A proposed future for the care, treatment and rehabilitation of mentally ill people in Fiji.

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Abstract

Admission to Fiji's sole psychiatric hospital St Giles attaches the stigma of mental illness to patients, which may impact on the course of their lives and on their social acceptability. We argue that alternatives to hospitalization are health promoting in that they avoid stigmatization and institutional dependency. Recommendations are proposed for the further development of a community-based mental health service, such that admission is avoided where possible and where services are provided in the least restrictive environment close to patient's family and community supports.

Introduction

Admission to a psychiatric hospital is a major life event in any society. In addition to the ravages of the disorder, many patients experience the social consequences of isolation, family rejection and the 'stigma' of mental illness. In Fiji that stigma is synonymous with the name of the mental hospital, St Giles. To 'go to St Giles' or to have 'been in St Giles' are commonly heard remarks across Fiji, so much so as to raise the concern that a single admission may adversely impact on one's position in the general community for a lifetime. Stigma is defined as 'a mark of disgrace' (Macquarie Dictionary). Accordingly, the provision of alternatives to admission should become an important service priority that may be considered both protective of adverse social outcomes and health promoting through strategies of social inclusion.

The Fiji Ministry of Health's mission is to provide quality health services for the people of Fiji with a vision towards an integrated and decentralized health system to foster good health and well-being[1]. It acknowledges the right of every citizen of the Republic of Fiji, irrespective of race, sex, color, creed or socioeconomic status, to have access to a national health system that provides high quality health services. The attachment of social stigma through the use of one of the Ministry's services is an issue of service quality and sensitive provision as much as it is of community perceptions.

'There is no development without health and no health without mental health.'

Health is the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[2]. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. It is poignant that few people appreciate the fact that mental health is the matrix on which all of health is built. Many do not understand that a healthy body finds its sanctuary in the serenity of a healthy mind. Therefore, it is impossible to achieve a true state of health when the mind is not in a state of equilibrium and peace. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.

Recently, disability due to psychiatric disorder or illness has received increasing attention since the Global Burden of Disease (GBD) report launched jointly by the World Health Organization, World Bank and Harvard University[3]. It has shown that mental disorders are responsible for 11% of GBD in the world and Major Depression alone is the fourth contributor to GBD at present and will be the second highest contributor by the year 2020. The World Health Report (WHO 2001) made the clear, emphatic statement that 'mental health, which has been neglected for far too long, is crucial to the over-all well-being of individuals, societies and countries and must be universally regarded in a new light'[4].

In the Pacific Islands Ministers of Health meeting in Tonga in March 2003, mental health was included on the agenda for the first time[5]. Health Ministers from the Pacific and other parts of the Western Pacific Region have forged an alliance with the WHO through the Ministerial Round Table on Mental Health at the 52nd session of the Regional Committee for the Western Pacific and at the Ministerial Round Table at the 54th World Health Assembly[6]. The commonly held opinion was: 'There is no development without health and no health without mental health.'

The Health Ministers unanimously agreed to feature mental health on their national health agendas and to consider the huge burden of mental health problems as a priority for national action.

Background

In 2000, the population of Fiji was estimated to be approximately 854,796, concentrated on the two largest islands, Viti Levu and Vanua Levu[7]. The nation's capital city of Suva is located on Viti Levu and is the location of the St Giles Hospital. With a 190-bed capacity, St Giles is where most mental health services are organized, coordinated and delivered.

Historically, the development of mental health services in Fiji from the late 1800s has been reaction-based rather than anticipatory or proactive. St. Giles Hospital, then named the Lunatic Asylum, was founded in 1884 mainly for expatriates. The care of the mentally ill was relegated to lay persons called wardens who, in turn, were supervised by a Board of Visitors. The Board of Visitors scrutinized committal orders and determined who should be discharged. The Attorney General, The Chief Medical Officer and a prominent member of society comprised the Board.

In the 1960s a psychiatrist was appointed as full-time medical superintendent. Wilson (1965) reviewed psychiatric admission statistics by "race" (Fijian, Indian, and "other") over the period 1941-1962 and found that the admission rate for Indians was about twice that for Fijians, and the rate for "others" (Europeans, Chinese, Rotumans, etc.) was higher still[8]. In an unwittingly amusing statement typical of the times, Wilson argued that the greater "Europeanisation" of the Indians made them more likely to be admitted for psychiatric treatment; and that Fijians were still being taken care of at the "tribal level". In the 1970s, services expanded to include forensic assessment and an outpatient's clinic. By the 1980s, a multidisciplinary approach was adopted and occupational therapy for inpatients was started. Community Psychiatric Nursing commenced in 1994 and included a Day Care Center.

