Long-term psychiatric care in Papua New Guinea

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Papua New Guinea is being forced to rapidly adjust to large changes with consequent effects on the mental well being of the population and mental health services. This paper describes my experiences and reflections on 14 months spent working as a psychiatrist between April 1991 and July 1992 in Papua New Guinea and describes Laloki Psychiatric Centre; the only long-stay psychiatric hospital in Papua New Guinea.

Papua New Guinea lies in the South Pacific just north of Australia and occupies the eastern half of the island of New Guinea. Geographically the country consists of a central mountain region, low-lying coastal areas and scattered islands. Forty-three per cent of the population of almost four million are under the age of 15. The presence of 790 distinct languages indicates the racial diversity within the country. The official language is English, but a pidgin English, Tok-Pisin, is commonly used. Papua New Guinea was an Australian colony until 1975 when the country gained independence and the colonial influence remains very much in evidence in the infrastructure of the country.

The health system has three tiers. Aidposts in the villages are staffed by community health workers with two years' training. Each Province contains several health centres staffed by either a nurse or a health extension officer (three years' training in a condensed medical course). Provincial hospitals are run by doctors and are usually administered by the government or occasionally by missions. Psychiatric facilities are limited. In 1991 and 1992, only three doctors were working in psychiatry in the entire country; all were based in the capital, Port Moresby. There are in-patient psychiatric facilities in only three hospitals; two of these are in Port Moresby. In seven provinces, psychiatric patients are cared for by psychiatric nurses and in the remaining nine provinces, patients are treated by general physicians or general health workers. The only long-term psychiatric and rehabilitation hospital in Papua New Guinea is Laloki Psychiatric Hospital (Burton Bradley, 1990*a*).

Laloki Psychiatric Hospital

The hospital was opened in 1964 replacing a small unit attached to the country's jail at Bomana. It is situated 15 kilometres away from Port Moresby in Central province (see Fig. 1). The degree of medical supervision of the hospital had varied considerably but had generally been limited; the hospital essentially had been run by eight psychiatric nurses. All had undergone a one-year post basic training course in Papua New Guinea and three had been to Australia for short specialised courses (Burton Bradley, 1990*b*). Four of the trained psychiatric nurses worked full time on the wards; the others were also responsible for the administration of the hospital, occupational therapy and social work. Nursing staff were helped by nurse-aides, and staff:patient ratios on the locked ward varied between 1:5 to 1:20. The posts of psychologists, occupational therapists, anthropologists and social workers which existed prior to independence were no longer filled.

The hospital consisted of three locked wards; only one of which was in permanent use, an open ward, a rehabilitation annexe and an occupational therapy unit. The main locked ward housed most of the forensic cases and the severely

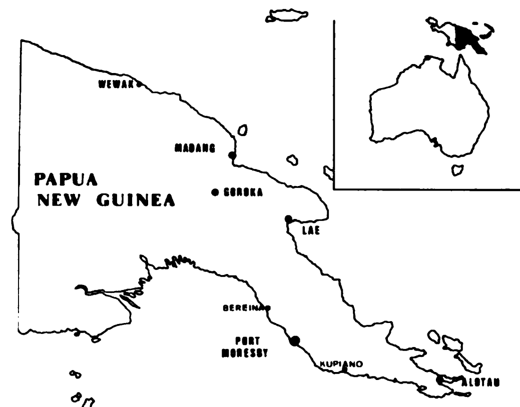

Figure 1. Laloki is 15 km from the centre of Port Moresby.

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mentally ill patients. Patients slept in rooms of bare concrete. Some had wooden beds, but others had to sleep on the concrete floor. Mattresses or pillows had not been replaced after previous destruction by patients. Patients spent most of the time in a large enclosure surrounded by concrete and security barred walls and were observed from the observation station through a large wire window. The adjacent large exercise yard could seldom be used as it lacked shade.

The open ward had similar rooms and an open living area. Although the patients acquired mattresses and pillows during my stay, facilities remained basic. Most patients were being prepared for discharge and were expected to look after the ward and keep it clean. An annexe was set down by the river, in a very beautiful and peaceful setting. Originally conceived as a halfway house to encourage rehabilitation into the community, it housed five institutionalised elderly men for whom rehabilitation had proved impossible. These men were semi-independent; they helped to cook and keep the ward tidy and earned money by working on the hospital farm.

