Novelty Journals

International Journal of Novel Research in Healthcare and Nursing
Vol. 1, Issue 1, pp: (15-20), Month: September-December 2014, Available at: www.noveltyjournals.com

Knowledge and Practice in the Management of Mental Patients at Mathari Hospital, Kenya in Relation to the Mental Health Act of 1989

[1]Benson N.Gakinya, [2]John M. Mburu, [3]Caleb J. Othieno, [4]Anne A Obondo, [5]David M Ndetei

[1]MB ChB. M Med (Psych) (Nrb), Department of mental health, Moi University School of medicine
[2,3]MB ChB, M Med (Psych) (Nrb), Department of psychiatry, University of Nairobi School of medicine
[4]BA, MA, PhD (Nrb), Department of psychiatry, University of Nairobi School of medicine
[5]MB ChB, DPM (Lond). MRCPsych (UK) MD, D.Sc (Nrb), Department of psychiatry, University of Nairobi School of medicine

***Abstract*: This was a cross-sectional descriptive study conducted at Mathari hospital, the national referral mental hospital in Kenya. The objective was to determine how the medical personnel manage mentally ill patients in relation to the Kenya Mental Health Act of 1989. A total of seventy-nine (79) nurses, 3 medical officers, 11 registrars and 6 psychiatrists were interviewed; and 223 patients' files reviewed. The medical personnel were interviewed using a structured questionnaire to determine their knowledge and practice regarding the Mental Health Act of 1989. Further, 223 patient's files were studied to assess factors related to the Mental Health Act, such as properly filled admission forms, frequency of patient review and modes of admission and discharge of all the participants, ninety (90) % of the doctors and 76% of the nurses interviewed were aware of the laws regarding the management of the patients. However only 50 % and 75 % respectively of personnel adhered to the recommended procedures. Although levels of knowledge regarding the Mental Health Act. (1989) were found to be high, the practice regarding the patients' management was unsatisfactory. Factors that might possibly contribute to this disparity between the knowledge and practice are discussed and recommendation made.**

1. INTRODUCTION

A significant number of mentally ill patients are known to lack insight. Because of their impaired cognitive abilities they are not capable of making rational decisions in recognition of the civilized societies have make laws governing the treatment or handling of such patients. These laws have not always been in the patients; best interests. For example, In Kenya, in the early twentieth century, mentally ill patients were detained in asylums.[1] These were essentially prisons and the patients had little chance of being discharged except maybe to make room for newcomers. The patients' rights and property were therefore not well protected.

Over the years the laws governing the admission and management of the mentally ill have been revised. In Kenya during the colonial times, the Indian Lunatic Asylum Act (1858)[1] was in use until the enactment of the Mental Treatment ordinance of 1949**.** The latter was repealed on May 1st 1991, when the current Mental Health Act (1989)[2] come into force. In it are rules governing the establishment of mental hospitals and the admission of civil patients – both voluntary and involuntary. The criteria for emergency admissions and the admission of patients from the foreign countries are also included. The Mental Health Act of 1989 was meant to simplify and improve the general management of mentally ill patients. However, since it came into force, no objective assessment has been made as to whether its initial aims have been achieved. This study evaluated the general management of patients of Mathari Hospital in relation to the Mental

Health Act of 1989. It looks at whether the provisions of the act are adhered to in the admission, treatment and discharge of the civil patients at Mathari Hospital.

2. METHODOLOGY

The study was conducted at Mathari Hospital in Nairobi, Kenya. It is the national mental referral hospital and serves as teaching hospital for the University of Nairobi. At the time of the study it had an in-patient population averaging 700. There were 38 medical doctors – 15 of whom were postgraduate students in psychiatry and 8 consultant psychiatrists. There were over 200 nurses, 14 occupational therapists and 4 social workers with only one clinical psychologist. All the nurses and doctors working at the hospital were approached and the purpose of the study explained to them. The questions covered the general management of the patients and enquired about their practices regarding admissions, treatment and discharge of patients. Knowledge of certain aspects of the Mental Health Act was also assessed.
At the same time data was gathered from a random sample of 223 patients' files. These were patients who had been admitted to the hospital within the previous 3 months. Using a structured form the following details among others were noted: the presence and completeness of admission forms, frequency of medical review and physical examination while in the ward, duration of stay and modes of treatment. The discharge process was also noted and the obstacles that the patients faced in going back to the society were recorded.

