Appropriate Technology

Mental health care in the district hospital

H G EGDELL

Psychiatric disorders are not peculiar to Western countries, and within the community served by a district general hospital in the Third World the incidence of major mental illness is about 1%; furthermore, the risk of any individual developing such a disorder is 10%.¹ Other studies in the developing world have found that 5-20% of patients have some form of psychiatric illness—commonly anxiety and depression—which may present with a variety of physical symptoms.² Few district hospitals have specialist psychiatric facilities or trained staff. This means that general duties doctors may have to take responsibility for providing care for patients with psychiatric illness. Help from the nursing and other health care workers is essential, although their co-operation may be difficult to obtain because of ignorance about, and prejudice towards, mental illness. My decision to initiate psychiatric visits to an upcountry hospital in Uganda was at first met with suspicion by the doctors, who thought that they would have to admit disruptive patients to their wards. Nevertheless, I received a warm welcome from medical assistants who were seeking help in the management of outpatients with somatic symptoms of anxiety and depression.

If psychiatric care is to be undertaken by general medical staff they must be familiar with modern psychiatric treatment and take the lead in preparing the other members of the hospital staff, and support them through their initial anxieties in looking after patients with psychiatric illness. It is also essential that priorities for care should be defined. Thus if Morley's guidelines are adopted those conditions that are common, disabling, disturbing, and treatable must be identified.³ In a study in seven developing countries community representatives, health staff, and research teams selected psychiatric emergencies (acute psychosis, suicide attempts, drug and alcohol abuse), grand mal epilepsy, and chronic psychosis as their priorities.⁴

Management of psychiatric emergencies

Community leaders and village health workers have no problems in identifying patients with psychoses.⁵ Many languages have their own words for the "run mad" and the "quietly mad"—for example, *eddal* and *l'akalogjo* in Uganda.^{6,7} Probably, however, treatment will be sought only when the patient is acutely disturbed or if a hospital shows a particular interest or success in treating such patients. Acute psychoses often present with unacceptable behaviour such as abuse, going naked, overactivity, and destructiveness. The patient may arrive at the hospital tied up, handcuffed, or fastened to a large log of wood. Whatever the circumstances it is important to obtain a good history from the relatives, the local headman, or the police. In particular seek evidence of physical illness, including epilepsy, ask about alcohol and drug intake, and establish whether the patient is always fully

aware of his surroundings and orientated in time, place, and person.

Patients often cooperate with the doctor given the opportunity. I once met a naked young man handcuffed to a hospital bed, which he dragged behind him through the hospital compound, waving a large stone in his free hand. The nursing staff had formed a wary circle around him. On being asked his problem the patient complained of too many injections in his buttock. After a further talk and a mug of tea he accepted a large injection of largactil into his arm. This anecdote illustrates that the staff's natural anxiety may actually encourage the patient's disturbed behaviour.

If faced with a violent patient keep calm and ensure that two or three male staff or relatives are near but not too close to be intimidating. Tell the patient that the staff are there to protect him from harm (from himself or others) and encourage him to talk. Offer food and drink but leave him plenty of "personal space." If he remains disturbed and overactive offer chlorpromazine 50-100 mg orally to help him "feel better and be in control." If he is cooperative arrange admission to a quiet room with minimal furnishings. Some hospital staff have an intuitive skill in calming the disturbed, and it is important to appreciate that time spent waiting for the patient to decide to accept treatment is more productive than a hasty attempt to overwhelm him. Physical restraint is rarely necessary and should be used only if violence persists. The aim of such restraint is to prevent the patient harming either himself or others and to administer a tranquilliser. It is best achieved by holding the patient's clothes, shoulders, mid-thighs, and calves, keeping the legs together and avoiding putting pressure on the neck, chest, or abdomen. The patient is then forced to lie face down on the mattress or floor. Remove any objects that may cause injury, such as shoes. Talk to the patient continuously, telling him when, where, and why the injection is being given. Chlorpromazine 100 mg intramuscularly (less if the patient is small or elderly) is effective and may be repeated every two hours. When oral medication is accepted the dose may be doubled, and the maintenance dose should be 200 mg (or less) four times a day. Haloperidol 5-10 mg intramuscularly half to one hourly (depending on size and age) followed by 10-20 mg given orally four times a day is an alternative regimen.⁸ These drugs may cause excessive sedation and hypotension, but the commonest error is to give an inadequate dose for too short a time.

