BACKGROUND DOCUMENT
BASED ON SUMMARY REPORTS RECEIVED FROM COUNTRIES

for reference and use at the

TECHNICAL DISCUSSIONS
"MENTAL HEALTH PROGRAMMES IN PUBLIC HEALTH PLANNING"

prepared by

A. QUERIDO, M.D.
Professor of Social Medicine, University of Amsterdam, Netherlands
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PREFACE

This background document has been prepared as a working paper for the Technical Discussions at the Fifteenth World Health Assembly in May 1962 on the subject: "Mental Health Programmes in Public Health Planning". It is largely based on reports of discussions in Member States in response to an outline document prepared in WHO and circulated in July 1961.¹

Up to the time of writing, reports have been received from 44 governments. In several countries a preliminary examination of the topic has given rise to a series of meetings, which in some cases are being continued for further detailed discussion of practical steps to be taken. One report states that the meeting convened was the first of its kind on such a broad basis, bringing together members of mental health and public health departments of the Ministry and several representatives of other disciplines: this was considered an important start to closer co-operation between services.

Four non-governmental organizations in official relations with WHO were also invited to participate in preparations for the discussions. The opportunity is here taken to thank the World Federation for Mental Health, the International Association for Child Psychiatry and Allied Professions, the International Union for Child Welfare and the International Union for Health Education for their assistance in informing their members about the Technical Discussions and urging them to co-operate with government discussion groups where possible. The World Federation for Mental Health also made available a record of a Conference held in September 1961, sponsored jointly with the Ministry of Health and Population of France, which brought together health officials from some 22 countries, consultants, and executives of mental health associations to discuss programmes for mental health activities and their implementation.

Mental health services in different countries show a great variety in pattern and stage of development, and this is reflected in the reports. It was therefore considered of value to trace the evolution of provisions, marking the steps that can lead - and in some countries have led - to a programme of mental health care giving wide coverage, within a comprehensive health plan.

¹ C.I. 24, 1961
Part I of this document outlines these developments; since it is mainly descriptive, some readers may prefer to proceed immediately to Part II, which deals with the more controversial matters to be considered in developing mental health programmes and integrating them into health services.

It will be noted that no mention is made of problems concerning the mentally subnormal, since the implications of this topic are too far-reaching to be dealt with satisfactorily as a subsidiary item.

The subject matter requires frequent use of terms that might possibly lead to misinterpretation because of the different structure of health services and the organization of medical care in various countries. This difficulty is met whenever similar subjects are to be discussed and has been dealt with in various WHO publications.\(^1\)

In the present paper "public health care" is used within the frame of the definition originating from Winslow (1923) and amended by the Expert Committee on Public Health Administration in its fourth report.\(^2\) The term is therefore used to designate care organized by community effort. However, in some countries organized community effort includes medical care for the sick, which may include hospital care as well as the activities of the general practitioner. Elsewhere either the hospital or the general practitioner or both may be partly or entirely outside organized community effort. In some countries organized community effort is limited to preventive activities; in other countries curative activities are partly or entirely included. "Public health care", therefore, refers to an organizational situation and it remains uncertain, without further qualification, which activities the term covers. When it is desired to refer to all preventive and curative activities in a given area - irrespective of organizational structure - the term "general health care" is used.


At the end of the document some suggestions are made as to points to be discussed. They are drawn from the second part of the paper. It is hoped, however, that participants will not feel restricted by these suggestions and will raise other questions for discussion as these arise from their experience.

Finally, it may be remarked that the author attempted as much as possible to mirror the contents of the reports received, but felt at liberty at some points to develop and expand the arguments arising from the reports.
PART I

I.1 INTRODUCTION

I.1.1 Definition of the subject

I.1.1.1 Operational definition of mental health care. For the purpose of this paper, mental hygiene or mental health care is conceived as the sum of activities, based on a body of scientific understanding, to promote, protect, maintain and restore mental health in man. Mental health is an integral part of the general concept of health as expressed in the preamble of the WHO Constitution.

I.1.1.2 Who is professionally concerned. Since mental health care deals with the relations of man to others, it will be the concern of all those who, by reason of their role, position or profession in society, influence these relations. The work of policy-makers, legislators, administrators, educators and of the mass-media experts all has implications for the mental health of the population. Just as physical hygiene, however, could only develop as a science from the understanding of the pathological, the scientific basis of mental health care took its origin from the experience gained in dealing with mental patients.

I.1.1.3 Delineation of fields of activity. While in the field of mental health care it is possible to delineate the proper domain of the psychiatrist - i.e., the care and cure of those suffering from or threatened with mental illness - there are a number of areas where other experts and professionals bear the main responsibility, but where the psychiatrist can contribute from his experience, until those experts have integrated mental hygiene principles in their own body of knowledge.

Therefore, for the present it does not seem desirable to attempt to define the field too closely, including certain activities and excluding others. It seems more appropriate to follow the historical pattern of development with the psychiatric activities in the centre and which fan out into adjoining areas.
I.1.2 Current reasons for intensified action

I.1.2.1 Increase in psychiatric possibilities. The therapeutic nihilism which reigned in the medical realm up to the first quarter of this century was slower to be conquered in psychiatry than in other branches of medicine. However, many reports show a clear awareness of the present preventive and curative possibilities in the psychiatric field. Among preventable factors are mentioned: environmental hazards such as intoxications, nutritional deficiency and accidents as preventable causes of mental illness, as well as emotional deficiencies impeding the development of the growing individual.

Among the therapeutic possibilities are mentioned the psychotropic drugs, individual psychotherapy, group psychotherapy and socio-therapy in a therapeutic environment, socio-therapy as a support for re-adaptation, educational therapy as a means for rehabilitation. Many reports make it clear that in applying these methods the more serious and long-term sequelae of mental illness can be averted or at least alleviated. The impediment to personal efficiency and interrelations caused by the numerically vastly important psychosomatic disturbances is receiving growing attention, often with gratifying results. Several reports emphasize the time factor: the earlier a condition is recognized and dealt with, the better the effect obtained in comparison with effort expended and in terms of results.

An active preventive and therapeutic policy, making judicious use of the large number of given possibilities, results in a quick turnover of patients and a decrease of the reservoir of chronic cases. Several countries which have been able to follow this policy for some time report a decrease in the number of mental hospital beds required.

Owing to the advances made in psychology and to the deeper understanding of psychodynamics which again led to advances in psychotherapy and social therapy, owing to the development of chemotherapy and to a better understanding of the possibilities of early treatment and prevention, psychiatry has changed from one of the most pessimistic branches of medicine to one of the most hopeful.
The evidence of this change as presented in many reports as well as in the relevant literature, constitutes a duty to make these methods available to the public. The question of how this is to be achieved is the main problem offered for the coming technical discussions.

I.1.2.2 Increase in demands for mental health care.\(^1\) The size of the mental health problem and the demands it makes on the personnel and material resources of the countries emphasize its urgency.

No single country reports an overall decrease in the pressure of the problem. The majority of the reports speak of shortage of beds in mental hospitals, serious overcrowding and lack of funds to improve existing hospital conditions. Several countries report, however, that the need for hospital beds remains constant or is even decreasing. But also in these latter countries - as in many others - an increasing demand for mental health care facilities other than hospital beds is observed.

It is worthy of note that no report ascribes this increasing demand chiefly to an increase in mental illness. It seems to be generally agreed that the incidence of the major psychoses at least has remained practically constant for many years. There is some suspicion as to an increase in incidence of neuroses, described in one communication as the "late flowering of civilization".

On the other hand, in many countries increase in mental health problems is ascribed to the fact that other health problems have dwindled in importance, and that increased life expectancy and decreased excess mortality may lead to a simulated absolute increase.

The rising demands are explained by a greater activity and increase in positive results of psychiatric treatment, by a growing trust of the population in mental health facilities, by a growing awareness among the public as well as the experts of the importance of mental health problems, and by the fact - generally known in public health activities - that more needs become evident as more services become available. Furthermore, some reports mention factors which tend to bring mental disturbances more into the open.

\(^1\) Wld Hlth Org. techn. Rep. Ser. 1960, 185
Among these factors are: social changes in the community; economic changes; industrialization and urbanization, changing the pattern and rhythm of family life. All of these changes tend to undermine traditional family structure, to render it less stable or to change the family role. The result may make it impossible for the family to care for its infirm and handicapped.

Since relevant statistical data, and especially other data than those concerning demands made on available facilities, are very incomplete, any pronouncement on incidence or prevalence of mental disease and its change in time or place can be regarded only with great reserve. However, it can safely be stated that numerous factors tend to bring the problems of those suffering from or threatened with mental disturbance more to the fore.

