Community mental health care in Botswana: approaches and opportunities

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Aim: The purpose of this article is to provide an insight into the developmental trends in community mental health care in Botswana. Different approaches are discussed and the opportunities that have emanated from them.
Background: Care of the mentally ill in Botswana is provided at different levels of coverage and sophistication. There is a single mental hospital in the country. Attached to the district hospitals are psychiatric outpatient clinics run by psychiatric nurses and a psychiatrist who visits them on monthly basis. Mental health care in Botswana has gone through a paradigm shift, from the prepenal years, penal years and institutional to community based care, which reflects a philosophy of citizen involvement and collaboration.
Conclusion: Several approaches have been utilized in the development of community mental health care. However, difficulties and challenges still exist in the provision of community mental health care.

Keywords: Approaches and Opportunities, Botswana, Community Care, Mental Health Services

Background

Botswana has a population of 1.7 million people (Central Statistics office 1995, p. 2). The population is served by one state mental hospital located in the Southern part of the country, which serves as a referral unit for the whole country. In Botswana, the healthcare system is under the portfolio of the Ministry of Health representing central government, which has overall responsibility for the improvement of the health of the nation (Manual of Health Services 2005). The Ministry sets the general goals, priorities and directions for development of health services and activities in Botswana.

The organization of the healthcare system

Two healthcare systems run concurrently in Botswana; the Western and the traditional forms of health care. Every Botswana has access to both the traditional health care and the Western healthcare systems. The selection of which health care to seek is influenced by the beliefs, customs and values of the people. The usual practice is that people exhaust the traditional healthcare services first before consulting the Western health care, especially if the person suffers from an illness whose aetiology is still not clearly understood such as mental illness.

The Western health care inherited at independence in 1966 was largely curative hospital-based care. Most Batswana did not have access to the Western healthcare system (Ministry of Health 1979). It is for these reasons that healthcare providers take into cognizance the operations of these systems and fully comprehend the belief system of the people they deal with in order to accommodate the two health systems.

The Botswana healthcare system is organized at different levels of sophistication and coverage. At the lowest level is the outreach where health care may be provided at a mobile stopping point. Next, there is the health post that consists of a small structure staffed by a nurse and a family welfare educator, which serves a population of about 500 people. The next level is the clinic, which serves a catchment area of about 4000 people and is staffed by community health nurses; a medical practitioner visits occasion-

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ally. Some clinics have recently been upgraded to include maternity and laboratory services and these are functional on a 24-hour basis and serve a much larger catchment area. The primary and district hospital follow in that order and provide a range of services from primary to inpatient services. At the apex of the service pyramid are the referral hospitals, which mainly provide specialist services. There are only three in the country, one of which is the Lobatse Mental Hospital. Although the Ministry of Health has the overall prerogative on health matters, clinics, health posts and mobile stops are administered by the Ministry of Local Government through local authorities. The primary, district and referral hospitals are administered by Ministry of Health at central government level.

Societal attitudes towards mentally ill persons

Botswana, like all other societies has had negative views about mental illness and mentally ill persons. In Botswana, mental illness constitutes only one disease entity called 'madness'. Persons showing signs of mental illness used to be laughed at, rebuked and ostracized (Ben-Tovin 1987). Families with persons who show signs of mental illness are still discriminated against and stigmatized. To date, mental illness still carries the stigma in that people frequently will not seek the necessary assistance at an early stage of the illness for fear of being either labelled or ostracized. The inequalities and disparities in the distribution and allocation of resources in mental health are indicative of the less important status accorded to this population group.

Approaches in mental health services

Care of the mentally ill in any society takes place within a complex historical, social, economic, political and cultural context. In Botswana, the care of the mentally ill has been impacted upon by colonialism, which has had a great impact on the healthcare system as a whole. During the colonial era (1885–1966), most Batswana were excluded from accessibility to Western health care. The institutions that existed then were not intended for Batswana but for their white colonial masters. When Botswana gained independence in 1966 most of the hospitals inherited from the British government were situated along the railway line where white colonialists mainly resided (Ministry of Health Annual Report 1979). The colonial healthcare system, which was predominantly hospital-based curative system, totally denied most people accessibility to health facilities (Ministry of Health Annual Report 1979).

