special articles

Psychiatric Bulletin (2000), **24**, 111–112

ROD BALE

A project to develop quality improvements in the Kuwait mental health service

In October, 1996, an expatriate team commenced working at the Kuwait Hospital for Psychological Medicine on a three-year government contract to develop quality improvements in the mental health service in Kuwait. The team comprised of administrative, medical and nursing staff, including nurse trainers and an occupational therapist and social worker. I was privileged to work on the contract for 17 months as Medical Director – this paper gives an account of my work from a personal perspective.

Organisation of services

The Kuwait Hospital for Psychological Medicine, which has approximately 450 beds, serves the whole population of Kuwait, comprising 800 000 Kuwaitis and 1.2 million expatriates. Each of the five medical teams serves one of the five regionates into which Kuwait is divided. The service offered was reminiscent of the mental health services in the UK before the development of the present community-style approach. There was a lack of trained nursing personnel and only 7% of the 280 nursing staff had had a formal training in psychiatric nursing. In addition, the social work staff, only numbering eight, was a serious deficiency. John Racy (1970) in an article entitled Psychiatry in the Arab East stated:

> "there is an acute need for professional staff in all categories; but if choices must be made or a list of priorities established, the order would be social workers first and foremost, nursing personnel second and psychiatrists last."

It was also clear that there is a blurring of the social work role and that of the occupational therapist. There was one trained occupational therapist on the team but none in the hospital.

The significant clinical areas of the hospital were: out-patients and casualty (which was open 24 hours a day), admission units, a long-stay/rehabilitation area and an addiction unit. Liaison occurred with the Kuwait Prison Service and a closed male ward served as a forensic unit. A specialised unit, the Al Reggae Centre, which had been set up after the Gulf War to treat patients suffering from post-traumatic stress disorder, was off site.

Medical assessment

An undertaking of the contract was to make an assessment of the medical staff; there were 39 medical staff below the rank of consultant and who were predominantly from Egypt. At first I approached the task in the form of an audit listing clinical grades, age, length of service and qualifications. However, when I felt I had become better known and accepted by medical staff, I did an assessment in greater depth. I devised a questionnaire covering medical and psychiatric training and experience. It also included views of their work in the hospital and attitudes towards audit, research and continuing medical education.

The results were predictable in that the greater strengths in the medical staff lay in the area of biological psychiatry. However, it was interesting to learn how many of the medical staff had had training and experience in aspects of psychotherapeutic treatment. Pressure of work was quoted as a reason for not using such skills in current work.

Steering groups

Steering groups were developed in the clinical areas mentioned, comprising a multi-disciplinary membership. The aim was to get a spread of interested people representing medical, nursing, psychology, social work and occupational therapy from these areas to discuss the problems arising in the clinical work. The groups did not have any administrative or executive powers but their deliberations were recorded and had an influence on the policies developed by senior management.

The steering groups engendered considerable discussion and to a degree a feeling of empowerment to their participants. I was able to gain an awareness of the socio-cultural background to the clinical work of the hospital. The life of a steering group was not fixed and some of them merged into more formal management structures of specific areas as these evolved.

It is interesting to consider the tension between the authoritarian and democratic dimensions of management. If too much democracy is introduced suddenly into

https://doi.org/10.1192/pb.24.3.111 Published online by Cambridge University Press

special articles

a social system used to an authoritarian approach, it can be threatening to many people in the organisation. However, where change is to take place in a clinical situation, it has more chance of being effective if those affected by the change agree to its purpose and are motivated for the change to work.

Working groups

Working groups to prepare specific clinical policies also took place. An early working group combining medical, nursing and pharmacy staff looked at in-patient prescribing. A specific problem was to establish that the patient had had the prescribed medication. It was felt that the prescription form introduced into the Kuwait General Hospitals should be used in the psychiatric hospital. A pilot project was successful and it was gradually introduced throughout the clinical areas of the hospital. The problems arising in the use of the form were continually monitored and appropriate instructions fed back to the clinical team.

A working group on the guidelines for the management of violent behaviour completed its work and in addition a protocol for the management of medication of such patients was added to the booklet. This was based on the guidelines for prescribing developed by the Maudsley Hospital in the UK (1977) but modified for use in the Kuwait Hospital taking into account current practices and the medication available in the State of Kuwait. A formulary containing similar guidelines for the management of common conditions including protocols for prescribing and administering electroconvulsive therapy were in preparation.

Medical meetings

The monthly meeting of the Medical Council was central to the management of the medical department. It was with the agreement of the Medical Council that four committees were formed, responsible to the Council, building on the existing strengths of the department:

(a) the Education Committee responsible for the educational activities of the Medical Department;
(b) a Drugs and Therapeutics Committee dealing with all relevant matters involving this area of work;
(c) the Quality Assurance Standing Committee which had been already in existence with an audit Sub-Committee;
(d) a Research and Ethics Committee to approve protocols of research proposals and consider any ethical matters arising in the work of the hospital.

We were fortunate to have excellent educational meetings and regular journal clubs at the hospital. English is the main language of medical education in Kuwait. Guidelines for presentation were developed through education committees to improve presentation. The concept of continuing personal development has not been formalised in Kuwait, but its principles are accepted by the medical staff. Interesting audits and operational research were carried out by medical staff during my time at the hospital and included the incidence of violent behaviour, the number of patients who self-discharged and the correlates of above average length of stay of patients within the hospital.

Medical health legislation

A final area of interest while in the role of Medical Director, was Mental Health Legislation. In September 1997, the Islamic Organisation for Medical Science in association with World Health Organization (WHO) organised a conference in Kuwait Inter-Country Consultation on Mental Health Legislation in Different Law Traditions including Islamic Law. The conference work was based upon the WHO Guidelines for the Promotion of Human Rights of Persons with Mental Disorders (WHO, 1996). Later that year a lawyer, Stephen Poitras from the WHO visited the country to further the course of formalising mental health legislation. I came to appreciate that working with unwritten rules of procedure, rather than formal legislation, does allow for flexibility in the management of the patient which has benefits for the clinician, when working with patients and their families. The family exerts considerable control over the individual family members in the Arabian culture. I was able to write a paper on this issue, comparing the practices in the UK and Kuwait. If mental health legislation is to be accomplished in Kuwait it will require the support of the public and law-givers and this will take time.

Acknowledgements

I am indebted to the staff of the hospital, particularly to Mohammed Araf, Chairman of the Medical Department and Dr Essam Ansari, Vice-Chairman and also my colleagues on the project team for their support.

References

RACY, J. (1970) Psychiatry in the Arab East. *Acta Psychiatrica Scandinavica*, **suppl. 211**, 1–171.

(1977) *Prescribing Guidelines* (4th edn). London: Bethlem and Maudsley NHS Trust.

WORLD HEALTH ORGANIZATION (1996) *Guidelines for the Promotion of Human Rights of Persons with Mental Health Disorders*. Geneva: Division of Mental Health and Prevention of Substance Abuse, WHO.

Rod Bale Consultant Psychiatrist, Nelson Marlborough Mental Health Services, Ngauhatu, Private Bag 38, Nelson, New Zealand

https://doi.org/10.1192/pb.24.3.111 Published online by Cambridge University Press