3. RESULTS

Medical doctors:

Out of the 38 medical doctors working in the hospital at the time of the study, only 21 (55.3%) returned completed questionnaires. These included 6 psychiatrists, 11 registrars and 3 medical officers. Among the doctors who responded, 90.4% reported that they were aware of the relevant admission procedures and gave appropriate explanations while the others (9.6%) gave inaccurate explanation of the procedures. The admission criteria used by the doctors are detailed in table 1. The mental health act gives the patients the right to appeal against their admission. Only 47.6% of the doctors interviewed knew this. Furthermore, the majority of the doctors (61.9%) did not routinely get consent for treatment from either the patients or the guardians. The reasons that they gave for failure to get consent included the patients' lacked insight (52.3%) and that it was not routine practice in the hospital (4.8%). Others (4.8% of the doctors) thought that only patients who were due for electro-convulsive therapy required consent.
Most of the doctors (66.7%), reported that admitted patients required physical restrictions to either enforce treatment (4.8%) prevent patients from absconding (19.0%) or both (28.6%). The patient's safety and that of others was stated as reason for restriction by 14.3% of the doctors. Once patients are admitted, the doctors reported using various methods to monitor their progress. These include regular mental status examination (66.7%), and occasional inputs from nurses and other health personnel (33.3%). The initial medical reviews were reportedly done within the first two days of admission (61.9%). A review of the patients' records however showed that 14.3% of the doctors conduct such reviews more than 4 days (96 hours) after admission, and that 52.4% perform subsequent reviews twice a week with only 9.5% reviewing patients daily.

A part from pharmacotherapy, the doctors also recommended other forms of treatment as shown in table 2. Their satisfactions with these treatments are tabulated as well. The doctors reported encountering difficulties during the course of their duties at the hospital. These include lack of essential dugs (38.1%), inadequate equipment (4.8%) or both (47.6%). Lack of cooperation from other members of staff and relatives were reported by 9.5% of the respondents. The procedures that the doctors followed in discharging patients are shown in table 3. All the doctors reported that some of their patients encounter multiple problems at discharge. These included abandonment by relatives (19%), inability to pay hospital bills (17.1%) or both (19%). Similarly 57.1% of the doctors reported that patients experience a number of problems during the follow up period. The main ones were patients' inability to attend the follow-up clinics due to financial constraints (38.1%) and lack of proper clinic organization on the part of the hospital (61.9%). Most of the doctors (95.2%) reported that patients stayed in the ward longer than was necessary. Reasons cited include abandonment by relatives (23.8%), financial difficulties (9.5%) or both (47.6%). Sixty one point nine percent (61.9%) of the doctors

encountered situations requiring them to discharge patients against medical advice. The relatives/guardians of such patients requested discharge mainly to seek alternative treatment.

The common sources of patient's information for the doctors included family members (100%), employers (57.1%), the police (66.7%) and neighbours or friends (52.4%). This information so received was shared with other doctors and health workers, family members (90.5%), employers (14.3%), and the police (23.8%). Reasons for sharing this information included facilitation of treatment (76.1%), learning purposes (4.8%) or both (14.3%). Family members who got information from doctors included parents (19.5%), spouses (90.5%), siblings (66.7%) and any other relative who in any way was involved in taking care of the patients (14.4%). However, 33.3% of the doctors felt that such information was often given out to other people without their consent. Those reported to have been giving out the information included nurses (33.3%), records officers (19.0%), subordinate staff (19.0%) and the other doctors (9.5%).

Nurses:

Out of over 200 nurses eligible for the study, 79 respondents were included in the study. Most of them (86%) liked working in Mathari hospital. Of the respondents, 60.8% had been working at the hospital for at least 4 years and 81% had acquired their basic qualification over 10 years ago. Sixty-four percent had post basic qualification in psychiatry nursing. Out of the 79 nurses, 75.9% knew the admission procedures in details but 86.1% were not aware of the criteria used by the doctors to admit patients into the hospital. Those who were aware considered dangerousness and self-request to be some of the reasons for admission. The fact that patients could appeal against involuntary admission was not known by 64.6% of the nurses.

Regarding the patient's management, it is interesting to note that 67.1% administered drugs not prescribed by the doctors. The reasons are detailed in table 3. The drugs used included injections of chlorpromazine and diazepam – 46.6% of them regularly prescribing these dugs. Analgesics were also commonly used (76%) and sometimes the anticholinergic drug, benzhexol (7.6%). In addition to drug therapy, most of the nurses were aware of other forms of treatment such as psychotherapy, occupational therapy physiotherapy and electroconvulsive therapy (ECT), as well as spiritual/religious interventions. Sixty two percent (62%) of the nurses admitted having to seclude patients mainly because of violent behaviour and aggression. Lack of insight was also cited as a factor by 7.6% of the nurses. Most of the nurses (78.5%) reported performing mental status examination in order to assess the patients' response to treatment.