Drug treatment has largely replaced electroconvulsive therapy. Two 60 bed provincial psychiatric units in Kenya have not used electroconvulsive therapy for over 18 months (Acuda, personal communication). On rare occasions, however, patients with resistant severe psychotic depression or uncontrollable excitement may need electroconvulsive therapy, and for this they should be referred to a specialised psychiatric unit.

Making a diagnosis

ORGANIC ILLNESS

Any patient who presents in an acutely disturbed state must be examined and investigated to exclude organic disease. The history

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is also very important, and evidence of clouding of consciousness, disorientation, impaired thinking and memory, and marked anxiety with a fluctuating general state must be sought. Minor impairment of memory may be established only by questioning about recent events and asking the patient to remember a name and address after five minutes. Visual hallucinations are common in organic psychosis. Table I serves as a guide to the aetiology of acute organic reactions. The doctor should be particularly aware of the common local diseases, and in this respect it is of interest to note that the two most commonly used drugs in Butabika Mental Hospital, Uganda, were chlorpromazine and chloramphenicol. This was due to the misdiagnosis of typhoid as a functional psychosis.

TABLE I—Causes of acute organic reactions. (Reproduced from W A Lishman's Organic Psychiatry³⁹ by kind permission) *

	Symptoms
(1) Degenerative	Presenile or senile dementias complicated by infection, anoxia, etc
(2) Space occupying lesions	Cerebral tumour, subdural haematoma, cerebral abscess
(3) Trauma	"Acute post-traumatic psychosis"
(4) Infection	Encephalitis, meningitis, subacute meningovascular syphilis. Exanthemas, streptococcal infection, septicaemia, pneumonia, influenza, typhoid, typhus, cerebral malaria, trypanosomiasis, rheumatic chorea
(5) Vascular	Acute cerebral thrombosis or embolism, episode in arteriosclerotic dementia, transient cerebral ischaemic attack, subarachnoid haemorrhage, hypertensive encephalopathy, systemic lupus erythematosus
(6) Epileptic	Psychomotor seizures, petit mal status, postictal states
(7) Metabolic	Uraemia, liver disorder, electrolyte disturbances, alkalosis, acidosis, hypercapnia, remote effects of carcinoma, porphyria
(8) Endocrine	Hyperthyroid crises, myxoedema, Addisonian crises, hypopituitarism, hypoparathyroidism and hyperparathyroidism, diabetic pre-coma, hypoglycaemia
(9) Toxic	Alcohol: Wernicke's encephalopathy, delirium tremens. Drugs: barbiturates (including withdrawal), bromides, salicylate intoxication, cannabis, LSD, prescribed medications (antiparkinsonian drugs, scopolamine, tricyclic and monoamine oxidase inhibitor antidepressants, digoxin, etc). Others: lead, arsenic, organic mercury compounds, carbon disulphide
(10) Anoxia	Bronchopneumonia, congestive cardiac failure, cardiac arrhythmias, silent coronary infarction, silent bleeding, carbon monoxide poisoning, post-anaesthetic
(11) Vitamin deficiency	Thiamine (Wernicke's encephalopathy), nicotinic acid (pellagra, acute nicotinic-acid-deficient encephalopathy, B ₁₂ and folic acid deficiency)

FUNCTIONAL (NON-ORGANIC) PSYCHOSIS

Schizophrenia with delusions of special powers or persecution out of keeping with local beliefs, and auditory hallucinations, may present with or without excitement. The manic patient is overactive, sleepless, and disinhibited with euphoria and grandiose ideas. Such patients need to be carefully examined for evidence of physical illness once their excitement has been controlled. Chlorpromazine 50-200 mg four times a day or haloperidol 10-20 mg four times a day, reducing slowly to smaller maintenance doses depending on response, usually provides satisfactory control. Stress induced psychosis is common in developing countries. It may follow adverse life events such as bereavement or assault, but more subtle personal precipitants may be difficult to identify. Most patients with acute psychoses settle rapidly and medication may be withdrawn slowly. Those with persisting symptoms—usually chronic schizophrenia (which has a better outlook than in Western countries)—may need maintenance doses of major tranquillisers. Depot preparations such as fluphenazine decanoate 25-100 mg intramuscularly or flupenthixol 40-120 mg intramuscularly every three or four weeks may overcome problems of compliance with oral treatment. These preparations are expensive but are cheaper than repeated admissions to hospital.⁹ It is advisable to keep a register of patients receiving maintenance treatment so that a failure to attend for further treatment and review may alert staff to take action to prevent a disruptive relapse.