I.1.3 Need to bring mental health into public health planning

I.1.3.1 Integration of mental health in public health care. At present a renaissance of medicine is being witnessed: the re-discovery of the patient as a human being, and, by implication, the introduction of mental health thinking into general medicine. It is remarkable how many reports have introduced this element in their argument. "Since people cannot be divided into physical beings and mental beings", states one report, "we are compelled to co-ordinate and integrate the goals and definitions of services and hence the services themselves." "Public health and mental health care services are so intimately interwoven that it would be difficult and indeed harmful to attempt a separation", remarks another. A third report observes that "mental health deals with persons and their environment as well as public health does"; a fourth that "...since 1950 a general tendency exists to make mental health care equivalent to general medical care", and, to finish these quotations: "the public health approach to mental disorders is the same as the public health approach to other groups of illnesses: prevent what we know how to prevent; terminate and mitigate what we know how to terminate and mitigate; reduce disabilities resulting from illness".

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While strong statements are to be found in the reports advocating integration of mental health programmes in public health activities, at the same time many point out that public health activities often or even always touch on mental health problems, since they are concerned with people, persons who often seek public health service because they are in a transitional or critical stage of their life. These again are arguments for the closest possible co-operation if not for the identification of mental health care as an aspect of general health care.

I 1.3.2 Integration of preventive and curative care. Many reports point out that no clear lines can be drawn between preventive and curative activity. If, for technical reasons, delineations must be made, the interaction between prevention and cure is so close that it is anyway impossible to separate their effects.

This same point has been emphasized in Mackintosh's paper on the Role of the Hospital in the Public Health Programme. He remarks that "it must be clearly stated, however, that preventive and curative medicine have reached the stage where they are no longer separable . . ." and "during the period following the Second World War there has been a very strong tendency to move towards the further integration of health and medical care. It may be confidently predicted that this movement will gain in strength". The course of events in subsequent years as well as the remarks in the reports on this point have confirmed Mackintosh's prediction.

I.1.3.3 Conclusion from the foregoing. From the reports which express themselves on this point it can be concluded that separation of cure and prevention in the mental health field is acceptable only when carried out for technical reasons. Furthermore, that assimilation of mental health care in general health care is highly desirable. It may be expected that this assimilation will increase the potentialities of both fields of endeavour and - more specifically pertaining to our subject - will bring the potentialities of modern mental health care to the population.

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I.1.4 Feasibility of modern mental health care programmes

I.1.4.1 The problems of limited possibilities. In the following pages a number of mental health care procedures and activities will be discussed (I.2) as they are gathered from the various reports.

However, many reports also mention the impossibility of carrying out these activities for lack of expert personnel and adequate funds. Frequently the remark is made that programmes advocating such activities are unrealistic in view of actual conditions, especially in developing countries. A tendency to employ meagre resources exclusively for the care of the most seriously deteriorated patients - who seem too often the most pressing, or indeed, the only problem - is unmistakable. Several reports, while acknowledging the importance of other activities, postpone these to some later phase when it is hoped more personnel and funds will be available. This means a perpetuation of the custodial mental hospital system for an indefinite period.

This attitude implies a danger, for without exception the reports make it clear that as long as the classical, i.e., custodial mental hospital, remains the main or only remedy offered, the problems will keep on moving in a vicious circle. Since double or even triple overcrowding in mental hospitals is not uncommon, the creation of adequate space alone will cause intolerable burdening of the budget; lack of personnel renders the service so unrewarding that no new personnel can be induced to seek service, and physicians feel no incentive to take posts in mental hospitals. Furthermore, it is well understood that increase of mental hospital accommodation does not offer any real solution but will only result in new accumulation of patients and new overcrowding.

Furthermore, it is not only developing countries that complain of lack of funds and personnel. The same complaint is heard in practically all reports.

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While it may be a philosophical question whether it will ever be possible fully to satisfy mental health (and general health) needs, even in developed countries the provisions are often dramatically below what is considered a minimum requirement.

One report from a highly developed country describes vividly the extraordinary difficulties - and failure - to make a radical change in the classical pattern of care for mental patients because of lack of funds and personnel.

The way the legislative and administrative base for the care of the mentally ill originated in many countries - custody and segregation being the main purpose - caused a development into patterns of procedure which at present cannot be regarded as adequate for the tasks of modern mental health care.

In some countries these patterns have been changed; in other countries they are so rudimentary that they are no impediment to change. In other countries - and especially in many developed countries - they are most extensive and replacement and rebuilding must be carried out while the everyday functions go on - a difficult problem for a building as well as for an organization.

The question of what shape a system of modern mental health care should be given and how the proposed transformation should be carried out - applicable to local circumstances - is another cardinal issue for the coming technical discussions.

I.1.4.2 A tentative solution.  

It is therefore well to bear in mind that the great majority of activities constituting modern mental health care programmes are functions which are not necessarily identical with an equal number of specialists, nor with the existence of various specific institutions. The expert worker can carry out, supervise and advise on a number of different functions, each representing an item in the programme, just as one building can have many varied activities going on under its roof.

Obviously a limited number of personnel will limit both the extension and the depth of the proposed activities.

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Both extensions and increases in depth (or sophistication) require more personnel and money. As to extension, it is not inevitable that the number of specialists has to be increased correspondingly with the increasing scope of the service. The provision of specialists whose functions would be mainly consultative and advisory would enhance their effectiveness without increasing their number in the same ratio.

As to increased depth in mental health care, this is achieved by specialization and differentiation co-ordinated in the mental health team. The psychiatrist becomes a social psychiatrist, a psychotherapist, a child psychiatrist, etc. Undifferentiated auxiliary personnel become mental hospital nurses, psychiatric social workers, occupational and recreational therapists, etc. The psychologist, pedagogue and sociologist are brought in.

In the light of practical experience it would, however, seem a mistake to try to establish a broad differentiation at the start of any mental health programme. Irrespective of the question of whether the start is made in a developing or an advanced country, further increase in depth and further differentiation can only develop as the results of the interplay of given conditions and current activity.

"To plan the mental programme in relation to the present situation and expand it as personnel becomes available and the situation warrants it is the essence of a sophisticated approach", as one report remarks.

At which strategic points the specialists should be placed and what could be regarded as the minimum requirements for the start of a mental health programme might be questions to be examined at the coming technical discussions.
I.2  EVOLUTION OF MENTAL HEALTH CARE PROVISIONS

I.2.1  The mental hospital, old and new roles

1.2.1.1  The classical role of the mental hospital. Many reports condemn, sometimes in the strongest terms, the mental hospital as being detrimental to the well-being of the patients. Frequently this detrimental influence is identified with the custodial functions of the mental hospital. It must, however, be accepted as an undeniable fact that it may be necessary to place a mental patient under custodial care, either in his own interest or in the interest of others; this fact is duly mentioned in several reports. On the other hand, it will be admitted - as again numerous reports point out - that this is only necessary exceptionally, and the period during which the involuntary stay has to be enforced may be short. If some levity be permitted it might be said "that you may have to lock up some patients sometime, but never all patients and never all the time".

It cannot be denied that deprivation of the patient's liberty may be detrimental to his condition and to his chances of recovery. The fact, however, that in some cases a stay has to be enforced does not obviate the necessity to provide treatment, and it is this treatment which is frequently reported as lacking. A similar deterioration of the inmates which some reports vividly describe, can be observed in those children's and old people's homes lacking adequate care but where there is no question of custody.

The detrimental influence, so widely ascribed to the mental hospital, is not chiefly due to its custodial function, but to the fact that apart from custody few or no adequate activities in the hospital are carried out to promote the patients' well-being and cure. As one report remarks: "The difference in length of stay in various mental hospitals is determined by the therapeutic principles applied". In the light shed by other reports, it might be added "and whether any therapeutic principles are applied at all".

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Several reports remark that the population expects or demands that the mentally ill be segregated and secured in closed institutions. This attitude is understandable as long as the fear for the "madman" persists. It may be pointed out that this fear is chiefly fed by the image of the patient as it results from long years of inadequate care, which image is identified with the mentally ill in general and with the hopelessness of the psychiatric case. The mass-media have done much to exploit this fear.

As long as the mental hospital remains a horrible place which indeed produces horrors, no other attitude of the population can be hoped for. It is only when the mental hospital can point towards positive results that this attitude can be expected to change.

I.2.1.2 The transformation of the mental hospital. The "no-restraint" movements of the 19th century arose from the understanding that the insane should be kept in a place that was more a hospital than a prison; d'Esquirol's ideas are still fully applicable today.

The systematic attempts to change the role of the mental hospital, based on an insight into normal and abnormal human behaviour, are now almost 50 years old and yielded considerable results long before the discovery of the ataractic drugs.

