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GENERAL PRINCIPLES OF PSYCHIATRIC CARE

by

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1. OBJECTIVES AND POLICY

In striving to deal with such difficult and complex problems as mental illness, the first principle to be considered is the setting up of realistic objectives and the drawing-up of a feasible programme for the proper development of psychiatric care.

Ideally, the aim of psychiatric care should be the promotion of mental health (WHO 1950) and the development of preventive, therapeutic and rehabilitation services. Operationally, while placing due emphasis on the importance of total approach in mental health work, and improving the quality and range of services and training possibilities, the psychiatric care programme should be well fitting into the local conditions, and developed as part of an all-round national health plan.

Time and again one is struck by the lack of objectives in mental health services and the absence of policy in psychiatric work. Indeed the conceptualization of what has to be achieved in psychiatric care, and how would it be achieved, and by whom to be achieved may be rather hazy and often vaguely envisaged.

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In a recent questionnaire, for example, circulated to twenty-two countries of WHO Eastern Mediterranean Region, for appraising the current situation regarding the state of psychiatric care, one of the questions read: Has a statement of a national policy on mental health services been formulated? The majority of the countries answered in the negative. This was not surprising as the development of mental health services, in general, has been rather slow and far behind other health services. On the whole, experience has repeatedly shown that in countries where there is no well formulated policy based on clear and accepted principles of psychiatric care, it is often the case that such services suffer from basic inherent defects. The relevance of this point becomes eminently important, when it is known that serious efforts to develop mental health services, have been frustrated due to lack of sound planning policy and deficiency of organized programming.

Again experience shows that in some countries, though the objectives of psychiatric care may be generally defined, the steps to be followed may not be clearly set, and the subsequent programming meets with disruptions and disappointments. In one of the countries for instance, in spite of the fact that there was acute shortage of qualified personnel to staff a newly constructed centre, the building programme continued all the same and two other centres were also built. It was clear that the obstacles to be met had not been foreseen, and that the necessary action to overcome them was not taken in the right time.

2. INFORMATION AND SPECIFICATION OF PSYCHIATRIC PROBLEMS

The importance of having adequate information which specify the extent of the psychiatric problems, assess the current needs, monitor the progress of services, and help in future development should be considered in the foremost of the general principles.

It is worthy to quote here an example from one of the countries where the question was raised, and this was by medical professionals, whether mental illness in developing societies, constituted such a problem that warranted active intervention comparable to other medical conditions.

As a matter of fact the dearth of knowledge on common psychiatric morbidity and the scope of mental health problems has weakened the case for proper development of psychiatric services. It is, therefore, important to affirm that various epidemiological studies in traditional societies, though limited, indicate a substantially higher incidence of psychiatric morbidity than was previously thought. Quite apart from cultural variations, one is often impressed by the similarity in general of psychiatric illness rather than by the differences between technically advanced and so called developing countries; and this has to be made known to do away with the unwarranted complacency which may still be found in some countries.

In essence, it is of major importance that psychiatric care should be designed on the basis of reliable information with due

regard to the nature of mental health problems, and the needs of the community to be served. In principle this implies that prior to establishing psychiatric care it is essential to delineate the size and nature of the problem for which the services are to be designed.

3. PHILOSOPHY OF PSYCHIATRIC CARE AND CHANGING CONCEPTS

(a) The search for more effective models

It is not intended here to go into the historical perspective of psychiatric care nor to recapitulate the significant movements in the mental health field. However, it seems relevant to this point that as a general principle the philosophy of psychiatric care must be properly conceived to ensure effective implementation.

For the sake of the discussion several questions may be posed in this connection. For instance, what is the psychiatric worker trying to accomplish? And what should be the philosophy on which the premises of psychiatric care should be based? Should the treatment be focused on the removal of symptoms and the modification of the personality structure of the patient? Or should it involve the inter-personal relationship and extend beyond the individual therapy, the clinical setting, the hospital confinement, and into the social structure? And with what purpose? And what should be the limiting boundaries of such a trend? And what social institutions or community groups be involved? And to whom should the therapy be entrusted? Should it always be the full members of

the well-known psychiatric team? And if such qualified workers are not available, like in many parts of the developing nations, to whom such responsibility be delegated? And what would be the methods or techniques to be used?

