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Opinion

General Hospital Plus Psychiatric Ward: Unseen Challenges in an Integrated Model

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In recent years, the lack of psychiatric beds, especially in developing countries, has encouraged the inauguration of psychiatric wards in general hospitals, which is usually fulfilled by allotting a number of medical beds to psychiatric patients, in the same building or in separate office blocks. To begin with, it seemed that such a strategy could lessen the load of psychiatric complications, and even some of the scholars believed that such an approach could be the beginning of the final closure of psychiatric hospitals and associated stigma [1], which, as stated by them, could drive from admission into psychiatric hospitals. So, a strategy that had been planned primarily and inevitably for responding to obvious deficiencies has turned into a new model which may substitute the present mainstay. But, can such an integrated model be as valuable as a standard psychiatric hospital? In keeping with existing observations, there is usually a strict restriction with respect to type of psychiatric patients who are permitted to be hospitalized in psychiatric wards that have been established in general hospitals. Accordingly, patients with suicidal ideation, psychotic patients, patients diagnosed as borderline personality disorder or antisocial personality disorder, and addicted patients are either officially or informally prohibited from admission. While the main reason for such kinds of ban seems to be due to lack of expert workforce, adequate devices or acceptable spaces, like standard isolated rooms, many times it is due to fear of other medical specialists and staff, who are working in internal, surgical, gynecological or pediatric sections, which are the essential units of a general hospital, from psychiatric patients, in general, and psychotic cases, in particular. Crying, shouting, violence, breaking the rules, sexual promiscuity, disinhibited conduct, frightening somatic patients and disturbing employees of medical wards are among the typical protests of objectors, who feel that the presence of psychiatric patients in their neighborhood can endanger their bodily and mental well-being. So, once more, the burden of the said banned patients is on public or private psychiatric hospitals. Though the creation of psychiatric wards in general hospitals, which has been programmed, as well as a national agenda in some countries for cost-effective provision of sufficient psychiatric beds, can supposedly compensate for such a lack in destitute places, in fact, psychiatry is not appreciated as resembling other somatic fields, and often makes psychiatry a subordinate field in comparison with other specialties. On the other hand, while the said problem is clear in general hospitals with separate spaces in the same office block for both medical and psychiatric wards, it may not be true with respect to general hospitals with distinct spaces in different buildings for psychiatric and medical wards. But, the later settings, which are usually later and, due to financial boundaries, lower than the first settings, are not usually the prevailing form of therapeutic service, especially in developing countries. The result of such a situation is nothing except admission of moderate psychiatric patients, like mild and non-suicidal depression or anxiety disorders, which are mostly curable without hospitalization, too. Thus, an approach that expects to respond economically to the deficiencies of mental health sanatoriums may turn into a wasteful policy, because it may not handle the main loads of psychiatric problems and emergencies. While in general hospitals per se, due to deficiencies and financial, legal or critical issues, occasionally, an invisible and managerial priority exists with respect to authority or operation of various specialties, then the near to the ground priority of psychiatry is predictable, especially during tragic socioeconomic pressures. Such a problem is deductible, also, from the fact that, generally, in both low and middle-income countries, the focus of much health policy has been, habitually, towards transmissible diseases that lead to untimely death, most notably tuberculosis, malaria and HIV [2]. On the other hand, lack of information among health care experts may be compounded by the stigmatization of mental illness [3], along with other studies that show that many professionals believe that such disorders are not curable [4]. Also, countries accounting for more than 2 billion of the world's population spend less than 1% of their total public sector health care budgets on mental health [5]. On the other hand, though these barricades may also be applicable to health systems, in general, they are likely to be more difficult to overcome in mental health settings. Indeed, their impact may be greatest in low- and middle-income countries, where human and financial assets are limited and where there are many competing claims on obtainable funds [6]. Furthermore, while the said problems are not merely based on administrative liabilities or budgetary paucity, they have cultural backgrounds too, which motivate the aforesaid hidden verdicts or priorities. Though such a type of ranking can not be condemned bigotedly or persistently, nonetheless, its implementation is not soothing, systematically, with respect to public mental health. In line with social psychiatry, systematic discrimination and prejudice against people with mental health problems produces a situation of suppression, deprivation, withdrawal and humiliation, usually driven by personal prejudice, cultural values and unaccountable social services. The outcome of such attitudes, as well, can be the marginalization of mental health patients, as a non-profit and demanding group. Administratively, too, low status, low funds, and low attention usually result in low study and inquiry about mental health on a national scale. So, commonly, there is little or no societal problem-solving strategy, especially in developing countries.

On the other hand, disability is not merely an individual phenomenon, and impairment can be reinforced by an ignorant society, which excludes psychiatric people from social activities [7]. Moreover, psychiatric patients are, first of all, part of the community, and de-medicalization of social work with mental health patients is mandatory; also, community participation should be promoted and prevail. Also, service providing should be founded on human rights, and not pity, and dealing with mental patients is a specialized responsibility, which requires commitment, skills, assessment, negotiation, advocacy, counseling and so on, and is not a secondary or subordinate activity, and should not be underestimated. In the beginning, and consistent with the medical model, which was the dominant style of approach in recent epochs, mental illness was a medical disorder with unrecognized etiology, and control of symptoms was the primary goal, which demanded patient's compliance, because diagnosis was the major key for further efforts and psychiatrist was the major decision maker about treatment and patient's future [8]. Afterwards, the therapeutic community model signified social and interpersonal functions, and stressed that therapeutic purpose includes encouragement and enhancement of social participation. So, according to that model, taking a role in the therapeutic community and assessment and deletion of barriers against a person's (not patient's) participation is accentuated. So, the therapeutic society was highlighted as the decision maker. After that, social learning model, too, was looking for impairment in acquiring basic skills. Accordingly, therapeutic purposes include training of necessary skills for a better social and/or occupational adaptation, and acquiring skills might lead to correction of behavior. Lastly, in the integrated psychiatric rehabilitation model, mental illness is a disability that needs correction (not treatment), and rehabilitation wants to defeat disability (it differs with treatment). So, the role of participant (not patient) is taking part in goal determining and movement towards that desire. Therefore, functional assessment is for determining interests and related barriers and services are organized for the participant's rehabilitation, and decision-making, also, is guided by the participant's choice. In consequence and disregard to common managerial issues, admission of psychiatric patients in general hospitals may emphasize, involuntarily, the organic cause of psychiatric disorder, not a bio-psycho-social and multifactorial etiology, which is not tolerable for many psychiatric patients. Hence, the unintended outcome of such a maneuver can be re-medicalization of a series of concepts, which, beforehand, got through the de-medicalization process for rehabilitative purposes, and may, consequently, strengthen the perceived stigma [1]. As a result, it seems that the institution of psychiatric wards in general hospitals, especially in a joint building, can not be a responding strategy, if it is planned to handle mental health, on a national scale. Therefore, in general, establishment of psychiatric hospitals seems to be a better approach than the aforesaid integrated model, which thus may end overt or covert ban or priority with respect to the entire spectrum of psychiatric responsibilities.

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