The importance of these drugs as offering enormous support to psycho- and socio-therapy is generally recognized. However, they can supply only a partial solution of the therapeutic problem, since they deal with certain aspects of the patient only. There is even some danger that they will detract from the main therapeutic target, that is, the totality of the sick person.

2 d'Esquirol, 1822, Mémoire statistique et hygiène sur la Folie
The so-called "active therapy" (Simon, Van der Scheer, T. P. Rees, Sivadon and others) was worked out during and after the First World War, and assimilated in many mental hospitals. The essence of this method is the creation of a therapeutic community, a miniature society in which the patient can be made to experience and to enjoy being a member. He receives recompense for his labour, has responsibility, lives as an individual, seeks recreation. The changes brought about by this regime in the mental hospital can only be called revolutionary. The revolting aspects of the mental hospital disappeared; the average length of stay decreased until it was counted in months instead of years. The interdependence with environment - not only of behaviour but of symptoms which were generally regarded as inherent to the illness - was once more demonstrated, as had been done by Pinel more than a century before.

It may be recalled that changes in the old and often dismal wards - changes essential to create a comfortable and permissive environment - were often carried out by the most primitive means and by the patients themselves. Furthermore, as a rule, the change of regime was carried out by the old staff; it was usually sufficient when one staff member had really studied and grasped the philosophy of active therapy and was able to direct and inspire the others. It must not be forgotten that it was not only the patients, but also the medical and nursing staff, who had to be exposed to an intensive period of re-orientation and re-education.

It is deeply to be regretted that the ravages wrought by World War II - in which mental hospitals and their patients suffered severely in many countries - destroyed much of this work. At present the mental hospitals in the world seem to show all stages, from the pre-Pinel and the pre-Simon to the therapeutic community.

I.2.1.3 Is the mental hospital bankrupt? From the tenor of most of the reports as well as from a number of explicit statements, the conclusion can be drawn that the old mental hospital concept is regarded without reservation as obsolete.
On the other hand, the mental hospital as a therapeutic community has to be considered as an essential link in the mental health care provisions of a community. A considerable number of patients require a procedure of re-education, re-socialization and rehabilitation. This process may take months and needs often a combination of various forms of psychotherapy, drug therapy, occupational, recreational and social therapy. This principle is at present being further developed; the interaction of the patient with his group and with the hospital personnel has been formulated in the terminology of modern psychology. New concepts of group psychotherapeutic mechanisms are being developed and tested. In countries in which the re-adaptation will have to be made with a highly-industrialized society, this will require institutions specially equipped with workshops, recreational facilities, extensive grounds. Apart from a number of more or less specific medical provisions, this new mental hospital therefore has chiefly the function of a rehabilitation centre, as we know the rehabilitation centres for the disabled by physical causes. Countries offering a more agricultural setting require a therapeutic community more conforming to this social pattern, as is shown by a most interesting description of a therapeutic community village in one report from Africa.

I.2.1.4 Open door and open ward. To educate and treat a patient by giving him trust and responsibility requires doing away with the locked door. Many reports mention that in some of the wards or part of the hospital the doors are open. This situation has to be distinguished from the "open ward" which in many countries is reported as a feature of the mental hospital.

While the "open door" system may be found in an institution which in itself is "closed" - the patient is legally committed in a hospital with an active therapeutic system - the "open ward" receives patients on a voluntary basis. The open ward is, therefore, a further step in what can be called the emancipation of the mental patient. There is considerable difference as to the frequency of these voluntary admissions and the proportion of "open" to "closed" wards. In a few countries no such facilities are reported; in others the number of voluntary
admissions may range from 10 per cent. to 85 per cent. of all admissions. The extent to which the open ward system is in use may be regarded as a fair measure of the level of psychiatric hospital care and of its acceptance by the population.

I.2.2 The evolution of extramural mental health care

I.2.2.1 Psychiatric after-care. One of the results which follow logically from an active regime in the mental hospital is the need for closer contact with society. Improved behaviour and disappearance of symptoms has to be followed by parole and discharge; the ties with the family must be maintained or strengthened; what the patient has been taught in the hospital must be applied outside.

Since the therapeutic community is an artificial society, it is possible to adjust the burden put by this society on its members according to what the patient is able to bear; this method, in fact, makes it a therapeutic instrument. Therefore, to consolidate the gains of intramural therapy, it might be necessary in a number of cases to assist the patient's adaptation to society after his discharge by a device for adjusting the burden of society, within limits, according to the needs of the patient. This device is the after-care system, which developed in several countries as a consequence of improved mental hospital regime.

In its first stage it extends certain intramural activities outside the hospital for the benefit of discharged patients. Guidance and support are given to the patient and his family by nurses, social workers and/or doctors. Mediation with all kinds of social institutions on behalf of the patient is carried out. If return to the hospital should be necessary, this extended influence makes it easier for the patient to accept and less of a traumatic occurrence.

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I.2.2.2 Development of socio-psychiatric and out-patient services. Gradually the tendency arises to project more activities from the hospital into society.

If the patient does not require the extensive adjustments possible only in the artificial hospital society, there are great advantages in leaving him in his own environment and bringing the therapeutic facilities of the hospital to him. In this way he may profit from occupational and recreational therapy by the organization of sheltered workshops and clubs. Psychotherapy, chemotherapy, group therapy may be found in day hospitals, out-patient clinics, etc.

As will be understood, when the possibilities reach this scope, they are no longer destined exclusively for patients discharged from mental hospitals, but also for other patients who have never been admitted to a mental hospital.

At this stage after-care activities begin to merge with preventive activities and other curative activities in the mental health care field; early diagnosis and treatment, marriage counselling, child guidance, vocational guidance, while public health activities are being approached (I.3) and important interaction may develop with other agencies (I.2.4).

Special mention has to be made of out-patient (polyclinics, dispensaries, etc.) services. Their development may, in some instances, be a result of the orientation of the mental hospital towards society: an after-care service may become the centre of ambulatory psychiatric treatment in the community. However, frequently the out-patient department develops independently of the mental hospital. In that case, it is a concomitant of medical specialization, which requires high-level ambulatory treatment, backed by hospital facilities such as laboratories, X-ray installations, etc. The psychiatric out-patient department offers early diagnosis and treatment in close co-operation with other medical specialties. Especially when linked with clinical wards on the one side and with a social service on the other, it may become a very important instrument for primary and secondary prevention.
At this stage it can be expected that these extramural activities are brought together in a comprehensive mental health care service, or at least in some foci of activity such as the mental health clinic, the out-patient service or the psychiatric hospital service. In this way the socio-psychiatric service comes into being, conceived as an organization co-ordinating a number of facilities that will ensure prevention, early detection, referral for adequate treatment, rehabilitation and follow-up in the mental health field. It is designed to give psychiatric care a dynamic character by fitting it to the requirements and potentialities of the patient at each stage of his illness and exploiting the available possibilities of the community to the utmost. Rural areas may profit from these activities by mobile teams based on a central organization as mentioned above.

I.2.3 Psychiatric wards in general hospitals

I.2.3.1 General. It has become clear from the reports that psychiatric wards have been in use in general hospitals in several countries for many years. In other countries the introduction has been made more recently; in some the possibility is under consideration and in a very few the reaction is negative. Among the advantages may be mentioned that the length of hospitalization is usually short and no commitment is involved, so that there is less social disruption for the patient and family. Early diagnosis and intensive treatment may eliminate the necessity for transfer to long-stay institutions. Furthermore, the presence of the psychiatrist may lead to consultation with other specialists and improve medical services throughout the hospital.

One report mentions as a possible disadvantage that the staffs of mental hospitals would be depleted and that only chronic patients would be sent to mental hospitals. On the other hand, the establishment of psychiatric wards in general hospitals might increase psychiatric manpower by attracting psychiatrists in private practice and by using these wards as teaching centres for medical and nursing students.
It is generally agreed in the reports that psychiatric units in general hospitals should not become too large and that the patients be selectively admitted (acute cases and psychoneurotic conditions as a result or complication of physical illness).

It may be remarked that in countries with very few psychiatrists there seems to be little point in admitting psychiatric patients to outlying hospitals, which can only infrequently be visited by psychiatrists.

I.2.3.2 The psychiatric ward as screening centre. Two reports mention a function of the psychiatric wards in the general hospital that may receive some emphasis.

When the total organization of mental health care shows enough differentiation to allow some choice, it becomes important to establish a screening centre in which the patient can be observed and examined and a course of treatment and rehabilitation can be worked out.

