GUEST EDITORIAL:

THE DILEMMA OF PSYCHIATRY

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INTRODUCTION

IN MANY developing countries, psychiatric services are provided from overcrowded and poorly equipped huge anonymous institutions that claim to be hospitals more by designation than by design. Any attempt to move away from these huge edifices takes time but is usually done in fits and starts, and sometimes at the expense of the already critical shortages of staff in the institutions. The result often is that "model units" that are started in general hospitals fight losing battles in their struggle to act as embryos of reform in psychiatric care in the country. The large institutions often win in the battle and remain entrenched as the backbone of psychiatric services together with all the associated evils (Goffman, 1968). "Institutional neurosis" is an iatrogenic disease caused by the system along which institutions are run — the rigid hierarchy, the climate of distrust and their dehumanising effects on the individual. The individual in a mental hospital becomes an anonymous being bereft of ties with kith and kin. His only sin is that he has mental illness.

COMMUNITY CONCEPTS

The problems of institutionalisation and backwardness in psychiatric care are recognized the world over. The answer lies in the decentralisation of psychiatric care to the level of the general as well as district hospital. It also depends on the move away from the institutional to a community-based concept of psychiatric care. The concept revolves around the theory that psychiatric disease is the result not only of disordered genetics or biochemistry but of stresses and discord in the environment of the patient — primarily in relation to his family. The management of the patient should therefore revolve around mental health, child psychiatry, family and marital therapies and preventive psychiatry. Thus mental illness, when it occurs, should primarily be managed in the community with the help of relatives and parents or in day centres. Hospitalisation in short stay wards should be for acute episodes of disturbed behaviour. Further, the rehabilitation of the patient should focus on the psychological, social and occupational aspects as soon as possible and be conducted in day centres and therapeutic communities.

To be successful, such a concept of community-based psychiatric care depends upon the availability of trained manpower. Despite liberal possibilities of volunteers and semi-professionals helping to run the system, it really depends on a core of professionals in the various specialities and sub-specialities of psychiatric practice. These include psychiatrists, child psychiatrists, social psychiatrists, adolescent psychiatrists, psychologists, psychiatric social workers, occupational therapists and psychiatric trained nurses *in adequate numbers.*

The contribution of psychiatry is not confined to the treatment of psychiatric patients but includes the promotion of mental health and the prevention of emotional problems. It's role in the prevention of emotional problems through community mental health programmes, providing of professional advice to vulnerable groups or occupations and providing expertise in the early detection and management of psychological problems, is hardly felt in Malaysia.

THE DILEMMA

The principal problem in improving psychiatric care in Malaysia is tied in to the lack of trained staff. There are only 19 psychiatrists out of 2500 doctors in Malaysia (not to mention the shortage of the other para psychiatric professionals). This menas that there is only one psychiatrist to 750,000 of the population. However, this figure is

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actually misleading since only 10 psychiatrists are fully engaged in the Ministry of Health as the other 9 are in the Universities, Armed Forces or private practices. Dax (1962) a WHO Consultant recommended that by 1968, there should be "the barest minimum of 11 psychiatrists as well as many more in training" in Peninsular Malaysia. Yet, today there are only eight psychiatrists in Peninsular Malaysia in the major service centres for psychiatric patients. As for specialists in the various sub-specialities, the problem is even more acute. There is only one clinical psychologist, in one of the medical schools, in the whole country. There is but one child psychiatrist in Malaysia which has over five million children. Can anything be urgently done to right this obvious imbalance?

THE TRAINING OF PSYCHIATRISTS

Psychiatry, being a speciality that is not considered popular, does not attract many trainees in most countries. In Malaysia, with its system of institutional psychiatry, it attracts even less trainees. Most of the present 19 psychiatrists have been trained overseas. It was not until 1973, that a local two year course leading to the Masters in Psychological Medicine was established in the University of Malaya. Thus far, five batches have undergone or are undergoing training at the University of Malaya. But despite its existence, the course has not been fully utilized and due to various factors, has added only two serving psychiatrists to the total in the country. Like the rest of the medical professions, the psychiatrists in the country have tended to emigrate. But the recent loss of ten psychiatrists (not to mention trainees) within thirty months is a most serious problem.

A figure of one psychiatrists per 100,000 population has been quoted as ideal for many countries. On such a basis, Malaysia would today need about 125 psychiatrists. However, there are only 19 today. If a figure of 1 : 250,000 were to be considered, Malaysia would still require a total of 50 psychiatrists now — or an additional 31 psychiatrists. Even if six psychiatrists were trained each year, this would require seven years before the requirements of 1978 were met, not allowing for wastage.

CONCLUSION

This then is the dilemma — we are trying to care for the mentally ill with a psychiatric system that is not only woefully outmoded but seriously undermanned. The effect that this has on the mentally ill, not to mention the emotional health of a young and growing population of children, is something that requires serious consideration. For too long, emotional problems and mental illnesses have been swept into institutions out of sight and out of minds. It is only when drug dependence or truancy hits the headlines that mental health comes to the forefront. Major problems include the shortage of psychiatrists, long-waiting lists and the lack of modern facilities for treating the mentally ill. There is an urgent need to make psychiatry less frightening to the people, and the training in pscyhiatry more attractive to our young doctors, so that the number of qualified psychiatrists can be increased. This can be done by the provision of more scholarships with perhaps less stringent bonds, the setting-up of modern general hospital units with provision for day centres, the practice of modern treatment methods and the use of trained para psychiatric staff.

The dilemma of psychiatry is not one of numbers alone, but one of attitudes. Do we care for our mentally and emotionally ill? Do we care that our children grow up not only healthy in body but also in mind to be the future generation of this country?

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