In raising these questions one had to bear in mind the present day differences in the levels of psychiatric standards between the various countries. Notwithstanding recent advances in psychiatry, there are certain countries where the care of the mentally ill patients is still practised in the custodial era. Several countries are just starting their services and would like to find out where to start, and how to start. However, as a matter of principle psychiatric services should be built from the base to the top, and not the reverse. A serious mistake which had been committed in some countries was that they borrowed the model of the traditional psychiatric hospital, and failed to move from there. While others started, rightly so, with an out-patient unit or a mental health centre and expanded the base of psychiatric care within the total health resources. Generally speaking, the search for new models has been increasingly felt, and organized research in this respect is most needed (Heseltine 1969, Huessy 1972).

(b) Population coverage

In general, it has been realized that treatment of individual patients in mental hospitals proved to be ineffective for the overall care of psychiatrically-ill patients and for the adequate

control of mental illness in the community, and hence new approaches had to be developed.

Among the central concepts which have influenced modern trends in psychiatric care is the shifting of emphasis from the traditional clinical practice of individual care to the population-oriented approach, and the placing of more emphasis on the preventive and rehabilitative aspects of mental health work. The new movement embodied in comprehensive community psychiatry, in spite of the criticism levelled against it (Kubie, 1968), should be regarded as a significant attempt in this direction. However, it is to be remembered as has been rightly pointed out by Caplan (1965) and others, that there are several problems which confront the extension of psychiatric care into the social structure and into the community at large. Apart from the need for working out general theories, effective community techniques, and new models, an organizational framework for comprehensive psychiatric care has to be developed.

There is no doubt that community mental health has found readily available theoretical models in public health teachings, but achieved relatively less progress in its practical applications.

As an illustrative example it may be of interest to examine, specially in developing countries with their limited resources, the implication of the principle of population coverage in the mental health services. In this connection it is worthy to refer to the proposed health plan by the WHO Regional Office for Africa (1973)

to provide full geographical coverage for African communities. Realizing that the existing health structures were inadequate, the establishment of "health centres and posts capable of providing seventy-five per cent of the population with acceptable and accepted services", was proposed. This seems to serve mainly the rural population "in the framework of an integrated approach to community health". The health centre which would be staffed by a physician, a nurse, a midwife, a sanitarian and some auxiliaries is supposed to cover 20 000 - 25 000 population. If this plan is taken as a basic model, one has to think of the place of psychiatric care in such a health system. The best approach in this regard seems to evolve round the psychiatric training of the staff of the health centres. I need not go into the details of this point as training will be dealt with by other contributors. However, the acute shortage of qualified personnel and lack of training facilities in developing countries in general is considered to be the most serious constraint in the development of psychiatric care. It is therefore, exceedingly important that the priority in psychiatric activities should be given to training of mental health workers.

In brief, the major issues which face new trends in psychiatric care are the manpower development, the effective implementation of new concepts, and the gap between the provision of services and the total population needs.

4. INTEGRATION OF PSYCHIATRIC CARE WITH GENERAL HEALTH SERVICES

Leading from the last point, it has been generally found (Baasher (a) (b) (c)1973) that one of the important principles in the development of psychiatric care is the integration of mental health work with the general health services. It may be conceived that in an affluent society and with exceptional economic support that psychiatric care may be developed separately from other health services. But in many of the developing countries, even if the material resources could be made available, the manpower bottleneck may constitute such a difficult obstacle which will not be easy to get through for many years to come.

Apart from the pooling of resources, and removing the stigma of mental illness, the integration of psychiatric care with general health services, as commonly known, would help in the early diagnosis, early treatment, follow-up, training, etc.

Furthermore, social agencies and public health services for maternity and child care, for family planning, for marriage guidance, for the care of special groups e.g. students, for law inforcement, for medical rehabilitation and others have a prominent mental health role to play. These examples and others indicate the necessity for close cooperation and coordination, at both the planning and operative levels, between mental health, public health, and social services.