Such a screening centre can be of great importance to the efficiency of the entire mental health care apparatus. To neglect this screening procedure enlarges the risk that the illness will be unduly prolonged or that the patient will be reduced to permanent invalidism. Apart from the human suffering that can be prevented in this way, the costs involved are only a fraction of what later on has to be spent on the care of those initially neglected patients.

It is not possible to give a generally valid ratio of in-patients to out-patients in such a centre; much depends on its relationship to other facilities. But as a general requirement it can be stated that, in order to fulfil its function, it must be able to make use of the full aid of specialist consultation and laboratory facilities of modern medicine. To erect such a centre as a separate hospital would be a costly duplication of a general hospital, and the same would be true if such a centre were attached to a mental hospital. The most effective way, therefore, seems to be to incorporate it into a general hospital, or to associate it very closely with it.
Under favourable circumstances this centre can become the strong point of the mental health care organization. It may function as a teaching unit for future specialist personnel, medical undergraduates and general nursing personnel. Its out-patient department may function as a socio-psychiatric service for the region; it may form the basis of a psychiatric emergency service. It can contribute enormously to the assimilation of mental health practice into the general hospital and in the public health and social services of the community.

I.2.4 Mental health implications in other fields

As mentioned previously (I.1.1.2), mental health care has no monopoly of dealing with inter-human relations and their disturbances. They are also the concern of many other agencies working in the community, such as the educational organization, public assistance, the agencies dealing with juvenile and adult delinquency, prostitution, and with special groups such as migrants and foreign labourers.

It is - or at least has been - a general complaint that these activities are locked in watertight compartments and that no interchange of experience, information or ideas takes place. A mental health service may often be instrumental in breaking through these compartments to mutual advantage.

It is often necessary, in order to make the existing possibilities in the community available to the patient, to contact social agencies, public and private organizations and the public health services (I.3). This contact may lead to two results. In the first place it may be discovered that the other agency has problems in connexion with clients who turn out to be mentally disturbed but who were not recognized as such. This contact therefore may provide an important means of case detection. In the second place further contact may lead to an understanding of mutual procedures that can be most instructive. In this way a consulting activity may arise which originally was more or less accidental and informal, but which may result in a diffusion of mental health principles at strategic points in the community.
I.2.5 Recapitulation: the three levels of prevention within the mental health care frame

I.2.5.1 General. In the preceding paragraphs an attempt has been made to show, on the basis of the reports received and the relevant literature, that mental health care can develop, is developing and, in some important instances in fact, has developed into a comprehensive chain of procedures that comes very close to the structure of current public health systems.

This development may be regarded both as cause and as effect of the increased possibilities in the mental health field as they arise from the interaction with their social (economic, political, cultural) setting. It may, therefore, be well, at this stage of the argument, to review the present day mental health care possibilities according to the three levels of prevention in which general health activities can be distinguished and which, taken together, can be regarded as a comprehensive health care programme as this is understood today. The majority of the examples offered in the following paragraphs are gathered from the reports received.

I.2.5.2 Primary prevention: the prevention of the occurrence of the disease. It is true that no specific prevention is known as yet for some of the major psychoses. The size of the problem offered is, however, not in the first place a matter of incidence, but of prevalence, because the disease may result in a longer period of continuous and total invalidism than almost any other disease known to man. To abbreviate this period is, however, a matter of secondary and tertiary prevention, which will be discussed below.

Many possibilities of preventing or at least of postponing the psychoses of old age are open at present. In part they are of a relatively simple and physical nature: providing adequate nutrition in old age seems to be a most important preventive measure. Partly, complicated psychological and social measures are required, which, however, are recognized, worked out or are already operating in many countries. Geriatric services as part of mental health care services or working in close association with them offer a solution.²

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¹ Expert Committee on Mental Health, Eleventh report, in press
The prevention of injuries to the central nervous system is often the responsibility, as Gruenberg\(^1\) points out, of agencies other than those providing mental health care. Intoxications, infections, deficiencies, brain injuries either caused by accidents or intra-uterine and obstetrical occurrences, are in the field of other specialists; close co-operation with mental health experts in regard to the prevention of the occurrence itself and its sequelae is indicated. The prevention of general paralysis is partly a matter of primary prevention, closely linked with the combat of venereal disease; partly it is one of secondary prevention and, as such, one of the most impressive examples of the possibilities of early diagnosis, treatment and follow-up.

In the vast field of the prevention of emotional disturbances and the prevention of abnormal development of the emotional life it is not so much a question of recognizing causative factors as of practical application of established knowledge. This can be carried out in part by the agencies of preventive mental health care and partly by enlightenment, training, education and consultations with those who deal with the growing individual.

I.2.5.3 Secondary prevention: mitigating or terminating the disease once it has become manifest. In the mental health field, perhaps even more than in the field of physical health, there is a most pernicious relation between the duration of the disturbance and the effort necessary to meet it. A disturbance of emotional development, leading to behaviour trouble in a baby, when discovered in the well-baby clinic, may be put right with one or two talks with the mother; when discovered at school, it may require half a year's work in the child guidance clinic; when discovered during adolescence, therapy may be necessary over a period of several years; in the adult it may well prove resistant to treatment. The same is true for a major psychosis; when detected and treated early and rigorously, re-adaptation may be reached within a few months; when initially neglected re-adaptation may take years or may never be attained. Therefore, case-detection in early stages by close contact with other general health and social agencies, by consultation services, out-patient facilities, general hospital psychiatric wards and other open hospital services will be able to fulfil the requirements of secondary prevention.

\(^1\) Gruenberg, E. M. (1957) Amer. J. publ. Hlth, 47, 947
Not only must the services be easily available, however, but the public must be ready to use them. This has to be brought about by education of the population of physicians and public health workers, and by obtaining the co-operation and insight of those persons holding key positions in the community. By this education - but no less by the type, level and results of work demonstrated in the mental health care organization - fear and prejudice connected with mental illness can, in the long term, be overcome (II.1.1).

Again, an important step towards this goal can be made by making the mental health care provisions as far as possible similar to other general health facilities and by removing any specific obstacles to seeking treatment. To quote from one report: "The new pattern (of mental health care) aims at linking psychiatry with general medicine in the hospital service and with the public health service in the community. In its final form this will enable the majority of psychiatric patients to find whatever advice or treatment they need within easy reach of their homes and with no more difficulty or formality than any other sick person".

I.2.5.4 Tertiary prevention: reducing disabilities consequent upon disease. Any long-term illness disturbs the personal and social relations of the patient and requires a period for rebuilding these relations, at the same time appealing to the uninjured faculties and potentialities of the patient. This has been recognized in the case of many physical illnesses but also in psychiatry, which in some instances has been pioneer in carrying out an after-care and follow-up programme. Supporting activities are of varied nature and have been mentioned before (I.2.2, I.2.3).

Here again we find a striking similarity with the rehabilitative measures taken on behalf of patients who have been suffering from physical illness. Just as the ex-tuberculosis patient, the polio victim or the victim of a crippling accident may need special measures to achieve psychological and social adjustment, the ex-mental patient may need the sheltered workshop, or supervised residency, re-training for employment, etc. These possibilities are provided in the social psychiatric service. Supporting psychotherapy and sustained medication may be given in the mental health centre, the out-patient department or the day hospital.
Often, however, it is necessary that this period of adaptation to society should be preceded by a period of in-treatment, in which re-education of the patient takes place and new levels of equilibrium have to be developed. Thus rehabilitation clearly cannot be distinguished from treatment, since both try to strengthen and develop the potentialities of the damaged person. It is therefore initiated by the medical expert, who retains the supervision while other experts in various forms of therapy take over.

The therapeutic community of the mental hospital or its equivalent (for instance, the therapeutic village; see I.2.1.3) is the logical centre for this tertiary prevention. Since, as has been mentioned above, one of the major problems of mental health care is the extraordinarily long or permanent invalidism of considerable numbers of mental patients when not adequately dealt with, this tertiary prevention can be regarded as one of the keys to the problem of the ever increasing burden mental illness puts on the resources of society.

I.2.5.5 Conclusions. From the preceding paragraphs it may be concluded that present day development of mental health care renders it possible to fulfil a programme of comprehensive care.

Many reports mention these activities in various stages of development and organization. Frequently, however, the remark is made that the necessity of carrying out the projects is recognized but is precluded by lack of expert personnel and funds. The weight of these objections cannot be denied; it is possible, however, that the preceding paragraphs will show them in a slightly different light.