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With regard to the care and treatment of mentally ill people in Fiji, the functions and responsibilities of the Fiji Ministry of Health are defined by the Mental Treatment Act, Chapter 113, (28th February 1940, Ed. 1978)[9]. It is 'an act to amend and consolidate the law relating to persons of unsound mind and to provide for the reception and detention of such persons in mental hospitals.' The Act empowers the Minister of Health to establish mental hospitals for such persons; St. Giles being the only hospital in Fiji established for this purpose.

But the Mental Treatment Act does not address patients' rehabilitation and reintegration into the community. Since it was a proclaimed, significant developments and advances in neuroscience have changed the approach to and management of mental illness. These changed approaches have not yet been adopted in Fiji. New legislation on mental health should consider elements for prevention, mental health promotion, early diagnosis, treatment and rehabilitation and other mental health concerns such as: issues relating to human rights and responsibilities; the welfare of vulnerable groups (women, children, elderly, and people with disabilities); natural disaster responses; the mental health consequences of HIV infection and AIDS; and the effects of the use of the newly emerging psychoactive 'recreational' drugs.

Current Services.

Most of the available mental health professionals in Fiji are based at the St Giles Hospital. They provide a wide range of services that are, largely, hospital-based, biologically oriented and symptom-focused. These include: Adult In-Patient Care; Out-Patient Care; Occupational Therapy; a Day Care Center; Liaison Psychiatry to support other medical practitioners; and Forensic Psychiatry. Outpatient consultations are provided on Mondays for adults, children and adolescents at Suva's major general hospital, the Colonial War Memorial Hospital (CWMH). The Community Psychiatric Nursing (CPN) team is also based at St. Giles Hospital and provides psychiatric nursing care only to the greater Suva area. Access to St Giles and its centralized services is therefore difficult for people living beyond the greater Suva area. Rural communities in the Northern and Western Divisions and in the smaller, distant islands suffer from an absence of mental health diagnostic and treatment services. The wide geographic spread of the population, land, terrain and waters make equal access to services an impossible ideal while services remain centralized and while budgets remain attached to hospitals.

Domiciliary Services are provided to attempt to address this problem. Discharged patients are referred for follow-up to doctors and zone nurses within their localities, but none of these have specialist psychiatric training. There are no certificate trained psychiatric nurses in Fiji although moves have been taken recently to re-introduce a course at Fiji School of Nursing. In an effort to ensure that patients do not run out of medication, individual packs of medications are sent from the St. Giles Hospital pharmacy to Zone Nurses and given to the patients during reviews. Although there are some reported delays in the delivery of medications to certain areas, this is still considered an effective means to encourage adherence to medication regimens, although high readmission rates (anecdotally 70% p.a.) suggest otherwise.

Although the ill effects of long term confinement in a mental hospital (institutional dependency) and the advantages of community based mental health services have been widely recognized, there is still much to be done in providing community based mental health services. Delayed treatment contributes to chronicity and negative prognoses. The principles of providing services in the least restrictive environment or close to family support are not yet guiding service developments. Currently there are no designated psychiatric beds in divisional or sub-divisional hospitals and the capacity does not yet exist in the Divisions to diagnose, contain and treat patients with primary psychiatric disorders, some of whom may present a danger to themselves or to others. The difficulties such patients present to medical

officers, nurses and to other patients results in rapid referrals to St Giles Hospital. Sub-Divisional Medical Officers have already identified and expressed the need for additional training for themselves and other health workers.

Unfortunately there are no baseline studies on the epidemiology of mental disorders in Fiji. In particular, there is a need to describe and analyse the past and current utilization of St Giles in order to identify the types of patients for whom alternative treatment options will need to be developed. A preliminary study on first admission was conducted by Seru-Puamau in 2005 focusing on the 143 first admissions for year 2002 (10) with the view to identifying characteristics that suggest that patients may have benefited from a community based service, thereby avoiding the stigma of a psychiatric admission. The findings of relevance to this discussion were that the average length of stay of first admissions was 65 days and that 15% of patients did not have a major (psychotic or affective) psychiatric disorder. Bridgman (1997) had found a major cause of male first admission of Pacific Islanders to psychiatric hospital in New Zealand was for involvement with drugs and/or alcohol[11]. Following the exclusion of 24 patients who stayed over 75 days, the mean length of stay in St Giles for the remainder was 23 days – a significant amount of time to be out of the community – but similar to the average length of stay of 25 days for first admissions to the Macquarie Hospital in Northern Sydney, a long term facility similar to St Giles [12].

The rationale for liberating the mentally ill from institutional care cannot be challenged, but the alternatives to hospitalization need to be adequately resourced.

Integration as an Overarching Issue

Roberts (1994) argues that in order to integrate mental health services with other health services 3 types of integration are needed[12].

