patients being admitted have had some community care, and so the relapse of their mental illness is not so severe.

For example, towards the end of 1989 and the beginning of 1990 the secure male ward had 80-90 patients. There were frequent abscondings, nurses couldn't possibly know the individual patients, reviews were infrequent and progress was very slow. Worst of all, the atmosphere on the ward was very tense and patients often became more disturbed when they saw others behaving very abnormally. During the same period in 1991 the number was 40-50 and the atmosphere is very different indeed.

~~This means that those very difficult patients who still need to come to us now get much better care because we have more time and resources for them.~~

There is more opportunity too for **rehabilitation** that is responsive to patients' needs. The aim of **occupational therapy**, for example, is to return the person to normal life as far as possible. We try to assess what an individual patient needs to cope well at home and then offer a rehabilitation programme that will restore those skills. Many chronic schizophrenic patients, even those who have been in hospital for a long time, can return to simple tasks such as cleaning or gardening.

Relevant research

There are many unanswered questions on mental health issues in Malawi. Examples include:

1. Are the major mental illnesses as common here as in the rest of the world? Is their presentation any different?
2. How well is anxiety recognised and managed in the general OPD? And how many patients in the OPD would be better managed with counselling than drugs?
3. Drug and alcohol abuse cause physical and mental disorders. How many people in Malawi drink more alcohol than is good for them?

4. Chamba smokers present difficult clinical management problems. What is the most effective treatment?
5. How might we predict if an epileptic patient may commit murder? We have in our mental hospital population a number of people who have murdered while mentally ill or due to epilepsy.
6. What are the special psychosocial problems of refugees?

Every health worker a mental health worker

Students of all cadres come to the mental hospital for their mental health attachment. We try to give them "hands-on" experience of caring for the mentally ill so that when they qualify and settle into a service post they will not want to send every mentally disturbed patient to Zomba.

One of the most important tasks for health workers is to identify mental disorder due to physical illness. This is more difficult to teach at the mental hospital since most of our patients should be primarily mentally ill. So teaching and learning about mental disorder goes on in the central, general and district hospitals too.

Of special interest to us is the training of enrolled psychiatric nurses, who will continue the work begun by their pioneer sisters at the district hospitals, in the health centres and the community.

MANAGING MALAWI'S MENTAL HEALTH SERVICES

The mental health service has often shared some of the problems of its clients: misunderstanding, suspicion, stigma and isolation. As in most developing countries, priority is given to "major" specialities and the mental health component of all health care is often forgotten.

One task of the mental health management team has been to raise awareness of mental health issues at every level. Developing district-based services has been tremendously exciting and rewarding and we pay tribute to all those district health teams and psychiatric nurses who have pioneered the process.

But a rational, relevant and cost-effective service must be policy led. The World Health Organisation has a longstanding interest in developing mental health programmes in developing countries. Out of their experience has arisen a strong recommendation for a coordinating group to be established at Ministry level.

From the service end it became clear to us that there were many ongoing activities with a mental health component, but that these often lacked cohesion and coordination. We urgently needed

help with data gathering, assessment of service needs, and a manpower development policy.

A multidisciplinary approach

As an initial step a mental health coordinator was appointed, and Mr. W.E. Limbe was given the mental health desk at the Ministry of Health. He is a registered psychiatric nurse and aims to be in contact with all departments to receive, distribute and coordinate information on all issues relating to the mental health service.

The Mental Health Action Group

The main work of managing the service is now the task of the Mental Health Action Group. This is a multidisciplinary group established by the Chief of Health Services with the facility to coopt members from other ministries when appropriate.

The main functions of the group include: policy making; planning; service development; coordination; manpower development; research (coordination of projects and dissemination of relevant research findings); mental health promotion.

Readers of this journal are encouraged to contact the Mental Health Action Group through the coordinator Mr. Limbe whenever they would like information or have information to offer; when they are planning projects; or if they need help with more effective mental health service delivery.

IN CONCLUSION

In a developing country with scarce resources, there is a great burden of health needs which must be addressed with maximum efficiency and cost effectiveness. Inevitably priorities must be set. So, in summary, why does Malawi need a mental health programme?

Mentally ill people have long been neglected and they and their families have been suffering. Mental illness is very disruptive to the individual, the family and the community.

Traditional healers have effective remedies for neurotic illness but not for psychosis or epilepsy. Many patients with neurotic illness come to Western services anyway and form large queues in our clinics. Effective recognition should lead to more appropriate treatment and smaller crowds in the end.

Mental illness and epilepsy are very disabling. Identification, early treatment and effective maintenance means that the individual can stay as well as possible, support himself and his family, and contribute to the process of development.

Much mental handicap can be prevented by good primary health care programmes. The mental

health worker will be able to add specialised support and treatment of the individuals who have already been damaged.

There is very little accurate epidemiological information on mental disorder in Malawi. We have found that beginning to provide a community service enables us to identify some of the major areas of need. A great deal of further research is needed to show us the best way forward for an efficient, cost-effective and relevant mental health service. This research is part of the day to day programme of mental health activities.

In all developing countries there are many stresses inherent in modern life. Pressures of education, employment and the faster pace of life in the cities; the availability of drugs and alcohol; loss of the extended family system; fragmentation of community support; the conflict between traditional values and Western ways all influence the mental health of the population.

Mental health services are vital in protecting those elements of culture which are promotive of mental health; in detecting mental handicap and mental illness and ensuring early treatment and prevention of relapse; in working with communities to reduce the stigma of mental illness and ensuring that the mentally ill and handicapped can take their place and play a useful part in society.

Further reading

1. BenTovim DI. Development Psychiatry: Mental Health and Primary Health Care in Botswana. London: Tavistock Publications, 1987.
2. Leff J. Psychiatry Around The Globe: A Trans-cultural View. London: Gaskell, 1988.
3. World Health Organisation. The Introduction of a Mental Health Component into Primary Health Care, 1990.

Vitamin A and Infant Mortality

Community based trials in Indonesia and India have suggested that Vitamin A supplementation reduces child mortality. A further Indian trial however failed to confirm this. Now a randomised, double-blind placebo controlled trial of Vitamin A supplementation in Nepal has shown that 200,000 Units of Vitamin A given every 4 months for a one year period resulted in a 30% reduction in under five mortality. It is suggested that routine Vitamin A supplementation in Nepal would prevent 15,000 deaths per year in children aged less than five years.

West KP, Pokhrel RP, Katz J, et al. Efficacy of vitamin A in reducing preschool child mortality in Nepal. *Lancet* 1991;338:67-71.