There are different approaches that emerged in the organization of mental health services. These were influenced by both internal and external factors and will be discussed under four distinct historical epochs: (1) the pre-penal years, (2) penal years, (3) institutional, and (4) community years.

Pre-penal years – before 1885

During this period mental illness was solely associated with witchcraft and or possession of bad spirits. Signs of mental illness brought shame to the family and hence persons suffering from mental illness were hidden until their demise (Schapera 1970). Mental illness was viewed not as an illness but a tragedy that had befallen the family. As a result, only the traditional doctor was called upon to name the person or persons responsible for the tragedy so that the family may in turn revenge their family member's tragic illness (Schapera 1970). No institutions for the mentally ill existed in Botswana during this period. Persons with mental illness were chained so that they could not run away and embarrass their families. Such practices can still be found sporadically in other parts of Botswana.

Penal years – 1885–1945

The penal years began with the consolidation of the British dominion in 1885 when the Bechuanaland protectorate was declared. The mentally ill were still cared for by their families during this period. Two dominant persons who became uncomfortable with the treatment of the mentally ill emerged at this period: Sidney Shippard, who was the earliest administrator of the protectorate and Chief Tshekedi Khama, a leader of the one of the major tribes of the time.

In a letter to the Governor in 1891 Shippard recognized that the care of the mentally ill was a problem. In this letter to his supervisors Shippard raised fundamental issues about the care of the mentally ill in prisons; that they required 24-h 'around the clock' care; that the prisons were not the right place for the mentally ill, and that they did not have a specific budget. The mentally ill thus consumed a cost from the Police budget, hampering the legitimate duties for which the police were urgently required. His main argument was to draw attention to the budgetary constraints imposed by the care of mentally ill persons. Shippard advanced two proposals to the government to assist the Bechuanaland Protectorate: either by confining the mentally ill to asylums in the Cape Colony, or building an asylum in Botswana in order to confine these patients and give them better care. The mentally ill who were cared for at home did not receive any better care from their families, and were left to wander about almost in the state of destitution (Shippard 1891).

Shippard encapsulated in a nutshell concerns about the care of the mentally ill for years to come because many concerns about their care still remain. Although during this period prisons were used as a resource, the preferred solution was confining the mentally ill in specially constructed institutions (Shippard 1891).

The utilization of the penal institutions to confine mentally affected persons was also a concern for Dyke (1933), a director of medical services of the Bechuanaland Protectorate. Dyke distinguished three classes of mentally ill persons as the dangerous luna-

tics who could be sent to South Africa and Rhodesia (Zimbabwe), lunatics who were merely destructive to property and were a serious nuisance who could be kept in local prisons, and lastly, the harmless imbeciles who could be cared for in the home by their relatives under the supervision of chiefs. The majority of the mentally ill persons who were committed to institutions outside the country lost ties with their relatives and families, and even lost their identity and knowledge of their places of origin.

Chief Tshekedi Khama of the Bamangwato also saw the confining of the mentally ill in prisons as inhumane. Chief Tshekedi was the most influential chief during the colonial period, and in his dialogue with the colonialists he tried to convince the government to build a mental institution in Botswana. This conviction together with the inability of the prison authorities to contain violent mentally ill patients, led in 1938 to the opening of the mental hospital in Botswana at Lobatse (unpublished minutes of the African Advisory Council 1944), which was then referred to as a mental home.

During this period, psychiatric or mental health nurses did not exist. Male attendants were employed on the basis of physique to help to detain the aggressive clients. No formal training for these attendants was provided or deemed necessary (E. Moagi, unpublished paper).

