Another side of African Psychiatry in the 21st Century – chaining as containment

Between 19th July and 19th August 2009, the Africa Mental Health Foundation (AMHF) conducted a mental health training programme for 8 general health workers (2 general doctors, 4 nurses, and 2 social workers) in Somalia. The training took place at Bosaso Hospital, the referral hospital for the Puntland State, one of the 3 semi-autonomous states of Somalia. Puntland state occupies the Horn of Africa, with the Red Sea (Gulf of Eden) to the North and the Indian Ocean to the East. Bosaso is a busy sea port on the Red Sea.

Bosaso Hospital has a total of 10 psychiatric beds – 5 for females and 5 for males, none for children. The outpatient psychiatric clinic receives about 5 patients per day. The psychiatric unit, tucked away at the backyard of the main hospital, is housed in a dilapidated four roomed building and staffed by a general nurse and 2 social workers. The psychiatric unit has only 5 drugs available: chlorpromazine, amitriptyline, haloperidol, diazepam and benzehexol; usually prescribed by a nurse or a social worker. Occasionally there is sodium valporate, carbamazepine and risperidone.

A 20 year old male who had been admitted to the seclusion area of the hospital for three days prior to being seen - in the presence of his mother who was staying with him – is illustrative. The seclusion area was a shed without walls but with a roof supported by pillars and located outside the psychiatric building. Patients in the seclusion area are looked after by the relatives, with the clinic staff going there only to administer drugs. He had been brought to hospital in chains on his hands because of his aggressive behaviour, and while in hospital continued to be chained. He was however able to sit on the floor mat supplied by the mother. The patient had a wound caused by beatings from members of the public in his rural village because of his provocative and aggressive behaviour. The mother decided to take him to the nearest psychiatric facility (300 kilometres away) – i.e. Bosaso to save her son from further beatings. On the 5th night of his admission the mother alleged that the patient had tried to hang himself by putting the chain around his neck. The mother, the only person nursing him at the hospital, and in order to further restrain his movement, chained both his legs (in addition to his hands) and extended the chain to the pillar. The patient could hardly sit on the floor. The mother insisted on the chaining as long as the patient was still in the seclusion area, where she was totally responsible for his security, safety, nursing and feeding. She could not take any risk of anything happening to her son by removing the chains. The nurse, who only provided the medicine, was not ready to take him to the ward where he would be disruptive to other patients. The general nurse had commenced him on chlorpromazine 100mg I.M twice a day and diazepam up to 5mg I.M up to four times a day as necessary. Ultimately haloperidol (oral) 5mg three times a day was commenced. He settled.

The staff reported that beating and physical restraint were the most practiced ways of handling aggressive behaviour in the communities. Chaining as a physical restraint was a standard practice in the seclusion area and it was often demanded by the relatives who were the only people to nurse such patients. Such practices, of chaining, have been observed first hand (DMN) in hospital wards in two other countries i.e. a few years earlier seeing patients chained in another psychiatric hospital in a neighbouring country and subsequently observation of the same practice in a psychiatric ward in Juba, Southern Sudan where the only psychiatric hospital for the region was inside a prison. Three naked patients were permanently chained to a hook on the concrete floor. They helped themselves there and their food was placed where they were chained. During the day they sat on the hot floor and at night they slept on the same floor, which was rough, cold and often wet.

The United Nations is clear that people with mental illness ought to be treated with dignity and their rights observed.[1] However, in many countries, beliefs related to the cause of mental illness i.e. attributed to other forces and not just biological makes it impossible.[2,3,4] Such beliefs often affect the provision of mental health care services for the sufferer. However, the mistreatment of patients with mental illnesses is rarely investigated[5] and in most instances such cases will only be brought to light by the media.[6,7,8,9]

Lack of knowledge of the cause of mental illness or the fact that such conditions can be treated may lead to mistreatment of patients with mental illness. When the relatives were informed that the behaviour of the patient mentioned was a result of psychiatric illness and that he could be treated, they seemed relieved. They asked questions to know more about his condition. This calls for the need to educate people on mental illness- an obvious statement within a developed and many developing world countries but a revelation within the

community from which the patient originated. It is possible that chaining is practiced more widely and in more countries than is realized. There is therefore a need for an audit to determine just how common this practice is – a practice which has no place in contemporary African psychiatry.

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