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The Sultanate of Oman: an experiment in community care

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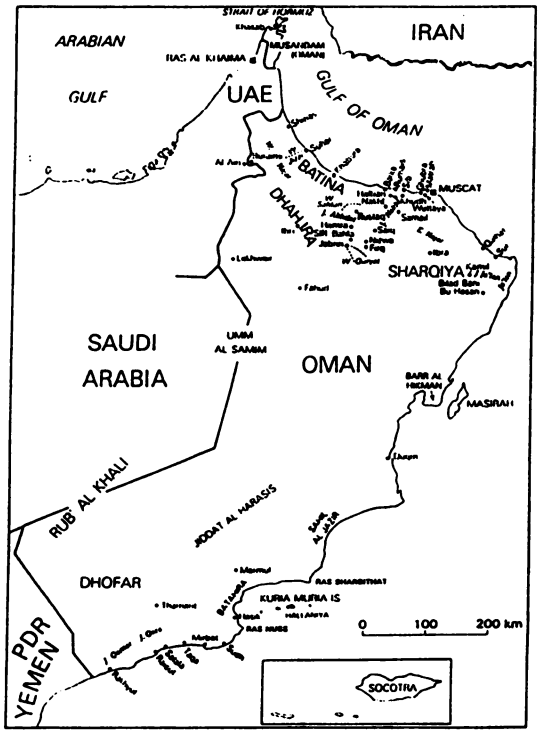
An experiment in community care, training Omanis with bachelor degrees in social work, psychology and education to act as psychiatric care givers in the community, is currently being developed in the Sultanate of Oman. This experiment is based on the Alma-Ata declaration to achieve Health For All by the Year 2000 (WHO, 1978) and WHO aspirations to move psychiatric care back into the community (WHO, 1990), and the fact that in many developing countries psychiatric care has remained on the fringe due to lack of resources and manpower.

The Sultanate of Oman lies on the South-East border of the Arabian Peninsula. It has an area of 312,000 square kilometres with a coastline of 1,700 kilometres. The country has not yet conducted a comprehensive population census, but the population is currently estimated at 2 million people (*Oman Statistical Yearbook*, 1990). This is concentrated in the north and the south, the two areas being separated by the intrusion of the Empty Quarter of the Arabian Desert into the Sultanate of Oman (see map). The major part of this distribution occurs in the north. Muscat, the capital, is in the north, strung along the coast, and is a major area of population with approximately half a million people. The remainder of the population in the north is distributed among the few large towns, rarely with more than 60,000 people, and numerous small villages clustered around them. Because of the mountainous terrain and as yet incomplete network of roads, some of these villages are almost inaccessible. Farmers and land labourers are found in all regions. Fishermen sail and trade along the coastal areas; settled people live in the villages and towns, while nomadic Bedouin roam the desert with their herds.

There is a close connection between the population in Muscat and the larger towns and rural areas, in that many men work in Muscat, separated from their families during the week, returning to their villages for the weekend, where their wives and children remain. This system is facilitated by the relatively small size of the northern part of the country.

In the south the population, estimated to be 160,000, is concentrated in the city of Salalah with a sprinkling of mountain tribes in the hills surrounding it. Again there is considerable communication and movement between rural and city areas and many families maintain double residences, one in each area.