The institutional years – 1946–1978

Lobatse is the second town of Botswana and after almost six decades its mental hospital remains the only one in the country. It was intended to provide alternative accommodation for the mentally ill. It had two rooms with 12 beds and was intended to act as a clearing centre for patients in transit to the Igutsheni mental institution in Bulawayo, Zimbabwe (Ben-Tovin 1987). Those who could afford to pay; especially the colonial administrators went to South Africa. Patients admitted to the mental hospital were seen by general practitioners from the nearby Athlone hospital, of which the mental hospital was actually an annexe. Patients were taken care of by attendants and were periodically visited by the matron from Athlone. Many of the mentally ill were still excluded from admission owing to lack of adequate space. As a result, a year after its opening, this new mental hospital suffered serious overcrowding with up to 60 admissions (Sbrana 1972). There were no outpatients' facilities, so every person who showed signs of mental illness was immediately admitted to the hospital (Lobatse Mental Health Report 1979). A District Commissioner's Conference of 1947 noted that the mental hospital was overcrowded and that no more clients should be accepted (Unpublished Conference Proceedings, 1947). It should be noted that at this time the mentally ill clients were referred to as 'cases', a terminology that still exists. E. Moagi (unpublished paper) made a revealing comment about the institutional years when she said:

> Lack of psychiatrists and psychiatric nurses made it impossible for the severely disturbed patients to be kept at the home because there was no drug therapy or nursing care.

The hospital was extended in 1966 to accommodate 64 patients. However, patients with aggressive behaviour were still sent to prisons, as they could not be contained in the hospital owing to the lack of trained personnel. Changes in the structure and treatment of the mentally ill started in 1969 with the arrival of the first psychiatrist in Botswana, Dr Sbrana. He started to use psychopharmacologic agents and electroconvulsive therapy. It was during this period that the recruitment of nurses began. Dr Sbrana gave nurses in-service education on how to provide care for these patients. Only four male nurses were recruited and they remained for 10 years (Sbrana 1972). The fact that these nurses were only men indicated the stereotypes that were held about mentally ill clients' aggressiveness.

Problems of overcrowding and undesirable living conditions in the hospital prompted the development of other alternative approaches for the mentally ill. The move was also influenced by external forces such as the World Health Organization (WHO), which entered into technical cooperation with a number of countries including Botswana (WHO 1995) when countries began to collaborate in reviewing problems and progress in the delivery of mentally health services. In 1979, two government policies were passed that had direct implications for mental health policy and nursing practice. These policies were a paradigm shift in the provision of mental health services. The first was the decentralization of community mental health services in Botswana, which resulted in the establishment of an outpatient department in the mental hospital grounds. The second was the adoption of the primary healthcare concept, which resulted in the creation of 13 psychiatric outreach clinics, and the employment of mental health tutors. The primary healthcare concept also advocated collaborative effort with non-health community agencies (Health Policy 1984; WHO 1995).

The post-institutional period or community years – 1978 onwards

This period is often referred to as the community mental movement or de-institutionalization of the mentally ill in order to integrate them back into the community (Ministry of Health Annual Report 1984). The impetus for community mental health care was in part, a result of the advent of chemotherapy, consumer involvement and influential ideologies borrowed from Western countries. The intent of the movement was to provide humane and good care for the mentally ill (WHO 2001). Community-based care, as in other countries, was supposed to take an integrative approach supported by the inclusion of beds in general wards for patients with acute psychiatric conditions. The intent was to

provide care for the mentally ill in primary care settings by primary care nurses. In Botswana, 13 outreach clinics known as psychiatric units were annexed to general hospitals. However, these were isolated from the mainstream of the hospital. This in the authors' view defeated their intended purpose. The prevailing ideologies of the time considered communities to be 'good' for mentally ill persons; communities were believed to be willing to assume responsibilities for their care; and it was believed that functions performed in the hospital could be performed better in the community (Bachrach 1978). Further, community care for persons with mental illness was seen as an alternative to long hospital stay. The community was also preferred as a natural environment for care because it enforces not only appropriate behaviour through healthy role models, but also provides an atmosphere for skill training and application (Solomon 2000). These ideologies sounded appealing to young and developing nations like Botswana. However, the optimism that prevailed about the de-institutionalization movement was short-lived.

Opportunities

Opportunities emerge out of the approaches that were used in community mental health care. These included community mental health education for nurses, integration of mental health services into the general health system of care and development of a national health policy.