As a matter of fact a lot of extremely interesting mental health work carried out by general social workers attached to schools in one of the countries (Baasher (a) 1973) has been observed. Other personnel also found to be interested in mental health work, were the school health officers and the general duty doctors working in community health centres. However, for an all-round development of psychiatric care into the context of the general health work, and for effective integration with community services, two major requirements have to be taken into consideration,

(a) the importance of training programme in mental health for general health workers (WHO 1961, 1962) and public orientation;

(b) the need for a central administrative machinery for proper implementation of an integrative policy.

Incorporation of psychiatric care in the general medical services, for instance, in countries of the Eastern Mediterranean Region in the form of psychiatric in-patient and out-patient units, though limited, has proved to be generally promising and effectively helpful not only for therapeutic purposes, but also for training and research. Such services are generally located in closer proximity to the community with easier accessibility and relatively relaxed administrative procedures, and hence are more acceptable to the people. This will be further elaborated in the next point.

5. CONTINUITY OF CARE

For achieving proper management of psychiatrically-ill patient an important principle which has to be followed, is the continuity of care to provide early treatment within the shortest possible time, to prevent deterioration and to help in a quick return to normal active life. It is commonly known that defects in the psychiatric system may lead to psycho-social complications and to chronicity, and that a series of organized efforts are needed to maintain psychiatric care during the various stages of mental illness. It has been reported, since the recent advent of the potent psychotropic drugs and the adoption of the open-door policy, that greater numbers of patients are more often discharged from the mental hospitals than hitherto known. Nevertheless, it has been similarly observed that in places where there are no provisions for continuation of psychiatric care, that the number of re-admissions has equally increased.

The most common factors causing disruption in the continuation of psychiatric treatment seem to be:

(a) lack of psychiatric facilities, specially extra-hospital services. This is rather obvious in many of the developing countries where an isolated psychiatric hospital may be the only existing psychiatric institution in the country, and the patient has to cover a long distance to pursue his treatment. Added to the physical distance, there may also be the difficulties

of communication, poverty, and lack of familiarity with modern medical system. In such circumstances one has to be imaginative and utilize whatever help is available in the community. In this regard traditional healers, for example, have been utilized in remote and rural communities in the early referral of patients, and for their support in encouraging the patients to continue the prescribed course of treatment, and reporting for follow-up;

(b) failure of communication between the mental health workers or with other health workers.

The team approach in psychiatric care is now universally accepted, and for its effectiveness the communication between its members should be adequately facilitated and clearly maintained.

The line of communication between the staff of psychiatric institutions, other health services, the family doctor, the social agencies and so forth must also be well developed to foster all possible continuity of care, and make full use of available resources.

6. RANGE OF FACILITIES

(a) General

It is commonly known that at the different stages of illness, psychiatric care should vary to meet the patient's needs. Together with the development of community psychiatry the need was felt for the establishment of a range of facilities, for improving the accessibility of services, increasing the utilization of public

resources, and augmenting the psychiatric programme for the control, treatment and rehabilitation of mental illness.

It is important that the whole range of services must be viewed as complementary to each other, and that due emphasis must be placed on the social as well as the medical aspects of treatment. Where this important principle has not been observed, it was found that the psychiatric services suffered badly from disjointedness and lack of co-ordination. Indeed the range of facilities must be well integrated to enforce joint efforts and ensure the effective use of available material and manpower.

On the whole this recent trend in psychiatric care has broadened the base of action, and provided new opportunities for alternative deliveries and diversification of mental health services, and over the last decade psychiatric care has witnessed significant changes in this direction.

To meet the patients' needs the range of facilities which has been currently developed include a variety of services, e.g.

- emergency services
- out-patient services
- partial hospitalization in the form of day or night hospital
- in-patient services, in mental or general hospitals
- rehabilitation services, training centres, educational programmes, industrial therapy
- domiciliary services
- after-care services such as hostels
- village system.

(b) Type of psychiatric facility

In general the type of facilities to be developed in any particular country depends on the local conditions and on the determinents of psychiatric care, which are notably the manpower resources and the money allocated for such services. With few exceptions, psychiatric care in developing countries has been mostly confined to mental hospitals, with relatively fewer out-patient services.