Map of the Sultanate of Oman

The history of psychiatry in Oman

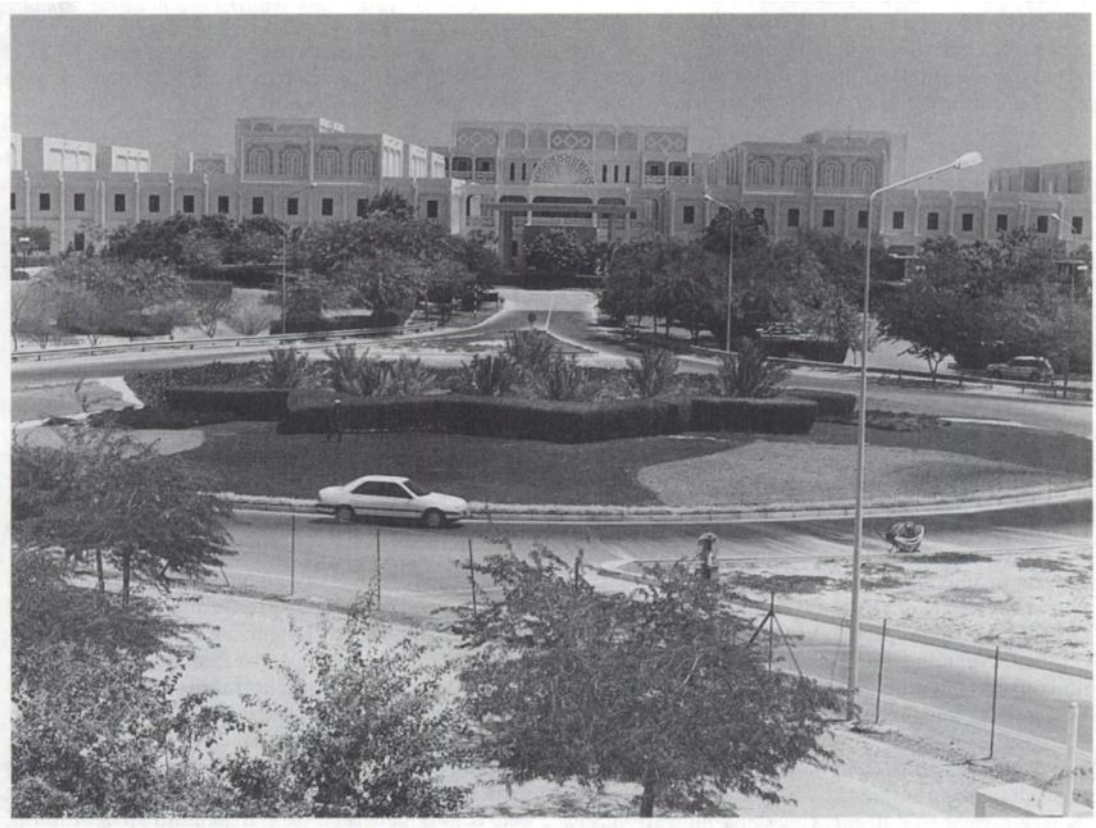
Before 1970, the delivery of health services remained rudimentary and there were no modern services in psychiatry in Oman. In that year the reign of HM Sultan Qaboos and the reawakening of the country began. Initially psychiatric services for the whole country were concentrated in a small mission hospital in Muscat. Subsequently, in 1983 a new psychiatric hospital was built. Because of public pressure, it was located in the middle of the desert and is almost inaccessible. It contains 60 beds (40 male and 20 female). These are barely adequate and

are considerably oversubscribed, and the general structure of the hospital and the facilities provided are somewhat inadequate. In the south there is a specialised psychiatric unit attached to the General Hospital in Salalah, which is also of limited adequacy.

In 1989 the University Department of Psychiatry began to function. This is a well designed modern unit, with 28 beds, within the University Hospital with occupational therapy and all the facilities of a large teaching hospital. It has yet to function fully because of the slow recruitment of staff. Its two senior psychiatrists are both Maudsley trained. It is hoped that in future it will provide up-to-date teaching facilities for students to an international level, as well as leadership in psychiatric services for the country.