In these paragraphs an attempt has been made to show that each activity is the result of development that has had to pass through certain stages. This development may be abbreviated or promoted in the light of knowledge gained elsewhere; mistakes may be avoided; procedures simplified. But no single health care activity can in any country start in a complete and finished state. A germ has to be planted in the soil of society and, if they are not too alien to each other and if there is sufficient need, the germ will develop, showing the fundamental characteristics that constitute its function or use and modified by the environment from which it receives its nourishment.
Furthermore, no single mental health care activity can function in isolation. It is impossible for extramural provisions to function satisfactorily when the only alternative is an obsolete mental hospital. It is just as impossible to have a mental hospital that functions satisfactorily while extramural facilities are lacking. Intramural and extramural services have the relation of communicating vessels. Their respective states are interdependent; both are determined by the society in which they function.

I.3 CURRENT PUBLIC HEALTH ACTIVITIES WITH MENTAL HEALTH IMPLICATIONS

I.3.1 General implications

A short review of the various mental health aspects of public health activities may not be out of place; many reports show a keen awareness of these problems.

It is frequently stated that a proposed health activity cannot be carried out satisfactorily if it is not understood by the population and, on the other hand, that an understanding of the population is necessary in order to prepare the public for the introduction of an activity. Since, as several reports remark, public health planners - and those who carry out the programmes - in many countries may come from a different social layer than the majority of the population to be served, a barrier to understanding must be taken into account. This barrier will increase many-fold when difficulties of dialect or language arise or when the planning takes its origin from a foreign culture.

The training of workers of the indigenous culture in another culture may give rise to just as serious difficulties of mutual understanding, as several reports point out.

Mistrust of authority, resentment for political or economic reasons, fear for threatened traditions and customs may unexpectedly wreck proposed programmes. Careful study of the way of life of the population to be served and instruction of planners and other staff is, therefore, necessary. For over-all planning the advice of social scientists is necessary; for smaller scale work on-the-job training seems invaluable. It will be the task of the psychiatrist - in close
consultation with the social scientist - to scrutinize the various sources from which resistance to the proposed activities may spring and to advise accordingly. In any case, it would seem advisable to bear in mind that disruption of existing life patterns in itself may be harmful from a mental health viewpoint. It would, therefore, seem desirable to carry out the proposed activities as much as possible through existing cultural and traditional channels and, if necessary, to adapt the activities to the circumstances. As a general principle, it might be stated that public health as well as mental health activities should be home-grown and not imported.

In recent years much attention has been paid to the mental health aspects of the general hospital, which can be summarized in the change of the patient from a case to a person.

In the same way any public health facility should bear witness of the principles from which it takes its origin: hygienic surroundings, neatness, order consciousness of the fact that living persons are to be served and their fundamental rights have to be respected should find expression in the layout of working space, reception procedure, and attitude of staff.

I.3.2 Specific public health activities with mental health implications

I.3.2.1 Mother and child care. According to many reports the possibilities for mental health care when dealing with the pregnant woman and with mother and child are appreciated. Referring to the remarks made when dealing with primary prevention of mental disorders (I.2.5.2), it will be understood that mother and child care will be one of the most important means of achieving this aim.

It may be pointed out that the services that deal with these activities do not offer solely an opportunity for case-finding. Apart from the need to recognize and evaluate more serious disturbances, it must be regarded as part of the routine

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duty of the staff to deal with the mental health needs in general of the clients. This requires training of the public health personnel and the provision of expert consultation, which will be discussed later (II.1).

Since mother and child care is often the first line of activity of the public health services, a considerable part of the mental health needs of the population may be met by channelling mental health care into these public health activities.

I.3.2.2 School health. The same is true of the school health service. Especially in the cultural setting of highly developed countries, a considerable burden is put upon the child by the adaptation required to this new and wider environment. This may bring out a number of shortcomings which, until school entrance, have remained hidden or have not been recognized as problems. Just as sensory handicaps may be detected in school for the first time, retarded mental development may have to be faced and attitudes that were tolerated within the family relations may develop into more or less serious problems.

It is certainly desirable that the teacher should be able to recognize these problems in the first place. A specialist backing is, however, essential and may be provided by the school health personnel, who again must be able to seek specialist consultation if the case requires it. The school health service may, therefore, act as an important instrument of case-finding.

Apart from this function, an important task of this service - in close co-operation with the teaching body - is to create a mentally healthy climate in the school. Discussion groups of the teaching personnel together with the school health team - and if possible with members of the mental health team if they do not form part of the school health team - may be instrumental not only in helping the teachers to understand the pupils but also in furthering good relations between staff members. This activity can be grafted on or extended to the parent-teacher meetings, which in many countries have been established for a considerable period. It may be remarked that parent-teacher meetings in themselves may make a considerable contribution to the promotion of healthy relations between home and school. From a mental health viewpoint the establishment of relations between teacher and family should therefore be encouraged.
Finally, when it is time for leaving school, the teacher's assessment of the pupil's work may be an important element in vocational guidance advice.

I.3.2.3 Industry and occupational health care. Many reports - especially from developing countries - mention the enormous changes brought by industrialization and the detrimental effects on family life which may be directly reflected in an increase in mental health problems. It may be added that the public health problems arising from urbanization, disruption of family structure, changes of food habits, slum formation, etc., seem to be just as serious.

Many reports give the impression that the situation is well recognized, but that few systematic attempts are made to meet it. This perhaps would indicate a lack of co-ordination at the highest levels of health care with the corresponding levels of economic planning and industrial policy.

A few reports point out that the mental health of the individual worker is protected by industrial medical supervision. This activity would indeed seem to be the logical way to meet the mental health needs of most participants in the production processes of a country, at least in so far as these processes have a mass character.

The mental health implications arising from the fact that the mother is working outside the household may be manifold. Some reports mention the problems without, however, offering a solution. In other reports measures in the interest of the children - and their mothers - are mentioned, which usually take the form of some system of day-care. This draws attention to the problems arising from handling children in groups which are met in day-care centres as well as in residential institutions. It is well known that care of children in groups may reduce the close emotional contact considered necessary for normal child development. Therefore a systematic use of day-care centres for children of working mothers should be carefully scrutinized as to needs and as to other solutions offered by existing circumstances. The day-care centre may be acceptable in industrial areas with a restricted family pattern, while an agricultural setting or a three-generation family structure renders such a provision less urgent.
On the possible influence of automation opinion is divided. In some countries the problems are recognized and are being studied. Here again several mental health problems may be discerned, such as job insecurity, necessity of re-schooling, of moving to other locations, of selection of workers.

It may be noted that hardly any report mentions modern traffic problems resulting from increasing urbanization and industrialization, nor the mental health problems involved in traffic and traffic accidents. Attention may be drawn to a recent WHO study on this subject.¹

I.3.2.4 Old age.² Several reports, especially from developing countries, mention that no special problems in regard to the aged are experienced.

In one report it is stated that the expectancy of life is not high enough to cause the presence of an appreciable number of aged in the population. Other reports mention that family structure and traditions are able to meet the needs of the aged. Other reports, however, make it clear that increasing industrialization will undoubtedly cause an old age problem, while in the most highly industrialized countries the problems of the aged are among the most serious that are to be met at present. These problems comprise a number of intricately interwoven elements: social, economic, physical and mental health. No approach from any single angle can be expected to be effective.

Comprehensive services for the aged, which take the various aspects into account, are being organized in several countries or are already operating. They can be regarded as one of the newer developments of public health activity. (See: primary prevention, I.2.5.2.) The necessity of research in order to enhance the preventive action of these services is well understood.

¹ Norman, L. G. (1962) Road traffic accidents: epidemiology, control and prevention (World Health Organization: Public Health Papers No. 12)

I.3.2.5 The role of the general practitioner.\textsuperscript{1} In a number of countries the
general practitioner is working in the organizational framework of public health
activities. In other countries he works outside this frame. However, irrespective
of his organizational position, his function is much the same. He is the first-
line physician, receiving the first impact of the problems posed by his patients;
he has to deal with medical problems directly as they arise in the community.

Providing and arranging for continuous care, knowing the patient, his social
background and his family, and determining his actions accordingly, are the typical
attributes of the general practitioner. He therefore has to deal with mental
health problems just as much as with the physical problems of his patients. On
the preventive side it is important for him to know that certain situations and
phases of the normal life cycle - adolescence, reproduction, old age, loss of
relatives, etc. - are critical in the sense that they may disturb a mental
equilibrium and that he be ready to help to prepare the patient for the coming
crises. On the curative side it may be regarded as an important part of his duties
to recognize a disturbance and to decide whether he is able to handle it himself or
whether the patient is to be referred to a specialist for advice or treatment.
Being in the front line of medical care, he will have to deal with emergencies.
In those cases he will often provide the link with the general and mental health
facilities of the community. His actions may well be decisive for the further
fate of the patient.