Acute alcoholic psychoses (delirium tremens) may be controlled by a benzodiazepine—for example, diazepam 50-75 mg daily reducing after two or three days and stopping in a week. Haloperidol is an alternative. These patients and their families will need counselling on the hazards of excess drink and the benefits of reduced intake. Patients with epilepsy may also present with acute

psychosis, which usually implies poor compliance with anti-convulsant treatment. Follow up should include supervision of medication as well as counselling of the patients and their relatives.

Management of patients with neuroses

A survey of 1624 outpatients in primary care clinics in four developing countries showed an overall frequency of psychiatric illness of 13.9%—mainly the physical symptoms of anxiety and depression.^{10 11} More than 20% of outpatients who complained of weakness, dizziness, or abdominal or chest pain had a psychiatric disorder. Those with three or more symptoms were twice as likely to be mentally ill. These patients make huge demands on the hospital staff and on the hospital budget because many undergo needless investigations. In my view, the general duties doctor must be prepared to assess and when necessary treat these patients, and to do this he must be attuned to looking for depression, stress reactions, the anxiety aspects of physical illness, and the chronic symptoms of the anxiety prone individual.¹²

Patients with depressive illness may not complain of depression, but there are cross cultural core symptoms of sadness, joylessness, anxiety, tension, lack of energy, loss of interests, loss of concentration, and ideas of insufficiency, inadequacy, and worthlessness.¹³ Antidepressants such as amitriptyline 25-75 mg twice daily may be very effective in these patients. In patients with anxiety, however, the doctor's first task is to help them understand that their condition has psychosocial rather than disease origins. Appropriate adjustments to their way of life may then become apparent. The doctor must promote self help and guide the patients towards tackling their own problems. Techniques of relaxation, desensitisation, implosion therapy, and brief psychotherapy with clear, feasible objectives may help the doctor to deal with patients who are often demanding and difficult to treat.^{14 15} Minor tranquillisers such as diazepam and chlordiazepoxide should be used to treat only acute, severely disabling, short lived anxiety. They cannot solve psychosocial problems, and Third World health services cannot afford to follow the widespread and largely ineffective use of minor tranquillisers that has been evident in Western countries.

Patients who deliberately harm themselves or attempt suicide must be assessed carefully. Underlying psychosis or severe depression needs to be treated and all cases need close supervision while the underlying stresses on the patients and their family are assessed. It may be helpful to refer patients to community or religious leaders or, in some cases, traditional healers, who can provide further support and counselling. Nursing staff and primary health workers seldom have the time or the necessary skills to provide specialised care for such patients.

Attitudes to mental health

Mental health is now part of modern training programmes, but many hospital staff are still not yet prepared to manage patients with psychiatric disorders, especially those with neuroses, which were given a low priority in recent recommendations by the World Health Organisation.¹⁶ I think that this is regrettable, especially with respect to depressive illness, which is common, easy to recognise, and treatable. In my view a major change in attitudes and allocation of resources to meet the needs of the mentally ill is needed. The first step could be to set up a local workshop where health staff could meet community and religious leaders, members of voluntary associations, teachers, and other interested persons to clarify priority problems and consider a community response to these. On an assignment in Swaziland, funded by the World Health Organisation, I found that the rural health motivators (mature and respected individuals with three months' general health training) grasped psychosocial concepts rapidly and were keen to help patients. Simple counselling skills could prepare them for potentially valuable work with outpatients, especially healthy young people who present with non-specific complaints such as eye strain, poor concentration, and academic failure. A manual for the

disabled has been published recently and has many other suggestions for community action.¹⁷

Some traditional healers specialise in mental health,^{18 19} but does this mean that the doctor should cooperate with them? I believe that the wide variations in skill among such individuals must lead the doctor to be cautious, and that he should make a careful local assessment of their skills, methods of treatment, and results before committing himself to any formal liaison. It is salutary to remember, however, that patients will attend these healers anyway, both before and after they receive their Western care, regardless of the doctor's views.