Distribution and planning of psychiatric care

The population distribution makes it unavoidable that specialised psychiatric services are concentrated in the capital area. This leaves large portions of the population relatively distant from these centres. Further, given the relative dearth of Omani doctors (the first batch will graduate from the medical college in 1993), it seems unlikely that enough psychiatrists could be provided for the country for a considerable period. Because of these considerations we wished to provide psychiatric primary care in the community, using a cadre of specially trained young Omanis. These are individuals with bachelor degrees in Social Work, Psychology or Education. They are employed in the Department of Psychiatry of the University Hospital, Sultan Qaboos University. Here they work alongside nurses in the wards or with doctors in the out-patient department and undergo training for 18 months, based on a formal modular course. They learn about psychiatric diagnosis, management and treatment as well as how to dispense drugs and give injections, the objective being their future independence in the community. An area specifically stressed is the ability to recognise the point at which the management of a patient in the community becomes unfeasible and referral to a specialist centre is needed.



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After training, it is anticipated that all these workers will be distributed throughout the country. Oman has a well organised system of internal government, based on the Willayat, a self-contained administrative unit usually encompassing a small town and villages dependent on it. There are plans to link the health care delivery system to these centres, and it seems likely that the psychiatric health care workers will also be so distributed. It is intended that in their areas they would know most of the villages, the psychiatrically ill within them, and the social, familial and economic circumstance of these individuals. It is also hoped that they would act as the first line of referral for the psychiatrically ill, as well as for the maintenance and distribution of psychiatric care in the community. They would act parallel to, but perhaps relatively independent of, the other local health care providers.

It is also intended that they would have direct links with the University psychiatric services initially, and with other suitably specialised services in the future, should these occur. These direct links could encompass the following areas: first, patient care and management and the capacity of these workers directly to refer patients to the University or obtain advice on the action and management for those patients who remain in the community. Secondly, it is expected that there would be ongoing programmes of education, appropriately distributed in groups, e.g. 2–3 days at the end of each month, which all workers would be encouraged to attend. It is hoped that renewal of acquaintance with the University psychiatric team and with each other as a group will avoid any sense of isolation that may occur.

This system, if effective, would allow more community care, with less dysfunction in the lives of patients. In addition, it will save money and reduce the load on specialist psychiatric facilities, whose distance from most consumers reduces their effectiveness. If such a system works, it may prove to be a useful model for other countries which are also limited in resources. Wig *et al* (1980) observed that care for mental disorders has been given low priority in that it exists mainly to serve a custodial function in many developing countries. The model evolving in Oman may represent an alternative in meeting the needs of psychiatric care.

References

STATISTICAL YEAR BOOK. Sultanate of Oman: Development Council: Directive General of National Statistics. Eighteenth Issue, 1990.

WHO (1990) *The Introduction of a Mental Health Component into Primary Health Care*. Geneva: World Health Organisation.

WHO/UNICEF (1978) *Alma-Ata Declaration 1978. Primary Health Care*. Geneva: World Health Organisation.

WIG, N. N., SYULEIMAN, M. A., ROUTLEDGE, R. *et al* (1980) Community reactions to mental disorders. *Acta Psychiatric Scandinavica*, **61**, 11–126.

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Community mental health services in Malaysia*

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The need to confine and restrain psychotic patients at the turn of the last century saw the building of a few large asylums which soon became overcrowded with the growth of the population. These asylums were the only service available to the mentally ill until 1959 when the trend to decentralise began with the building of general hospital psychiatric units.

There are now a number of psychiatric in-patient and out-patient units in general hospitals and district hospitals. Almost all general hospitals in 13 states of Malaysia have psychiatric units. There are four existing psychiatric (mental) hospitals with from 300 to 2,500 beds. Two are in Peninsular Malaysia and two in East Malaysia. In addition, there are psychiatric units in two University hospitals. There are a total of 5,852 beds in the four psychiatric hospitals; of these about 500 are not in use. The total number in the general hospital psychiatric units is 728. This gives a bed – population ratio of 3.9 per 10,000 for psychiatric hospital beds alone and 4.3 per 10,000 for all psychiatric beds. The 3,852 psychiatric hospital beds form part of a total of 35,683 hospital beds in the country, giving a ratio of one psychiatric bed to 4.5 general hospital beds (Tan & Lipton, 1988).

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