The number of psychiatric beds per 1 000 population varies tremendously from one country to another. In the Eastern Mediterranean Region it ranges from 0.01 in Pakistan to 1.3 in Cyprus (EM/GR.MT.MH./17, 1972), while in the European Region (EURO 5405, 1971) it varies from 0.2 in Turkey to 5.9 in Ireland. While it has been found that quite a number of countries, even those with low ratios, had reached the target set by the WHO Expert Committee in 1952 recommending a minimum of one bed per 10 000 population for the care of the mentally sick who are a danger to themselves or others, the deficiencies are generally obvious in the psychiatric resources, in the organizational structure and in the development of efficient socio-therapeutic techniques and good models

Through the administration of early treatment, intensive care, family support, and social manipulation, it has been found possible to keep quite a number of mentally ill patients in the community. However, there are over-riding factors which may necessitate inpatient treatment such as:

1. Severe psychotic reaction and personality disorganization
2. Violent behaviour which may constitute a danger to the patient or the society
3. Suicidal tendency
4. Absence of a responsible family of a deteriorated patient.
5. Serious medical complications which warrant hospitalization.

In spite of all recent developments, the care of chronic patients in all countries developed or developing, still constitute a major problem which has to be faced (BMJ 1971). It calls for intensive efforts, specially in the field of prevention and rehabilitation programmes. The need for further research is obvious and schizophrenic disorders which form approximately sixty per cent of the chronic hospital population in many countries should merit special consideration.

Serious efforts have been observed in several developing countries to forge a more advanced psychiatric care programme out of the old hospital-based services and establish a network of facilities. For such countries and for those starting afresh, an integrated community mental health service with out-patient facilities, emergency beds and inpatient services in general hospitals could form a good initial basis for developing psychiatric care programme. Such a service, apart from providing diagnostic and therapeutic care, at out-patient and inpatient level, should aim at:

(a) domiciliary care

(b) supervision of care given to other institutions

(c) collaboration with general health workers

(d) provision of psychiatric consultation for social agencies and community services (e.g. school services, industrial and labour organizations, special insitutions for the delinquents, the handicapped, etc.)

(e) public education

(f) collection of information

(g) training

Differential treatment for certain groups of patients such as the mentally deficients, the mentally ill offenders, drug-dependent persons seems to be generally needed.

In 1961 the WHO Expert Committee gave an example to the type of mental health units which would provide services for a catchment area of 150 000 inhabitants, and recommended that the staffing in the first place should be 1 - 3 psychiatrists, 3 - 9 trained nurses and secretarial assistance. In the United Kingdom the Tripartite Committee (1972) proposed that the multi-disciplinary mental health team for every 62 500 of the population should be composed of two consultant psychiatrists two junior psychiatrists etc. Such staff population ratios sound rather high in the light of the serious shortage of qualified psychiatric workers in developing countries, but they should not be discouraging. There is certainly a great challenge here which has lead to a lot of innovative work, and there are several examples of efficient deployment of the limited number of mental health workers and community involvement.

(c) Need for a central administrative machinery

Only a very brief reference will be made here to emphasize the importance of an underlying general principle for the proper management of such a range of psychiatric facilities. As has already been stated in the foregoing

sections, mental health work involves a rather complex and varied activities which call for a central administrative machinery. This seems to form a gross defect in many of the national mental health programmes, and has to be remedied.

Countries differ in their background of health services, in their needs and demands for psychiatric care, and in the administrative relationship in the health field. In general there are more than one ministry involved in mental health work. Commonly there are the ministries of health, local governments, social affairs, education and justice. In the United Kingdom for an instance, it is interesting to take note of the recent development in the unification of the mental health service. (Report of the Tripartite Committee, 1972), and the establishment of psychiatric departments in the general district hospitals.

The main function of a central administrative organization will be : collection of information, planning, co-ordination, follow-up, evaluation, setting-up of standards, training, research, formulation of administrative and legal regulations, etc.

7. Community, culture, and psychiatric care

In principle, three important issues should be considered with regard to psychiatric care and the community :

(a) that the community attitude which is often neglected, should be studied and relevant information for programme development and decision making be made available;

(b) that a healthy community attitude towards the psychiatric care programme should be sought and fostered,

(c) that the community be influenced to play an active role in mental health work.