Community mental health education for nurses

The training of community mental health nurses started in 1984 but ceased in 1988 having produced only 10 community mental health nurses. The discontinuation of this training was in part due to a lack of well-prepared mental health educators and a lack of applicants. Recruitment of staff from outside the country was however, realized in 1990, with the assistance of WHO. Thus, retraining began in 1991 and vigorous recruitment of both staff and students was made. Since then the programme has produced an average of 20 students every 18 months with a quarter of these students coming from within the region. To date, there are 120 psychiatric mental health nurses; 112 prepared at advanced diploma level, six at masters degree level and two at doctoral level. This represents considerable progress, but these nurses are still inadequate to meet the demands of community mental health services.

Training of community mental health nurses is an opportunity that arose from the many approaches that were used and those that are currently in use. Efforts to sustain training programmes in general in Botswana are currently being stifled by the migration of nurses that the healthcare delivery system is currently experiencing. Nurses are leaving for countries that can offer them better employment and advancement opportunities. Consequently, this trend continues to deplete the already inadequate nursing work force.

Family support systems

Community based care created increased recognition of the need for support for the family and community. Respite centres were established in some communities in Botswana and counselling services were provided at most governmental institutions. As the HIV/AIDS epidemic escalated and home based care became the norm, community mental health care provided an exemplar for this alternate type of care.

Integration of mental health services into the general health system of care

Integration of mental health services into the mainstream of health was initiated after 1978. Many strategies were used in its implementation and included: (1) attaching psychiatric units to the district hospitals in major villages, towns and cities; (2) decentralizing medications from psychiatric units to other healthcare facilities where there are trained nurses and general practitioners; (3) in-service training for general nurses and many workshops for both the general nurses and general medical practitioners were organized; and (4) decentralizing training of psychiatric mental health nurse training and developing the position of mental health service coordinator. All these strategies were used but have not borne many meaningful results as more challenges and difficulties continue to be confronted.

Development of a National Health Policy

The National Health Policy on mental health was developed to provide a framework for the incorporation of the objectives of the mental health programme into the existing general healthcare services (Ministry of Health 2003). This was to be implemented through the primary healthcare strategy and the Ministry of Health Corporate Plan aims at ensuring an improved health status of the nation, quality service, system efficiency and customer satisfaction (Ministry of Health 2003).

Challenges and difficulties

Opportunities that emerged were not readily successful as numerous factors stifled the successes and affected the direction of the community mental health movement. Claims about the efficiency of community mental health services in handling an array of mental and emotional health and human service problems were tempered in practice by harsh realities. The release of mentally ill patients into the community setting without adequate social, personal and community support services in place to assist them at such an important time of transition impacted negatively on this movement. The aim of the community mental health programme

was to focus on prevention activities at primary, secondary and tertiary levels, but budget allocations and administrative responsibilities did not reflect realistically this increase in responsibilities. There continues to be confusion in health policy as to which sector is responsible for the community-based programmes. Ideally, community-based care should be the responsibility of the Ministry of Local Government. Surprisingly however, community mental health services fall under central government because psychiatric outpatients are attached to and operate under district hospitals. This creates a conflict in the philosophy of providing health services because central government focuses mainly on institutional care as opposed to community-based care.

The other main inhibiting factor is the low allocation of resources to mental health services. Even though community mental health was acclaimed as a locus of care and befitting the primary healthcare concept, nevertheless it was given insufficient funding with a total lack of rehabilitative programmes that led to high relapse rates (E.A. Seloilwe, University of California, San Francisco, unpublished doctoral dissertation).

Community-based care has not achieved its purpose of integrating the mentally ill into the community owing to a lack of back-up support services. Budgetary limitations make it difficult to provide the services required to make the community mental health system the primary system of mental care in Botswana. When mental health budgets are placed in competition with other health and human services, they have not fared well (Boyer & Heppner 1992). In addition, the provision of mental health services has not been the priority and focus of the national health policy. Community mental health has come to be seen as a cost-cutting exercise that has resulted in fewer services for the mentally ill rather than a change in the direction of service delivery.

The primary focus has been more on more life-threatening health problems such as maternal and child health services and communicable diseases. For the past decade, the Botswana healthcare delivery system has been experiencing tremendous strain and challenge imposed by the HIV/AIDS epidemic. The epidemic has diverted the focus and attention of the healthcare delivery system and has exhausted most of the country's healthcare resources.

