Community participation in mental health: a case study

Bophelong, the only state hospital offering psychiatric services in Bophuthatswana, is situated in the Molopo Region, about 12 kilometres from Mmabatho.

Although this hospital is built in a semi-urban area, the majority of the population it serves is concentrated in the rural areas. There are about 46 villages varying in distance from Bophelong by about 5 to 150 kilometres, together with the urban populations of Mafikeng, Mmabatho and Danville, which are also served by it.

A close look at services provided at Bophelong indicates serious staff shortages and inadequate financial resources. The specialized mental health services which do exist are insufficient to meet the needs of people who suffer from symptoms of mental, neurological and associated social malfunction. This means that the hospital serves an essentially custodial function and therapeutic and preventive approaches are neglected.

This article investigates potential community participation in both the promotion of mental health and the institution of preventive programmes in Bophelong. The first part describes existing services, while the second part makes recommendations for community participation.

Description of existing professional services at Bophelong

Psychiatric and psychological services

Bophelong's psychiatric section has two full-time, and one part- time professional psychiatrist. These three psychiatrists are expatriates (Ugandan, Israeli and Indian) who are not fully familiar with the local language and culture, which makes

effective psychotherapy extremely difficult. The major part of psychiatric work therefore is limited to diagnostic and curative (medical) treatment.

There is only one psychologist providing professional services in psycho-social diagnosis and treatment. Like the psychiatrists, the psychologist is also an expatriate (Iranian), which again means that psychotherapeutic work may only be attempted with those patients able to understand English. This factor prevents the provision of psychotherapeutic services to the majority of clients, who are Tswana.

There are two fully qualified staff members who are mainly involved in casework. The high caseload makes it difficult for them to practice other methods of social work, such as group and community work.

Nursing services

Nursing services are offered by thirty-eight registered psychiatric nurses, assisted by a small number of enrolled and assistant nurses.

As the hospital is also a training centre for psychiatric nurses, the student nurses in block training are periodically allocated to the psychiatric units for their practical experience.

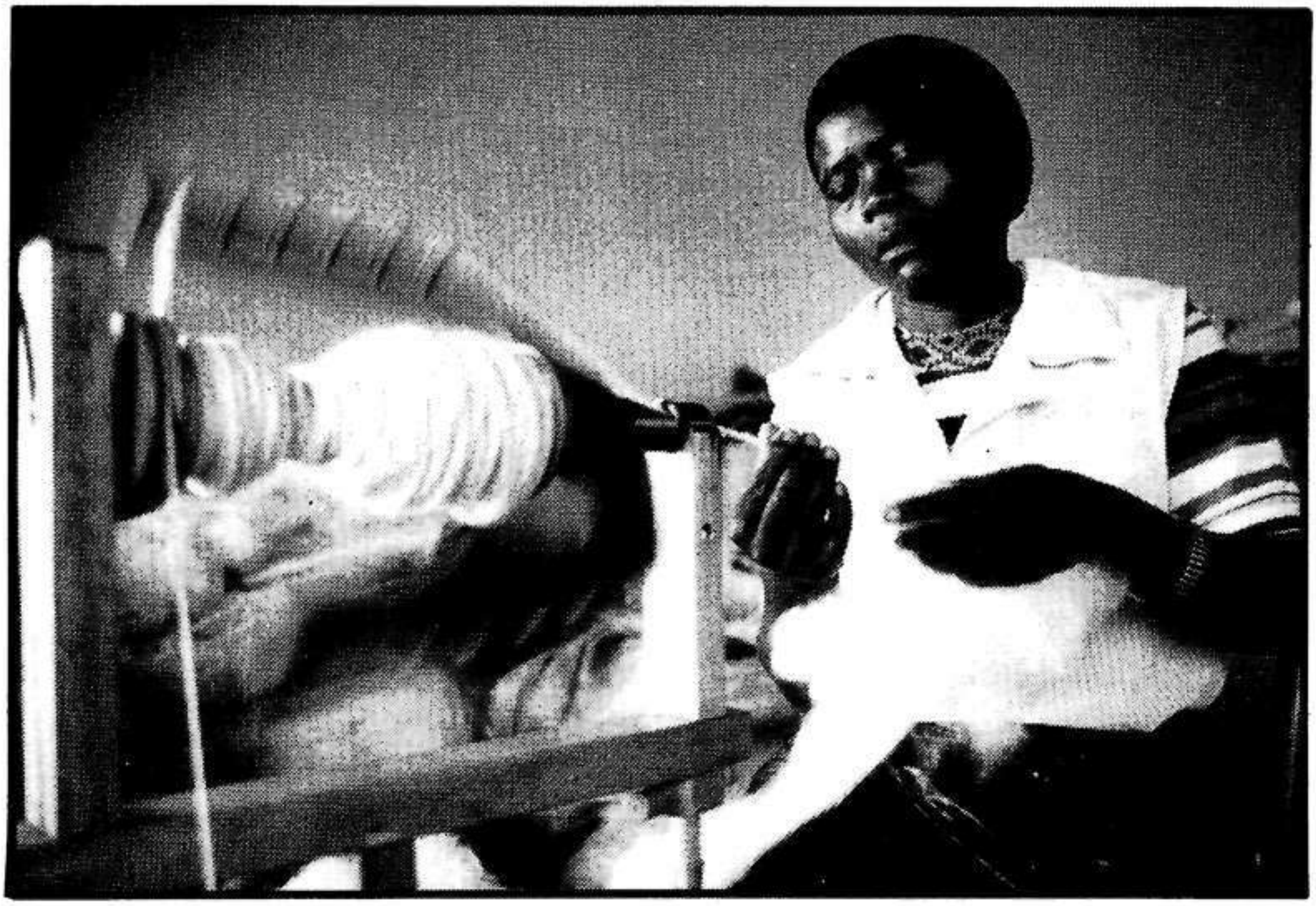
Psychiatric commmunity services form another aspect of the nursing services. These services include:

- the spread of information regarding available psychological and health resources, and communal facilities;
- the co-ordination of hospital services with those of other organisations;
- the initiation of group therapy programmes and home visits for the after-care and follow-up of patients

Nursing services are offered by 38 registered psychiatric nurses, assisted by a small number of enrolled and assistant nurses

The success of these programmes is limited by staff shortages, transport problems and the long distances to be covered between villages and the hospital.

Occupational therapy



The occupational therapy department provides recreational and craft activities

The occupational therapy department is headed by one professional occupational therapist. This professional is assisted by a registered psychiatric nurse and five nursing assistants, who are called work instructors. The main function of this group is to provide recreational and craft activities. The hospital is presently experiencing difficulties in financing this department and patients are therefore seldom fully occupied due to insufficient supplies of the necessary materials.

Shortcomings in primary prevention

Shortcomings in primary prevention are attributable to the following factors:

- an acute shortage of human and financial resources;
- the lack of co-ordination of health services with firstly, voluntary groups such as church or youth groups, and secondly, other government departments such as the Education and Manpower Departments.

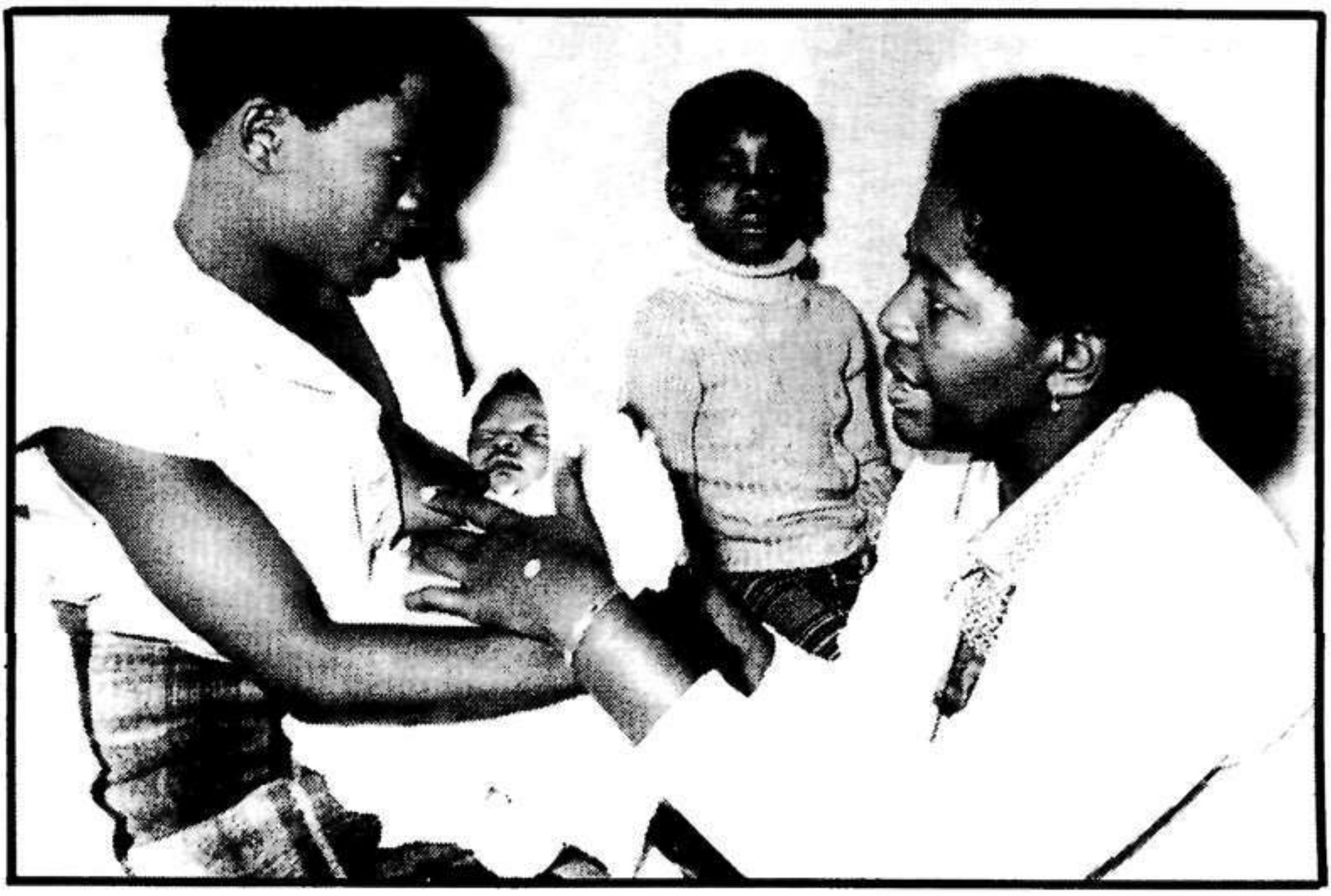
People, moreover, only come into contact with mental health education indirectly when they approach the health services for some other reason such as maternal and child welfare or through occasional health talks.