Patient population

Laloki accepted referrals from all over Papua New Guinea. In the 1970s to early 1980s the annual admission rate ranged from 30 to 50 patients per year. The subsequent trend to try to keep patients within the community or close to their home villages has led to a fall in admission rates to a mean of 11 patients each year over the last five years. Some referrals were seen by members of staff who travelled out to the provinces to assess the need for admission and advise about optimal management. The patients who have been admitted recently could either not be managed in their own provincial health system or required more formal rehabilitation; the latter were usually referred from the acute psychiatric unit in Port Moresby. Forensic patients from Bomana prison were admitted following assessment at the prison.

In April 1992, there were 31 in-patients in Laloki. Over the preceeding year, 47 patients had been resident for at least part of this time (all male, mean age 38.0 years). This included two patients with learning difficulties who could not be managed elsewhere because of their need for intensive nursing care. Of the 45 psychiatric patients present at Laloki over this year, 18 (40%) patients were new admissions. Seven of these were referred from the Provinces, four from the acute ward in Port Moresby and seven through the courts or prison. Fifteen patients were discharged over the same period, one to his local provincial hospital, 12 were accompanied back to their village and two were sent back to prison. The median length of stay in hospital was 3 years (range 1 month to 28 years). Eleven patients (24%) had been admitted for less than a year and this group were discharged more quickly (median stay 6 months). Nineteen (40%) had been in hospital for more than 5 years. The ages of patients (estimated in many of the elder patients) on admission ranged from 10 to over 50 years (mean 31.5 years). Six patients (13%) were less than 20, 31 (68%) between 20 and 40 and eight (17%) over 40-years-old.

Diagnostic categories

Most long-term patients had been diagnosed as having schizophrenia on admission. However, the maintenance of intact personalities in many of them cast doubt upon the original diagnosis. Signs of institutionalisation in some made reassessment of their formal diagnosis difficult. However, on review, a wider range of diagnoses was made (Table 1). Twenty-three (51.1%) patients had some evidence of a psychotic illness (delusions, hallucinations or formal thought disorder) over the year. Diagnostic facilities were limited and organic disease could not always be excluded.

Treatment

Inevitably, chemotherapy was necessary in the management of many patients. Facilities for electroconvulsive therapy have not been available since the 1980s. Chlorpromazine was the only neuroleptic readily available to all health staff, although trifluoperazine, haloperidol and fluophenazine decanoate were available at Laloki. Amitriptyline, benzhexol and carbamazepine were also available. Diazepam was also used extensively in the community. Lithium was available but not used because drug levels could not be measured. In April 1992, of 31 in-patients, six were on no treatment, 15 on chlorpromazine only, one on carbamazepine and nine were on more than one drug. By the time of discharge, drug treatment had been simplified. Of the 15 patients discharged in the preceding year, four

Table 1. Diagnostic categories

Diagnosis	*n*	(%)
Schizophrenia	23	(51.1)
Affective psychosis	4	(8.9)
Chronic institutionalisation	4	(8.9)
Possible organic	3	(6.7)
Mental retardation	3	(6.7)
Substance abuse	2	(4.4)
Personality disorder	2	(4.4)
Depression	2	(4.4)
Epilepsy	1	(2.2)
Amok syndrome	1	(2.2)

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were on no treatment, seven were on chlorpromazine, three were discharged on fluophenazine decanoate, and one was receiving chlorpromazine and trifluoperazine.

The redevelopment of the occupational therapy (OT) unit allowed the teaching of simple cleaning, gardening and farming skills; important basic skills for most villagers who live off the land. Small items, such as stools, were made with native materials which were sold to provide income for the OT department. Art materials were available and games sessions were held on the ward, in occupational therapy and outside. The development of training in counselling allowed nurses to use a problem solving approach with the more able patients.