Further, the lack of initial comprehensive plans for this approach left communities without any rehabilitative and vocational services in place. At present, the services that exist belong to non-governmental organizations and agencies such as Rankoromane, SOS, Tlamelong, Cheshire Foundation and Motsweding, to name a few. The focus of these rehabilitation programmes has been on those with learning disabilities and children and adults with disabilities. This has excluded the mentally ill who are also desperately in need of these services. Although the government of Botswana places great emphasis on community-based care for the mentally ill, regrettably little commitment or resources have been available for the total welfare and good quality care of the mentally ill.

Persons living with mental illness in the community do not have access to resources like other persons. This lack of access is further complicated by their lack of social skills, not only in identifying the problem, but also in their inability to negotiate and compete for resources owing to their compromised judgement and other effects that arise from the disabling nature of the illness. If the community is considered the least restrictive, alternative treatment available in Botswana, it should afford clients with mental illness the ability to adjust and conduct fruitful lives. Instead, persons with mental health needs are over-represented in poverty; alcohol and drug abuse; lack of or inadequate housing; physical and sexual abuse; lack of access to family planning services and other needs. Several research studies have converging findings on the great demands that community-based care has on families and communities as they attempt to provide care to their ill relatives at home (Chafetz & Barnes 1989; M. Mantswe, University of Botswana, unpublished dissertation; E.A. Seloilwe, University of California, San Francisco, unpublished doctoral dissertation; Skodol-Wilson 1989).

The community mental health programme has not realized the goals for which it was designed. It lacks the ingredients and guiding principles. The guiding principles of community support systems philosophy as outlined by Stroul (1989) are that services should empower clients, be consumer-centred, be flexible, focus on strengths, and incorporate the natural support systems to meet the special needs of the mentally ill. Yet many of the needs of the mentally ill in the community are not met. These include basic needs of food, shelter, clothing and employment.

E.A. Seloilwe (University of California, San Francisco, unpublished doctoral dissertation) noted that when the mentally ill persons are admitted to the Lobatse Mental Hospital they are supplied with all the necessary resources to meet their basic needs; but when they are discharged these resources do not follow them to the community. The burden of care is therefore, left to the families who are already impoverished. According to the income and expenditure survey of 1993/94, about 47% of the families in Botswana live in extreme poverty (Central Statistics Office 1995). With an escalating economic recession, high rates of inflation and unemployment and many natural catastrophes, this situation will not improve but may be expected to worsen. Community-based care for the mentally ill is thus being seen as too demanding and unbearable for the families. The ultimate outcome will be a perpetuation of poor quality care for this population.

Implications for nursing and midwifery

Team dynamics and group processes are an integral part of community health care. It is within this premise that nurses and

midwives working in the community should share information across their practice spectra. Nurses and midwives should adopt a care provider facilitator role. Teamwork and multidisciplinary approaches ensure comprehensive and holistic care to patients in the community. The patient derives greater benefits from such coordinated care and fully utilizes resources available to them. The curriculum for nursing and midwifery must of necessity widen its scope to include this area of care. Nurses should also be prepared to educate the community about the care provided and the approaches used.

Conclusion

There were many opportunities that resulted from the approaches that have been used in developing community mental health care. However, the de-institutionalization movement has resulted in dramatic implications for mental health providers and challenged the role of the community mental health nurses. The community mental health approach requires a well-prepared plan to ensure support to the natural, family systems, which in turn are required to provide care and assist in the integration of the mentally ill patients. As the philosophy of the community support system unfolds throughout the country, effective models of caring for the seriously and chronically mentally ill in the community will have to be developed. Consumers and families should be empowered with an aggressive community outreach and a psychosocial approach of 'true' integration of mental health services.

Factors that negatively impact on this system of care will have to be tackled. This includes the provision of adequate resources for communities and advocacy programmes, which will act effectively as the mouthpiece of this disadvantaged group. Finally, continued education of the community on mental health and illness is essential to ultimately change the attitudes of the public towards the mentally ill.

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