I.3.2.6 First aid and emergency services. Medical first aid, as it is dispensed
especially in the larger cities, may be provided by the public health organization,
by the hospitals; or by the police. It may be pointed out that it always contains
a mental health element. In the first place the emergency service may have to
deal with all kinds of mental disturbances (suicide, homicide, confusion states).

\textsuperscript{1} World Health Organization, Expert Committee on Mental Health, \textit{The role of
the public health officer and general practitioner in mental health care.}
Its personnel needs some understanding of these states and how to handle them. Even if a serious disturbance of the peace occurs as a result of a mental disturbance, the patient should be brought as soon as possible under medical supervision. Secondly, in the case of the ordinary accident, the personnel has to deal with people in a highly emotional state who may suddenly be faced with fear of death and, perhaps for the first time in their life, are confronted with the awesome machinery of the modern hospital. Next to expert handling, a psychological approach is therefore essential.

When a catastrophe occurs, providing food and shelter, preventing the outbreak of disease and assisting the wounded has first priority, for which usually all the potentialities of available public health provisions are mobilized. However, as experience has shown, even from the very onset of assistance the application of mental health considerations (as, for instance, avoiding the disruption of family ties) may contribute to lessen the misery and to prevent future sequelae of the emotional upheaval the victims have experienced. The same principle holds true if a group is exposed to sudden change by human action, for instance shifting of population for industrial reasons, and migration.

I.3.3 Activities in related fields

As a rule a number of health considerations enter into certain fields of public planning. Usually these considerations are based on the techniques for protecting the population against a number of environmental hazards (sanitation, housing, sewage disposal, water supply, etc.). However, it does not seem to be generally realized - only a few reports mention this subject - that broad fields of public planning have implications for the mental health of the population. The privacy offered by a dwelling - determined by the building material used and the siting - the relation of the dwelling block to the street, the creation of a community centre in new developments, the differentiation in dwellings for families in various stages of their evolution, the development of recreational sites for children and for adults, the siting of residential areas, working and shopping areas and the problems of communication involved - these are only a few
examples which touch directly on the mental health of the people. On the other hand, the pernicious influence of slum dwellings and slum quarters - both on the physical and the mental health of the dwellers - hardly needs to be emphasized.

Just as in many countries the problems of sanitation are no longer primarily a concern of the physician, but are dealt with by other experts - engineers and architects - so the mental hygiene problems that are involved in building and planning may in the future be met by specialists in these fields. At present, however, it can only be hoped that the mental health care expert will be consulted in these matters. Public planning which takes mental health principles into account will yield indirect contributions to mental health promotion; the fact that they are indirect, however, does not make them less important.

RECAPITULATION OF THE ARGUMENT

In section I.1 it has been argued that the development of modern medicine renders it imperative to bring preventive and curative activities together and to recognize mental health care as an aspect of general health care.

In section I.2 it has been shown that mental health care at present has evolved in such a way that it can provide in its own field a programme of comprehensive care.

In section I.3 it has been shown that public health activities in themselves carry a number of implications for mental health care.

Therefore it can be concluded that public health care in its content has many mental health elements, while mental health care in its structure and in its aims has become more and more an aspect of general health care. It would seem, therefore, that the time is ripe to increase and expedite attempts that will lead to a merging, assimilation or integration of mental health programmes in public health planning, resulting in a comprehensive activity of general health care.
The following sections of this paper will be devoted to the examination of the question of how this aim is to be achieved. It is realized that no single answer is possible and that in the final analysis each country will have to find its own solution. It can, however, be assumed that the longer the history of the various provisions in a given country and the more complex the current state of development of these provisions, the more difficulties will be met in achieving this merging. Countries which still have to build the major part of their health organization have, in this respect, a great advantage.

When analysing the reports received, one is impressed by the fact that fundamentally there is very little difference in the problems to be faced, irrespective of the state of development of the country. This may seem hardly credible in view of the vast differences in resources and in sophistication of organization. It would seem, however, that the similarity of problems to be solved and the way to solve them largely overrides the differences, which are more a matter of quantity than of principle.
PART II

II.1 ORGANIZATION, TRAINING, RESEARCH

II.1.1 General

These subjects are interdependent and so interwoven that they are brought under one heading although systematic treatment of each will be attempted.

Ideally, first should come surveys to determine the nature and extent of needs. This would offer the possibility of drafting an organizational scheme that would answer the questions of functions and facilities required and the strength of the necessary personnel. This again would lead to the establishment of a quantitative and qualitative training schedule from which a timetable could be drawn up to show when the organization could be expected to become operative.

Next to a quantitative study of needs, a study of population attitudes is necessary to determine the measure of tolerance of the community in regard to the mentally ill, which, of course, will be an important factor in establishing the extent and the nature of the provisions actually to be provided. Furthermore, the study of population attitudes may be the basis for the educational and informative campaign that will be necessary to gain the cooperation of the public in regard to the proposed facilities.  

(See also: I.3.1.) In practice this procedure is seldom strictly and fully followed. Apart from the fact that the type of research needed is lengthy and costly and manifest needs will press for action, it is very difficult to carry it out before some organization has been established. Facilities may stimulate demands which were not present, and on the other hand shortage of personnel and difficulties of recruitment may make it necessary to postpone execution of plans.

In the light of past experience it may, however, be stated that well-planned preliminary research, even if it would postpone action and absorb funds that seem so urgently needed for the alleviation of manifest needs, will make it possible to avoid costly mistakes and will result in higher efficiency of the established services.

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1 Research is used to include epidemiological and other surveys and deliberate studies undertaken to provide information for the planning or evaluation of services.

II.1.2 **Priority of training over organization.** In the reports it is unanimously stated that training of personnel has to have priority over organization of services; the fallacy of having services which cannot be manned is pointed out.

This signifies that it is the general opinion, as represented by the reports, that the scope of services is determined by the strength of personnel available. This may seem to be an undeniable fact, but it requires qualification, as will be shown below.

II.1.3 **Training priority must be qualified.** As is pointed out in one report, in various countries considerable differences will be found in the need of personnel to be trained for carrying out mental health programmes. In one country the most urgent need may be to have more social psychiatrists or child psychiatrists; in another country the need for social workers or home visitors may be more pressing. Therefore, it does not seem enough to give training priority over organization. The question of the level of the personnel trained has also to be considered. It would seem that here a point of primary importance is raised which requires further examination.

What are the organizational factors determining the level and strength of personnel required?

II.1.4 **Organizational considerations**

II.1.4.1 **Organization based on individual needs.** The usual way of starting a mental health activity - in developing as well as in advanced countries - is by the establishment of a nucleus, activated by some inspired person or group, by a pilot study or a demonstration project. It is expected - and in many instances the expectation has proved to be justified - that the example established in this way will cause a chain reaction, which will extend the activity in due time in scope and depth. This is how mental health activities have been established in most countries.

As a rule these activities were started with a view to individual needs and no quantitative considerations concerning the needs of the total population were taken into account. Indeed, the initiative did not have this purpose; it was in the first place taken in order to ascertain whether the activity was workable in a given setting and not to provide a service for the entire population, as for instance would be the aim in establishing an organization to combat a widespread infectious disease.
II.1.4.2 Failure to meet needs of population. From many reports, especially those originating from developing countries, the impression is gained that many projects initiated as nuclei or pilot studies fail to cause the desired chain reaction. They do not propagate, it turns out to be impossible to extend the activities and this is ascribed to the lack of personnel.

At the same time advanced countries, in which mental health provisions have been operating for some time, begin to relate existing provisions to the needs of the population as a whole, and come to the conclusion that a wide gap exists between available provisions and estimated needs, a gap which again is due to lack of expert personnel.

II.1.4.3 Impossibility of meeting these needs. Furthermore, a study of the figures shows that in most instances it will not be possible to fill this gap in the foreseeable future. Taking the highest current figures of +1000 physicians per million population of which +50 are psychiatrists, and using furthermore the usually accepted estimate that in the same countries 5 to 10 per cent. of the population is in need of some psychiatric case, we find that even in the most advanced countries this number of psychiatrists would have to be increased between 5 and 10 times, equalling half the total number of physicians, to give every patient one hour's time a month. Obviously this is not a realistic goal.

Fundamentally this problem is the same for developing countries as for developed countries, although the even greater gap existing in the former may necessitate different practical solutions.