A social worker (trained psychiatric nurse) was crucial in maintaining links with the community (Robin, 1979). He organised weekend leave and home assessments prior to discharge. Part of his role was the education of local health workers, the family and village. Upon discharge to another province, a member of staff accompanied the patient to help re-integrate them into their local community and would also spend time with the local health worker or psychiatric nurse in an educative role. Discharged patients were followed up by their local clinic/health centre with advice from staff at Laloki.

Comments

It is difficult to portray the initial impact of Laloki. It was as though one was walking back into a nineteenth century asylum; naked men roamed around in a large cage staring out at me as I stared back at them with a mixture of fear and sadness. However, as I spent more time there, I began to appreciate what was being done in the face of such limited resources and training. Containment was initially achieved by incarceration and chlorpromazine, inevitable given the lack of experienced psychiatric input. I was surprised at the rarity of problems with aggressive patients; nursing staff were very good at containing difficult situations when they arose and the level of violence on the wards was remarkably low. With increased input and guidance, the nursing staff became a more active team, overcoming the difficulties of poor morale and limited resources. Patients began to experience some freedom and we were able to review their physical and mental state. Patient facilities were improved by gaining essential items through collections from local schools; this also gave us an opportunity to educate the local community about the problems of mental health. Regular training of staff was welcomed enthusiastically.

To practise psychiatry in another culture was an unique experience and privilege, albeit frustrating at times. One of the obvious difficulties was that of language. Although I was able to learn Tok-Pisin, it is a language with a limited vocabulary; a single word may encompass diverse emotions from feeling sad to being profoundly depressed. Some interviews had to be conducted through interpreters; the information that I received was frequently dependent as much upon the nurses' belief system as upon that of the patient. Interestingly, the large number of distinct languages in Papua New Guinea meant that many of my colleagues were equally handicapped in being unable to talk to patients in their first language.

One of the fascinating aspects of psychiatry was the addition of another dimension to consider, that of cultural beliefs with which I was totally unfamiliar. In a culture where ancestral spirits, magic and sorcery are part of everyday life, the evaluation of the significance of delusions and hallucinations becomes much more difficult. One patient admitted with mania and apparent paranoid fears that her husband was going to kill her, was interviewed by a medical student. He presented a history that the women believed her husband had killed her mother. The mother had been in her hut when a dog had walked in and shortly afterwards her mother had died. The woman believed that her husband had turned into a dog, entered the hut, administered sorcery and had left before turning back into his human form. When asked whether this represented a delusion, the medical student said that this could have occurred and that the patient was right to be fearful of her husband.

The rapid changes as Papua New Guinea becomes rapidly westernised has had several implications for psychiatric care in the country. Traditionally, mental illness has been relatively well accepted in most communities in Papua New Guinea; patients presenting to the medical services are often violent or behaving in a very bizarre fashion. Once they had been treated, they were accepted back into the community. The loss of tight-knit tribal communities and urban drift appears to be leading towards the breakdown of this "wantok" system of being cared for by your family and village; community care of mentally ill patients may be much more difficult in the future.

It also appeared that the pattern of mental illness was beginning to change in Papua New Guinea. Urban migration of people looking for work, rising unemployment for some educated people and the law and order problems increase the level of stress. The increasing use of alcohol and marijuana add to the potential problems and somatic presentation of mental health problems is often seen in medical clinics. However, in a country where health spending in general is

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limited, mental health is not seen as a priority (Burton Bradley, 1975). There is a need for experienced psychiatrists in Papua New Guinea. Until more national doctors become interested in psychiatry, there is an unique opportunity for experienced psychiatrists from other countries to work in another culture where psychiatric illness and its management present many challenges.

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References

BURTON BRADLEY, B. G. (1975) *Stone Age Crisis*. Vanderbilt University Press: Nashville, USA.

— (1990*a*) The Mental Health Systems of Papua New Guinea and their modernization. *Papua New Guinea Medical Journal*, **33**, 51–54.

— (1990*b*) Psychiatry. In *History of Medicine in Papua New Guinea* (ed. B. G. Burton Bradley). New South Wales: Australian Medical Publishing Company.

ROBIN, R. (1979) *Psychopathology in Papua New Guinea. A collection of four papers*. University Printery: Port Moresby.

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