Patients' profiles:

A total of 223 patients' files were included in the study, 144 males (64.6%) and 79 females (35.4%) patients respectively. Ninety three point three percent (93.3%) of the patients had been admitted involuntarily but only 87.4% had properly filled, valid forms. Application forms for admission had been filled by either a brother or a sister (36.3%), parents (26.5%), uncles or aunts (4.9%), other relatives (8.5%), the police (2.2%), and other persons such as neighbours, friends and workmates in 8.5% of the cases. The reasons for admission noted on the patients' files are shown in table 4. In about 90% of the patients, physical examinations (including vital signs) were neither done at admission nor during their entire period of stay in the wards. The records further show that only 5.8% of the patients were reviewed within 24 hours after admission. The main mode of treatment was drug therapy. Psychotherapy, occupational therapy and ECT were used in only 1.3%, 2.2% and 1.3% of the patients respectively. A psychologist had attended to only one out of the 223 patients. The social worker had been involved in 37.7% of the cases. About half (50.7%, n = 113) of the patients studied had been discharged. Out of these only 38 patients were unable to leave the hospital. The reasons noted included inability to pay hospital bills (16.9) and unavailability of relatives (7.5%). About 2/3 of the patients were able to leave the hospital within a week after being discharged home.

4. DISCUSSION

The Mental Health Act (1989) was enacted so that the procedures of admission and discharge for mental patients could be simplified and the mental health services made available and accessible to the general population. Since then a great transformation has been noted within Mathari hospital. Patients are now admitted without any hindrances, are able to access available treatments and get discharged promptly. Decisions under the Act are taken with a view to minimizing the undesirable effects of mental disorder, by maximizing the safety and wellbeing (mental and physical) of patients,

promoting their recovery and protecting other people from harm. This is similar to the expectations in the UK code of practice for the mental health act of 1983 and has resulted in the wards being less crowded, more habitable for the patients and better to work in for the service providers.[3] This transformation was noted in the patients records in which some were admitted without any referral notes; with their duration of stay being considerable shorter with most staying in the hospital for only a few days to weeks as opposed to the period before the current mental health act when hospital stay was measured in months or years. This compares well with the observations by Winterson and Barraclough six months after implementation of the UK mental health act of 1983 in which they noted a reduction in the use of emergency orders and hospital stay.[4] However in a recent report on the monitoring of the mental health act in the UK, it was observed that the number of detained patients was increasing unlike the observation in this study.[5] this could be attributable to the complexity of the UK act compared to the Kenyan one which is simple and more liberal.

Staff profiles:

The members of staff have increased considerably in numbers and the variety of specialties. However, they are still not adequate to offer optimal services to the patients. With a total of 38 doctors this offers a fair doctor: patient ratio, however, the number of psychiatrists is not fully commensurate with the number of patients and needs to be increased so as to improve the services. Similarly, a modest increase in the number of nurses, occupational therapists, psychologists and other cadres of staff should be considered. In view of the small number of clinical psychologists – there was only one clinical psychologist at the time of the study; the nurses should also be formally trained to offer psychotherapy.[6] This process is commonly referred to as task-shifting and is often seen as offer in hope for the need of patients being meet though it overburdens the health worker. Hopefully this should shift the management to a more holistic approach rather than relying mainly on physical forms of therapy.

Knowledge:

The doctors and nurses working at Matheri hospital were found to have a reasonable level of knowledge of the mental health act. They were noted to be offering modest and probably agreeable services to the patients in line with the provisions of the act. However, these provisions were occasionally not adhered to as they were constrained by various factors including lack of equipment. There is clear evidence from recent research from various parts of the UK that medical practitioners, most particularly psychiatrists, and even those using the Mental Health Act on a day-to-day basis, do not necessarily possess a detailed knowledge of the law. This study did not look at a lot of details but could be comparable if the parameters of study were the same.[7] Among a random UK sample of Section 12(2) approved medical practitioners in the West Midlands, none of those interviewed was able to define the term mental disorder as used in the Act, and only just over one third correctly identified the four legal categories of mental illness, mental impairment, severe mental impairment and psychopathic disorder. In this study, lack of enough office space, study areas and recreation facilities for patients make it difficult for doctors and nurses to interact and work optimally. In particular, the nurse, who is also a therapist is not able to perform optimally as expected in psychiatry nursing practice.[8,9,10] Since dealing with emotional problems can be exhausting it is essential that such interaction be encouraged in order to boost morale. The number of nurses should also be reasonably increased to ensure they do not expose themselves to burnout; a situation that would compromise care.[11] Frequent evaluation of staff performance against such expectations should also be made to ensure optimum performance at all times. [7'10]