4.1. The clinical integration of the care of the mentally ill with general health services - termed 'mainstreaming' - is a strategy to reduce the stigma associated with mental illness, which is partly generated by seclusion into different treatment facilities, such as St Giles. In this approach, general health facilities are used to provide mental health services. Accordingly, there will be a need to conduct training for staff nurses and others and to institute criteria for referral to St Giles, where necessary, but as a back-up facility, not the first option.

4.2. The administrative integration of mental health services with general health services requires the inclusion on mental health staff, budgets and service administration into the Divisional structure. This will require administrators to understand that mental health is a health issue like any other and cannot be relegated to a low priority or managed in a separate structure. The transfer and application of the current mental health budget into the Divisional structure should be monitored by the Ministry of Health so that is occurs without leakage.

4.3. The social integration of the mentally ill with the general community can only be achieved when people with psychiatric disorders can be effectively monitored and treated in community settings. This will require awareness raising among the general community and rapid and sensitive handling of patients' problems as they arise. Response teams will be required to work around the clock, equipped and able to respond to psychiatric emergencies and situational crises (and not to confuse the two). Arrangements should be made to avert new patients from becoming dependent on institutions for long-term residence, by identifying alternative residential options within community settings.

Recommendations

This review of the current situation in Fiji leads us to proffer the following recommendations.

5.1. That the Ministry of Health develop a set of guiding principles and policies that will direct the development of mental health services into the future. These principles could include the following.

Treatment to be provided in the least restrictive environment and as close to the patient's home as possible.

Mental health services to be integrated with general health services to reduce the stigma of mental illness and to extend training in psychiatry to other cadres in the health care system.

Divisional mental health budgets to be managed by community-based services in order to minimize resort to hospitalization.

Community services should be staffed sufficiently for treating people in the community whenever possible.

5.2. That a Technical Working Group be established by the Ministry of Health to determine the resourcing needs of decentralization, including physical infrastructure, residential options, staffing of all cadre and their training needs, and to make recommendations to the Minister according to their findings.

5.3. That service development proceeds on the basis of participatory planning with non-government organizations, patients, patient advocates, community groups and potential funding agencies, such as the Ministry of Women, Social Welfare and Housing.

5.4. That the Ministry of Health discussions with the Fiji School of Medicine and the Fiji School of Nursing the further development of post-graduate programs in Psychiatry for doctors and Psychiatric Nursing for nurses.

5.5. That the Fiji School of Medicine and the Fiji School of Nursing examine the potential for providing flexible learning approaches to courses in Psychiatry and Psychiatric Nursing.

Concluding Remarks

The mental health system and the services at St Giles Hospital and in Fiji generally are urgently in need of reform. As in many countries, mental health in Fiji has been in the

'too hard basket' for many years and has been neglected. But now, patients' advocacy groups are beginning to form and there is a growing awareness in the community that mental illnesses are relatively common, even if their etiology is still misunderstood. The great emphasis that the World Health Organization now places on mental health compels us to consider this area more carefully. It should be noted that mental health system reform has proven difficult elsewhere but much of what we hear has been focused on negative outcomes. The many thousands of patients who have benefited from modern service arrangements remain unheard. The rationale for liberating the mentally ill from institutional care cannot be challenged, but the alternatives to hospitalization need to be adequately resourced.

This will require a much wider understanding of psychiatry and preventative mental health among the health workforce, particularly primary health care workers. The amount of training needed to achieve this will be extensive and will require some to be formally trained to the level of certification, while many others will need exposure to content and current issues on a more informal basis. Fiji's training institutions should be encouraged to respond to these needs by providing courses for flexible delivery.

The current work on the revision of mental health legislation provides an opportunity to challenge the basic assumptions upon which prevention, treatment and rehabilitation are based. It is anticipated that a significant budget will be needed to implement the changed legislation, so the draft of the Bill should include the guiding principles upon which service developments will proceed. It is essential that the Ministry of Health establish and support a Technical Working Group to discuss these issues in the light of the international experience and the resource constraints that operate in Fiji.

To conclude with a vision of the future, we anticipate the day when a young person undergoing mental stress, or succumbing to a mental illness, will be counseled in a primary health care setting, referred to and diagnosed by community based practitioners and treated with the support of family and friends in the home and community. Where this is not possible, we anticipate that such a young person would be admitted to a general hospital close to their home and family, appropriately treated there and returned to the community as soon as possible, to receive follow-up visits from trained community mental health workers, and participate in Day Care activities with other young people in similar situations. We anticipate that such a young person will not go on to develop a 'career' as a stigmatized psychiatric patient, but rather to learn to manage his or her condition with the help of family and friends, while supported by qualified and enthusiastic mental health staff located nearby.

Bringing about this change is the challenge that lies ahead of us.

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