It must be realized that the stigma of mental illness, and the prejudice against psychiatric institutions are still commonly seen. In brief bias against institutions could be attributed to three major factors : the organization, the personalities, and the culture.

There is no doubt that the past custodial psychiatric institutions with isolation from urban life, and insulation from the community, have perpetuated the sense of alienation and rejection to psychiatric care. It is only recently after the adoption of an open-door policy, the development of therapeutic community expansion in out-patient clinics, day care, domiciliary services, etc., that the community has become closely associated with psychiatric care and the public attitude changed favourably towards it.

To bring a desirable change is not easy and could indeed be painstaking and tedious. In one of the countries, for example, it took two years to convince the director of a general teaching hospital to accept the idea of establishing an inpatient psychiatric unit, and even later when the building construction was completed, there was strong pressure to forego the project for another isolated area. This example and several others demonstrate clearly the strong resistance to change by personalities, nevertheless once the inpatient unit was established in that particular hospital it proved to be most instrumental in bringing about significant changes in community as well as professional attitude towards psychiatric care.

It has also been observed that medical students trained in old and dilapidated hospitals and exposed to the experience of seeing only chronic and deteriorated patients showed a strong feeling against psychiatry.

Not surprisingly the impression they got was a sense of hopelessness for mental illness and that psychiatry was not the speciality to be entertained

for a professional career. Obviously the development of psychiatric institutions to the acceptable standards will go a long way to change such attitudes.

Community attitude and behaviour towards mental illness are intrically enmeshed in the cultural heritage, and a lot of efforts are needed to change centuries-old beliefs and wrong concepts. It is only through continuous health education to the public, and the demonstration of the efficacy of modern treatment that harmful concepts such as demoniacal possession, could be shaken out of community thinking.

Community involvement for the promotion of mental health care could be enhanced through joint co-operation with voluntary organizations, social institutions and by the effective use of mass media. The support of community leaders such as ministers, top-level administrators, religious leaders, trade unionists, journalists, teachers, etc., together with the association of patients'families, and social agencies is most important for the identification of the community with psychiatric care programme, and its active participation. Various techniques could be developed in this connection (WHO 1959) within the context of available means, and with due awareness to the local conditions and the potentialities of the culture.

6. CONCLUSIONS

1. The setting-up of realistic objectives, and the formulation of a national policy with clearly delineated principles are considered of central importance for the proper development of psychiatric care.

2. It is essential that the steps to be taken in programme development should be well defined, and attention be drawn to the possibility of ob obstacles to be met and attempts be made to overcome them in the appropriate time.

3. Reliable information on psychiatric problems, the state of the services, and the current needs should be made available to monitor the progress of work, and help in future programme development.

4. That psychiatric care should be based on accepted and acceptable philosophy. Because of the complexity of mental illness and the amounting needs the search for new models and more effective techniques has to continue.

   Due emphasis should be placed on the change of emphasis from hospital-based care to community-oriented services and the endeavour to achieve population coverage.

5. The need for integrating psychiatric care with public health work, and social services has been underlined, and the major requirements to implement such a policy have been considered.

6. The continuity of psychiatric care to provide early treatment, follow-up, and sustained support until a successful return to normal life takes place is regarded as a fundamental principle.

   Lack of extra-hospital facilities and failure of inter-professional communication are considered the two most common factors which lead to discontinuity of mental health care.

7. The establishment of a range of facilities to cater for the needs of patients at the different stages of illness constitute a basic principle in psychiatric care programme.

The network of facilities should be flexible and the services should be harmoniously designed with the available resources, and well fitted with the local conditions.

8. Intensified efforts are still needed for the development of more effective preventive models, the care of the chronics, and the special groups, e.g. the mental deficients, the mentally ill offenders and drug-dependent persons.

9. A central organizational set-up for efficient administration and development of all-round psychiatric care programme is always needed.

10. Training of personnel must be given the priority in psychiatric care programme, and a lot of innovative work is needed for local training in developing countries.

11. Educational programme and public orientation in mental health work are essential components of psychiatric care programme; and the study of cultural background is generally important for fostering favourable community attitude and enlisting public support.

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