Problems in childhood

Primary health care workers in the Sudan, Philippines, India, and Colombia have reported mental health problems in 12-29% of children seen.²⁰ Symptoms that are inconsistent, unusual, or associated with special circumstances are helpful pointers to diagnosis, as is the opinion of the attending adult.²¹ Hyperkinesia may be associated with brain damage, developmental problems, or family problems.^{22 23} Amphetamine up to 30 mg daily may help, though small doses of chlorpromazine, slowly increasing to 50 to 100 mg daily, may be all that is available. The attitudes of the family and school are crucial. Hysteria, manifested for example as aphonia or paralysis without physical illness, usually follows stress, though details may need tactful exploration. Admission to hospital may allow a face saving recovery while the underlying stress factors are explored and ameliorated. Nocturnal enuresis has been managed effectively by parents in Swaziland by ignoring wetting and rewarding dry nights using star charts (Guinness, personal communication). Similar management of encopresis is possible.²⁴ Care of children with epilepsy must include measures to overcome negative attitudes in the community.

Mental handicap is considered to be untreatable by some doctors, but communities have placed it high on their priorities for care.⁴ Parents lose heart and fail to teach domestic and self care skills, and unsatisfactory habits are established. A simple approach is to start with the control of fits or hyperkinesia and then teach that the mentally handicapped can learn but that they do so slowly. Various techniques have been devised for family use.¹⁷ A scheme using mothers and village aides as teachers of mentally handicapped children is proving successful in Kenya (Horsfield, personal communication).

Training

The doctor in a Third World district hospital should initiate training schemes for health staff concentrating on a few tasks that are seen as priorities—for example, the use of drugs, restraint of the violent patient, and community care. Ask the country's psychiatrists and health teachers to visit the hospital for joint discussions with local health trainers and to take part in teaching the staff and arranging workshops. Brief psychiatric secondment for selected health staff is feasible in some countries—for example, in Bangladesh regular courses are run for district hospital doctors (Dr Hidayet Islam, professor of psychiatry, Dacca). Zambia has a well established training scheme for medical assistants, which was started by Professor Alan Haworth. In India a similar approach has potentially wider application.²⁵ Further ideas may be gleaned by reviewing local pilot systems of care.^{26 27} Training manuals may be most helpful, and several have been produced.²⁸⁻³⁴ The use of flow charts is another valuable way to teach health workers.³⁵

It is useful to compile a list of psychotropic drugs that are available in the hospital, together with standard dose regimens (table II). A local glossary of psychiatric terms is also helpful together with a list of local interpreters who need a brief training in how to elicit a psychiatric history. The use of non-hospital staff implies that policy decisions should be made to sanction their participation in the care of patients with psychiatric disorders. Their responsibilities and training will require the cooperation of

TABLE II—Recommended psychotropic drugs for district general hospitals (second choices in parentheses)

Chlorpromazine	{25 mg, 100 mg tablet 25 mg/ml injection
Haloperidol	5 mg tablet
Fluphenazine decanoate	25 mg/ml injection
(Trifluoperazine 5 mg tablet)	
(Flupenthixol decanoate 20 mg/ml injection)	
Procydiline	5 mg tablet
Diazepam	5 mg tablet
Amitriptyline	25 mg tablet
(Imipramine 25 mg tablet)	
(Lithium carbonate 250 mg tablet)	
(Mianserin and Nomifensine are antidepressants with fewer side effects but very expensive)	

Health staff will need guidance sheets.

local and probably national health trainers. Finally, the success of any training programmes should be evaluated.³⁶⁻³⁸

Conclusion

The general duties doctor can provide effective mental health care in a district hospital. Although psychoses usually take precedence over neuroses, local priorities of care must be identified. Intervention and appropriate management of these disorders may be achieved with limited facilities and scant resources.¹⁶ The most important hurdle may well be that of overcoming local ignorance and prejudice.

I thank Mrs Irene Tierney for secretarial help and Mrs Betty O'Brien and Mrs Dorothy Howard for help with references.

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Suggestions for further reading

Tropical Doctor: Issues July 1983 to April 1985 contain a series of articles on the recognition and management of mental illness in adults and children for the general doctor working independently and far from advanced medical centres.