II.1.4.4 The problem of coverage. The problem which is met here can be formulated as follows: the purpose of any health service is to make the full range of medical knowledge existing in a given field available to the entire population or population group deemed in need of that service. Ideally this would mean that each member of the population should have access to the specialists and provisions in that field. In a very few - albeit important - instances this ideal seems on the way to being realized; in the vast majority of countries the reality is far from the ideal state, certainly in the mental health field.
This being the case, it has to be asked: what is the highest level of the health organization at which the personnel is in sufficient numerical strength to provide total or optimal coverage in the field in question - in this case, therefore, in the field of mental health care? The answer will vary according to the country. In the majority of developed countries coverage can be provided by the general practitioners; there are sufficient general practitioners to be reached directly by any member of the population. In developing countries this is often not the case; here the highest level to give optimal coverage may be provided by nurses, or again, when sufficient trained nurses are not available, by a body of health workers with a simpler training. However thin the lower level may be spread, it will always give more coverage than any higher level and, furthermore, since training is shorter, increase will be more rapidly achieved.

II.1.4.5 Increasing coverage by echelon formation. Therefore, if the highest level of skill is numerically not strong enough to provide the desired coverage, the skill has to be made available to the population by encompassing its permeation into a lower level where there are many more professional workers.

If this principle could be accepted, the scope of a service would not remain limited by the strength of its highest expert personnel, as at present is often the case in mental health services, but by the way the required levels of skill are distributed in the service and the lines of communication between these levels. It will be understood that the level of skill may not be determined by a single specialist activity such as psychiatry, mental health nursing, psychiatric social work, etc., but by the combined activities of a group of specialists, which make up a mental health team.

II.1.4.6 Echelon formation in mental health services. The problems which are faced at present when further development of mental health activities is contemplated (II.1.4.2-4) may be seen in the light of mal-distribution of specialist potential. It may be that echelon formation - as outlined above - could offer some solutions; in that case the problem is made much simpler when it is also possible to channel mental health programmes through public health activities.
Since, as has been remarked (I.2), the public health workers are eo ipso concerned with the mental health aspects of their activities, the training necessary to establish a mental health echelon at their level will not imply an extension of their allotted tasks but a rounding off of this task itself. The same may be true for workers in allied fields such as education, social workers, etc.

II.1.4.6(a) Echelon formation in the mental health organization of advanced countries. What has been a single level of activity would become at least two or perhaps even three.

The first contact, initial screening and dealing with the cases of average type, will have to be entrusted to personnel working at levels which give more coverage to the population. In the advanced countries this will be the general practitioners and the personnel of the public health services such as mother and child care, school health services, industrial health care, care for the aged. It may be possible to establish a more advanced echelon by making use of the teaching staffs of schools and social workers in various allied fields.

The specialists themselves will have to be placed at a level at which the specificity of their aptitudes can be fully used to the advantage of lower echelon workers: by advice, consultation, supervision and teaching, and by dealing with the more special cases. Usually the specialists will be working in a team - the mental health team - consisting of psychiatrist, social worker, psychologist or other or more sub-specialized workers. It is characteristic of the mental health team that each member carries his own responsibility in regard to the case at issue. Therefore, if it is deemed necessary in order to increase effectiveness to move the specialist to a more consultative and advisory level, the team should be regarded as a unit that has to be moved as a whole.

It may be possible to organize an intermediate level at which persons are trained to perform therapeutic activities without having had the training of the physician.

It does not seem desirable to state dogmatically where the proposed expert level should be placed within the organization as a whole. Here various countries will require different solutions. If a screening centre (I.2.3.2) should have been developed in the sense of the central point in a comprehensive mental health organization, this would seem the logical place. However, this place may also be in the mental health department of a comprehensive health service, or in the psychiatric department (provided it gives clinical, social and out-patient care) of a large general or teaching hospital.
II.1.4.6(b) **Echelon formation in developing countries.** Countries which still have to develop their mental health programmes will have to start with nucleus or pilot projects as before, which, however, does not detract from the necessity of establishing representation at administrative level, as will be discussed under II.2.

It is of the greatest importance for future success that the place of this nucleus in the existing or proposed health organization is chosen with regard to its strategic value. For, assuming that this nucleus will be run by experts, they will be the very few experts available in the country for an appreciable period. Their initial position in the organizational frame determines the level from which they will operate later on. If the level chosen is too low, the same difficulties that are experienced in advanced countries will be felt, only they will come sooner and be more serious.

Although the choice of operating level of the initial project and of the experts is most important, here again dogmatic pronouncements must be avoided. A good place would seem a hospital in which teaching of medical undergraduates and general nursing personnel is carried out. A psychiatric ward in such a teaching hospital might form a centre from which out-patient activities and the mental health care in the area the hospital is serving could be developed and directed.

It might also be possible to use as nucleus a new-style mental hospital with out-patient facilities from which co-operation with general hospitals and the other existing health facilities might be developed. Here again, the importance of training future specialists, general practitioners and public health personnel at all levels should be kept in mind.

The two initiatives mentioned above are based on either general or specialistic hospitals. It may, however, be argued - as has notably been done in the Sudan, for example - that a first principle of mental health care is to maintain the links and the affinities of the patient with his family and his group. Therefore, the initial structure and the backbone of a mental health programme might consist of out-patient services, hospitalization taking second place. This concept seems to be very important and worthy of discussion. It must be remarked, however, that a system of out-patient services can be established only if a certain number of specialists are available; it may be possible to limit this number by placing the out-patient units in echelons, but
obviously a minimum of specialist staff will be required to make the system workable. Furthermore, it would seem - but this again may be a point of discussion - that it is not possible to carry out all psychiatric teaching in an out-patient service, although the possibilities are larger than is usually assumed. Some clinical teaching, however, will be necessary, if only in order to integrate psychiatry with other branches of medicine. The out-patient service (which might be part of a public health service) should therefore be combined with a psychiatric clinical teaching unit, preferably, as has been remarked, in a general teaching hospital.

There can be little doubt that the echelon providing the most coverage in these countries will be the first line of public health workers, albeit this line itself needs further development. In these countries the vast reservoir provided by the exponents of local health customs must be taken into account as a pre-formed channel to bring mental health care to the population.

II.1.5 Training

II.1.5.1 General. It will be understood that the carrying out of echelon formation and the channelling of mental health programmes in public health services, as suggested in the preceding paragraphs, will have implications for training. Many of these implications are discussed in the report of the expert committee on mental health dealing with the role of public health officers and general practitioners in mental health care. Furthermore, many reports received from countries show clear awareness of the fact that an integration of public health and mental health activities will have consequences for the training curricula of both groups of workers.

While on the one hand, therefore, the conclusion is drawn that public health workers need to receive training in principles of mental health thinking for carrying out their public health task, training in public health will become necessary for mental health experts as mental health programmes become more closely associated with public health services. It need hardly be emphasized, after what has been said before (I.2) that this training will have to be undertaken for all personnel, irrespective of the level at which they are working. If one group should be omitted, it would immediately cause a weak link in the chain of provisions.

\[1\] Eleventh Report of Expert Committee on Mental Health; in press.
II.1.5.2 Methods and content. Many reports refer to the various methods by which mental health training is introduced, and most methods of modern teaching are mentioned. Emphasis is put on refresher courses and on the importance of in-service training with guidance and supervision. From the reports it would seem advisable to limit training in other cultures as much as possible and for the country to be served to develop training centres of its own culture as soon as feasible.

It does not seem appropriate within the scope of this paper to enter into details of methodology. A few general remarks may suffice.

There is, of course, a relation between the responsibilities attached to a given function, the general level of education of the person carrying it out and the teaching material to be offered to him. On the other hand it may be stated that the same mental health principles will have to be taught at all functional levels, the difference lying in the way the material is treated and the scope it is given. So any public health worker will have to be taught the principles of human motivation and behaviour and how they develop in relation to family, school and society. For the first echelon field worker with the same cultural background as the people to be served this teaching may consist in giving him a systematized awareness of his own experiences. For the physician this training will deal with sociology, psychology and psychopathology, psychiatry and cultural anthropology.

In the second place the training has to be relative to the functions the trainee is expected to carry out, i.e., to the place of his echelon in the organization. Therefore, the content of the training is highly dependent on the organizational structure.

The thinner the coverage, the more the workers in the first line will have to be "all purpose"; the weaker the higher echelons are numerically, the more they must be relieved by the activities of the lower.

Apart from the over-all requirement to teach the basic principles of mental health thinking, in some settings it may suffice if the first line personnel are able to recognize disturbances and to effect adequate referral; in others they must be able to differentiate between situations which they will be able to handle themselves or not, and again under other conditions they must be able to carry out part or parts of the specialists' tasks.
This policy would require an analysis of the specialist's activities with the purpose of distinguishing between tasks which absolutely require the full range of his training and experience as directly applied to the patients' problems, and tasks which could be delegated to properly trained personnel without decreasing their value or effectiveness.