Secondary prevention

Secondary prevention is only minimally practiced. Population screening is not available. As a result, disorders which could have been treated at an early stage, are left until they require prolonged hospitalization and intensive treatment techniques. There are no crisis intervention units and the people who would normally come into contact with people in crisis, are not fully trained in dealing with such situations.

Early diagnosis is hampered by a lack of general mental health education, both on the part of the general public and on the part of other professionals outside the field of mental health. This means that the latter are unable to anticipate mental disorders arising from stressful situations, or to recognize symptoms.

Early referral is further hampered by the inaccessibility of services. Although there are health centres in the more populated rural areas, many of the centres are staffed by nurses who are not psychiatrically trained, so that a large number of cases have to be referred to the hospital.



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Tertiary care

At the tertiary level, there are no opportunities for ex-patients to be eased back into society through transitional facilities. This situation results in an increasing number of relapses and re-admissions on the part of mentally-vulnerable patients. The two main causes for this absence of transitional facilities are lack of money and planning. Adequate coordination and planning with alternative sources could help to counterbalance the lack of available funds.

Recommendations for community participation

In order for preventive and promotive programmes to be successful, the communities' participation is vital. Communities should be involved right from the planning stage of programmes. They should be encouraged to identify their own mental health needs and priorities, and be advised on how they themselves can solve their own mental health problems.

The participation of the community in preventive and promotive programmes is vital

The use of non-professionals in crisis intervention

With limited training, proper consultation and adequate supervision, mental health workers (including volunteers) could be of assistance in handling crisis situations.

The input of mental health workers could improve mental health care at little cost and with the least disturbance of traditional home functioning and child-bearing practices

They could be trained in crisis intervention techniques and behaviour modification methods. The aim of the training would be to equip such workers to distinguish cases of serious mental illness from short-term problems. The training should enable mental health workers to deal with short-term problems while providing first aid to those who suffer serious symptoms, until they can be seen by mental health professionals.

The input of mental health workers could improve mental health care at little cost and with the least disturbance of traditional home functioning and child-rearing practices. Such services would increase referral and support facilities, a problem presently facing the mental health institution.

Research and education

A Crisis Intervention Clinic consisting of staff from Bophelong and the University of Bophuthatswana, could be established at the university. This unit would act as a consultative centre for commmunity health workers. Research into community mental health needs and solutions, in keeping with prevalent cultural and social attitudes, would be initiated from this clinic and the faculties involved. Findings from such research activities would provide a curriculum which would lead to a unique training facility for professionals in Bophuthatswana.

It is important that the community be actively involved in undertaking such

fact-finding endeavours so that they are motivated to participate in the actual preventive programmes.

Mental health education is an essential aspect of prevention. As a result of negative attitudes regarding the mentally ill in Bophuthatswana, participation in mental health issues is unlikely to be spontaneous. Mental health education should therefore aim at reducing the stigma attached to mental disorders, and at encouraging community participation in preventive care and after- care supervision of the mentally ill. Such mass education would require a great deal of staff input and time.