- Asuni T, Swift CR. *Psychiatry in an African setting.* (Mental health: rural health series.) Nairobi: African Medical Research Foundation, 1977.
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- Barker P. *Basic child psychiatry.* 4th ed. London: Granada, 1983. (Paperback £7.95.) Principles and practice that can be adapted to the Third World.
- Essex B, Gosling H. *Programme for identification and management of mental health problems.* (Tropical health series.) Edinburgh and London: Churchill Livingstone, 1982. (Softback £2.30.) Carefully evaluated and practical flow charts especially useful in teaching health staff who will work in isolation.
- World Health Organisation. *Organisation of mental health services in developing countries.* (Tropical health series.) Edinburgh and London: Churchill Livingstone, 1982. (Softback £2.30.)
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The following publications illustrate that mental health is a broad, positive concept and not simply the absence of mental illness. They are helpful in provoking staff to think beyond hospital walls.

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Writing it down

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In medical practice it is all too easy to drown in paperwork or, at the other extreme, to jeopardise the results of a job well done by leaving vital facts unrecorded. In developing countries it is particularly necessary to avoid wasting time and making inaccurate or unnecessary records, so what are the arguments in favour of keeping medical records? What is the best form on which to record information? Who should record the information? And, finally, who should keep the records?

Why keep records?

Records are needed to aid management of individual patients and for obtaining information for epidemiological purposes. The latter was the subject of Dr Peter Cox's article in this series (16 June, p 1814) so in this article I will concentrate on the requirements for individual patient management. In my view records serve three purposes, which may be reflected in separate documents or combined in two as described here:

- (1) To give to whoever may attend the patient at an accident the bare essentials that may prove useful for emergency treatment.
- (2) To give to the patient (or his family or friend) information that he needs to play his part in restoring or maintaining his health.
- (3) To remind or inform the doctor (or other health worker) of the diagnosis, medical history, previous investigations, etc, so that at any future encounter information on what has previously been found and done is readily available.

Which form?

The conflict in keeping good medical records lies between completeness and accessibility, and in my experience the extremes are an encyclopaedic dossier that is filed in the bowels of a teaching hospital and a simple record of an event in the form of a tattoo or a scar. Other considerations include the time it takes to fill in the form and the degree of skill required to complete the record. Accuracy and confidentiality are also important. The ideal solution to good record keeping will vary because of the widely different circumstances of district hospitals in the Third World. Nevertheless, the system described below may prove of interest. It was devised (after drawing on many people's ideas,¹ and with some juggling and

refining over 15 years) in a mission hospital in the Ivory Coast. The work of the hospital and its health workers included providing an extended village programme and many hundreds of patients were seen each day.

WALLET CARD FOR THE BARE ESSENTIALS

For a card to have any chance of being read at the scene of an accident it must be brief, and it should be kept with the identity card in those countries that have them. The essential items to include are: blood group; state of tetanus immunisation (and advice concerning boosters or serum in case the victim has dirty wounds); allergies; relevant medical disorders—for example, diabetes; regular medication—for example, steroids. Nevertheless, the cards may not be read and, even if they are, may not be acted on, so their value needs to be assessed with a degree of scepticism.

OUTPATIENT RECORDS KEPT BY THE PATIENT

We found the best form of outpatient record to be a single document kept by the patient. Single because if information is dispersed over two or more documents they do not receive equal attention in a rapid consultation. Thus we found that if a child's weight was recorded on a chart on a different piece of paper from that on which clinic notes were recorded (albeit kept in the same plastic envelope) one or the other record sheet was neglected.

Letting the patient keep the record has distinct advantages, because time is saved by not having to hunt for notes when the patient returns to the outpatient department and because information is always available wherever the patient presents, be it at the village, local health centre, or hospital. There is also the advantage that the patients get concerned more directly with their own health. Furthermore, entrusting the record card to the patient implies a degree of respect and trust that should facilitate communication and cooperation with health service staff.

The possible objections to a single document are threefold:

- (1) space for writing notes is cramped;
- (2) the patient may lose his card;
- (3) the patient may read information that it might be better to withhold from him.

For these reasons we experimented with keeping a separate card, which was kept in the hospital, for all those patients who saw a doctor (as opposed to a nurse practitioner). We soon gave this up, however, because it created a sharp distinction between the doctor's and other people's consultations, and on a simple time and motion basis it meant writing notes twice.

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