Patients:

It was noted that a small but significant number of patients could not meet the hospital stay and drug charges. This led to prolonged stay in the wards after being discharged. Some of the relapses and readmission cases could be attributed to lack of money for purchasing drugs. Early screening of patients by the social worker to determine the needy could assist in formulation ways to help such patients. Apart from fee waivers there could be other organizations willing to assist. A free drug programme for special cases such chronic schizophrenia should be initiated. This has worked well for other diseases such as HIV-AIDS and tuberculosis in the Kenyan setting**.** It is interesting that no foreign patient was found at the hospital at the time of the study. The admission procedures for such patients are slightly different since an application has to be made to the Director of Medical Services before they are admitted. Probably this can discourage some patients. Alternatively, they could be getting treatment from other private hospitals or failing to declare their nationalities. The procedure should however be simplified for those who may wish to be admitted.

In conclusion, the mental health act has gone a long way in streamlining the procedures of admission and discharge of patients from the mental hospital. A corresponding improvement in the quality of services has also been noted. The knowledge of the doctors and nurses regarding the MHA is high but there are significant problems that hinder the full implementation of the act, notably the poor physical facilities and low level of certain cadres' staff.

REFERENCES

[1] The Mental Treatment Ordinance. Government printers. 1949

[2] The Mental Health Act, Chapter 248, Laws of Kenya Government Printers Nairobi 1989

[3] Code of Practice for the Mental Health Act 1983.First published 2008 ISBN 978 0 11 322809 6 UK dept of health

[4] Winterson MJ, Barraclough BM. Effects of 1983 Mental Health Act. Lancet 1985;ii: 1426.

[5] Monitoring the Mental Health Act in 2012/13. Report Presented to Parliament by the Secretary of State for Health pursuant to section 120D(3) of the Mental Health Act 1983

[6] Nursing Human Resources in Kenya. Case Study Developed by Chris Rakuom for the International Centre for Human Resources in Nursing Copyright © 2010 by ICHRN

[7] M. S. Humphreys, J. P. Kenney-Herbert & R. V. Cope How to keep up with the Mental Health Act Advances in Psychiatric Treatment (2000), vol. 6, pp. 407–413

[8] Gournay K (2000). Psychiatric nursing techniques. In New Oxford Textbook of Psychiatry, (Eds. Gelder MG, Lopez-Ibor JJ & Andreasen NC), PP 1495-1500. Oxford University Press, Oxford.

[9] Gournay K & BOOKING j (1994). The CPN in primary care: an outcome study. British Journal of Psychiatry, 165,231-238

[10] Marks (1985). Nurse therapists in primary care. RCN Publications, London.

[11] David Kiima and Rachel Jenkins; mental health policy in Kenya -an integrated approach to scaling up equitable care for poor populations. International Journal of Mental Health Systems 2010, **4**:19

APPENDIX- A

List Of tables:

Table: 1 Admission criteria used by doctors

Admission criteria	Frequency
Dangerousness	21 (100%)
Pressure from relations	3 14.3%
Pressure from colleagues	1 (4.8%)
Pressure from nurses	2 (9.5%)
Admits all patients	1 (4.8%)
Destruction of property	16 (76.2%)
Degree of illness	20 (95.2%)
Self request	14 (66.7%)

International Journal of Novel Research in Healthcare and Nursing
Vol. 1, Issue 1, pp: (15-20), Month: September-December 2014, Available at: www.noveltyjournals.com

Table: 2 Forms of treatment prescribed as reported by the doctors (n = 38)

Forms of treatment	Prescription (%)	Satisfaction%
Psychotherapy	76.2	23.8
Physiotherapy	4.8	4.8
Occupational therapy	61.9	23.8
Electro-convulsive therapy	28.6	19.0

Table 3: Reasons for administration of non-prescribed drugs

Reasons	**Frequency (%)**
Emergencies	25 (31.6
Violence/aggression	18 (22.8)
Patients requests	1 (1.3)
Presence of side effects	6 (7.6)
Patients refusal of treatment	1 (1.3)
No reason given	27 (34.1)
Total	**79 (100)**

Table 4: Reasons for admission as shown on the patients' records

Reasons	**Frequency (%) (N = 223)**
Abnormal behaviour	16.1
Presence of "psychotic symptoms"	18.4
Aggression and violence	31.4
Substance abuse	5.4
Refusal of medication	6.7
Suicidal tendency	0.9
No recorded reason	21.2
Total	**79 (100)**