Community leaders as a resource

Respected community leaders such as headmen, priests and teachers could be effective resources in helping to change peoples' attitudes and in motivating action. Examples of other possible strategies likely to bring about successful results are:

- The organisation of interested community members in an intensive education campaign.
- The involvement of such people in preventive and rehabilitative services.
- The formation of an active committee comprising members of the medical, business, educational and journalistic worlds, to organize mental health weeks on various aspects of mental health. The aim of such a committee would be to draw the attention of the community to the needs of the mentally ill and to raise money for community based mental health facilities, which, as pointed out earlier in the study, are grossly inadequate.
- Once this group of interested people is formed, then methods of disseminating information could be utilized. The existing means of communication available in Bophuthatswana are the television and the radio. There are also a large number of village welfare societies, womens' organizations and youth clubs which could be approached for their support.
- The collaboration of mental health professionals, eg psychiatric nurses, with headmen would also simplify the task of organizing support groups and spreading information in the villages.

Psychiatric nurses

The part which psychiatric nurses are able to play in the training and co-ordination of community health workers should not be underestimated.

An interesting example of the role of psychiatric nurses in community-based care is provided by the development in Botswana of village-level psychiatric services.[1] There, psychiatric nurses train and supervise village health workers, who

are called Family Welfare Educators. These are chosen from the village and by the village. After an eleven-week training period, they work essentially as health educators and motivators, promoting preventive activities and giving first aid and treatment for minor ailments.

Support systems

In Bophuthatswana, there are no formal mental health networks such as marriage counselling centres, child welfare societies, mental health societies and the like, to supplement the services provided at Bophelong. Rehabilitation facilities are grossly inadequate. This situation necessitates the use of support systems.

The family can function as an important support system. In cases where it is appropriate, family cohesion should be encouraged in order to protect and maintain mental health.

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Poverty, poor wages and the migrant labour system, are all seriously implicated in the fragmentation and destruction of the family life of most black people. Where however, extended families still exist, health and welfare services should avoid segregating and isolating family members.

With regard to the aged and especially the mentally ill, care should, if possible, be provided at home and full hospitalization avoided at all costs.

In cases where hospitalization is unavoidable, it should be as short as possible and professionals should encourage family visits to the hospital.

Diagnosis and therapy should involve the active participation of family members. Wherever possible, health care technology should be combined with family care so that, for example, the chronically ill can benefit from home care help. Through such care, the reliance on hospital care may be reduced, whilst the quality of life of the chronically ill is enhanced.

The decentralization of health services

This task would be further achieved with the decentralization of health services to the level of district clinics. The hospital could ensure that small psychiatric units with daily out-patient facilities form part of these clinics. Such units would then be under the day-to-day charge of a psychiatric nurse.

Other support systems could be provided by voluntary groups and the churches.

Indigenous healers

There are a number of factors which favour the recognition of indigenous healing:

- Findings in psychological research show that the effectiveness of the healer is based upon the extent to which the healer's value system matches the value system of the patient.
- Consistent findings in the field of community mental health have demonstrated that non-professionals in a helping role can offer equal or better services than professionals.
- Western medicine has failed to explain successfully a large variety of conditions related to specific cultural syndromes such as the "thwasa".
- Western medicine, particularly hospitalization serves to increase the feeling of alienation of the patient from his family and his community. Indigenous healing on the other hand is inextricably woven into the fabric of community.
- Western diagnosis makes little sense to western patients and even less sense to patients in a non-western culture.

Policy issues

The following alternatives which may promote the greater cohesion of the extended family and other caregivers are suggested:

- The initiation of housing programmes that provide residential accommodation that enables old people and their families to live in the same house.
- Housing for the aged should be distributed throughout the community and not be segregated far away.
- Where feasible, installation of telephones at a low rate should allow old people to communicate with their children.
- Public transportation should be financially accessible to old people so that they can visit their families frequently.
- There should be motivation in the form of remuneration or exemption from paying tax for those families staying with their old people or mentally ill persons.
- Part-time and shared jobs for women would be a positive step towards ensuring proper child-rearing practices.
- Subsidies should be made available for rehabilitation projects initiated by voluntary organizations and other support groups.
- Legislation should make provision for the participation of non- professionals in mental health practice.
- Legislation with regard to the involvement of indigenous healers in mental health should be considered.

Conclusion

In summary then, mental health institutions should become less centralized. Because of inadequate resources, the contribution of non-professionals, support systems and indigenous healers should be encouraged and incorporated into the mental health system. Furthermore, the training of mental health professionals should be designed according to the social and cultural needs of the country.

Reference

1. David I. Ben-Tovim. 'Community-based care' in WORLD HEALTH: MENTAL HEALTH, A New Day Dawns; WHO, Geneva., October 1982.

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