As one report remarks, a ward of 200 mental patients with one physician allows the doctor very little time for each patient. But it may be asked whether it is really necessary for the various therapeutic activities to be carried out by the physician himself. It would seem that quite a number of these: occupational, social and recreational therapy, can be carried out by personnel trained for these tasks as is already practised in many institutions. A number of diagnostic activities are carried out by non-medical personnel such as laboratory staff and psychologists. It might be asked whether the same procedure can be followed by psychotherapy, the physician remaining the supervisor and adviser. In many organizations the (psychiatric) social worker has a therapeutic task to fulfil. In these instances the required number of specialists would not depend on the number of patients he is able to handle, but on the number of co-workers he is able to supervise.

II.1.5.3 Place. In advanced countries mental health training will have to be carried out where medical, nursing and public health personnel are trained. This will be, therefore, in medical schools, schools for public health, nursing schools, training centres for social workers, teachers, etc.

In developing countries it would seem of great advantage to establish a teaching centre, which logically would be affiliated with the initial mental health care project. In this training centre the expert nucleus would provide the training for future specialists and for medical students, and would train the trainers for the lower echelons. The relation with the mental health care organization would ensure that clinical and social teaching material were available.
II.1.6  Research

There is no report which does not emphasize the importance of research in the mental health field, and each report mentions the difficulties arising in this regard.

II.1.6.1  Epidemiology.  In public health, epidemiological research is rightly regarded as basic for planning.  Epidemiological problems in the mental health field are, however, complicated; the more so because terminology and classifications are far from uniform.  Much has been said in this respect in the Eighth Report of the Expert Committee on Mental Health\textsuperscript{2} and one of the reporting countries adds an extensive study of the criteria to be fulfilled by epidemiological mental health studies.

For the purpose of planning, data on the movement of patients - admissions, discharges, from various institutions, visits paid to out-patient arrangements, etc., - remain basic, but should be related to the factors of the total social setting before being applied or compared with others.

II.1.6.2  Clinical research.  The reports leave no doubt that clinical research is regarded as essential.  It is pointed out that new methods may be evolved as the result of clinical research which may require new provisions or procedures in mental health care, or result in radical changes of the existing ones.  This again may influence design, extent, organization and requirement of the over-all service.

Many of the developments described in section III have been due to or supported by clinical research; to mention only two examples: the development of drug therapy and the control of general paralysis are typical clinical achievements.

II.1.6.3  Evaluation (operational research).  As has been remarked at the beginning of this section, the planning of a mental health service is seldom based on well-established evidence of quantified needs.  As a rule this evidence begins to be gathered after an initial period of activity.  Furthermore, even if the original plan has been based on previous research, the original design has to be continuously tested against the actual needs evolving in the course of time.

\textsuperscript{1} Wld Hlth Org. techn. Rep. Ser. 1961, 223
\textsuperscript{2} Wld Hlth Org. techn. Rep. Ser. 1960, 185
Very often when, for scientific or practical planning purposes, questions are asked about the functioning of a provision in society or within the organizational frame, it becomes apparent that these questions cannot be answered without lengthy and costly ad hoc investigations. The means of evaluating a service should, therefore, be foreseen and designed as part of the organization.

II.2 ADMINISTRATION

II.2.1 General

According to the general tenor of the reports, integration of mental health and other health service activities is advocated. Most reports recognize the need to achieve integration in the administrations concerned, while some reports state that this integration has already been carried out at some or all administrative levels of the country. On the other hand, some reservations are made.

In one report doubt is expressed as to whether mental health activities will have a better opportunity to develop when they are administered as part of public health activities. In this situation they may suffer from the "competition" of public health care, because these latter are older, more firmly established, more extensive. This danger would not occur with separate administration for mental health care. This is similar to the remark made by Mackintosh in his introductory paper on the function of the hospital,\(^1\) where he mentions the possible difficulties arising from an integration of curative and preventive care in which preventive care might suffer from the same kind of competition.

It would seem that the reality of this situation has to be recognized. On the other hand, it can be argued that this competition - if it may be so called and if it indeed exists - will be found in any administrative pattern.

General health care and mental health care cannot be regarded as competitors - for public funds or interest - when it is realized that their aims are identical and that it is to their material advantage to use as much as possible identical means to reach

\(^1\) Paper prepared for the Technical Discussions at the Tenth World Health Assembly (roneographed document A10/Technical Discussions/1).
these aims. Only when this is recognized will the possibility of adequate and balanced distribution of funds and interest be achieved. It would seem that the chances of creating this situation are better when administrative integration exists. "A mental health division separated from the public health activities - for instance by departmental boundaries - will be in great danger of becoming isolated from the main stream of medical development", as is remarked in one report. "Separated" is here the operative word.

II.2.2 National level

About half the reports mention adequate representation of mental health care in the top administrative level of the country. Either mental health is represented as a department of the health ministry, or some mental health experts are officials in the health department. In the latter case they are usually - but not always - hierarchically placed under the highest official for general health in this department.

One report states that the chief general aims of mental health care are: to provide service for the people, to train personnel, and to register trends and changes, both in needs and in methods. (It may be noted that these aims are exactly the same as those of public health care.)

At the national level, therefore, there should be one person or organization responsible for programmes, one for training, one for evaluation of programmes and results. On this basis it would be possible to determine national policy in this field. In a number of countries these tasks are divided between governmental and private organizations. In those cases this pattern is usually also found at lower levels. This division - arising from historical reasons and the structuring of public affairs in the various countries - does not preclude the need for top co-ordination and representation of mental health activities. Close co-operation between governmental and private organizations is necessary.

In many reports from less developed countries, it is remarked that expert representation at national level is recognized as desirable but cannot be achieved because of lack of expert personnel. Here again we meet the question of the strategic placing of specialists. Not everybody, not every physician and not every psychiatrist or mental hygienist has the aptitude or the inclination to work at high administrative
levels. On the other hand, it is a very important question whether, when only very few specialists are available, it is most efficient to use all their skill at the level of treatment and small-scale organization. It may be very tempting, and under the pressure of urgent needs almost unavoidable, to charge the few available specialists with the task of setting up a good mental hospital or reorganizing one or arranging clinical and out-patient facilities. Those facilities, in that case, will be established with a view to individual, immediately apparent needs, and not with a view to more extensive coverage (II.1.4.3). It may be that the experts concerned will be fully absorbed by their tasks and will take no initiative to increase coverage. It may also be that they are conscious of this need but do not get satisfactory response and co-operation from higher administrative levels because there is nobody to understand them. On the other hand, an expert in the national administration would be able to review the whole field in regard to coverage and the steps necessary to increase this. It would, therefore, seem at least a point of consideration whether, even when few experts are available, it would not be of long-term advantage to place one at the highest administrative level.

In a number of countries a National Institute for Mental Health is established. Other countries are contemplating its establishment according to the reports. Sometimes it forms part of a National Institute for Health, sometimes it is independent. Such an Institute, as a rule allied to the Institutes of higher learning of the country, may serve to carry out research in the mental health field, to co-ordinate research, and to advise the government in national mental health problems. It therefore has a unifying and co-ordinating function at the national level.

II.2.3 Intermediate and local levels

The reports make it clear that integration at lower administrative levels has generally advanced more than at the national level. However, serious difficulties have been encountered and are not always overcome because the administrative origins of the various measures may be widely divergent.

Usually the mental hospitals are originally under different administrative bodies - often at a different level - than public health activities and the general hospital. Each may develop facilities in the mental health field: the mental hospital an after-
care service, the general hospital an out-patient service, the public health service a domiciliary care programme or an emergency service. For administrative reasons these activities will initially be isolated from each other, although they may deal with the same problems and often with the same patients. Integration starts from the bottom, i.e., by the mutual contact of the workers, and may proceed upward.

As several reports show, this lower level integration may in its turn promote integration at higher levels. When it is proposed to carry out closer co-operation as a matter of policy, administrative integration becomes a preliminary necessity. When, indeed, channelling of mental health activities through public health services is contemplated, an administrative merging will have to come first.

II.2.4 Mental health advisers

There is no divergence of opinion about the need to make use of the counsel of mental health experts in public health activities. "In all problems of social medicine, general hygiene and other problems of the protection of public health, counsellors and experts in mental health must be taken into account" - to give one quotation from many similar ones.

It has been pointed out (I.2.4) that in many other fields of public service mental health elements are present and may require the advice of the expert. Here again shortage of experts may limit the possibilities of calling them in, although it may be remarked that it certainly is a task of the expert to make workers in other fields conscious of the mental health problems they have to meet. A strategic placing of the expert may increase his possibilities, both as an adviser and for giving enlightenment to others. Calling in an adviser may often be the first step to future co-ordination or integration.

To use a specialist mainly working at the executive level as an adviser on the administrative level might be a temporary solution of the problems offered by shortage of experts and urgency of manifest needs.
SOME SUGGESTIONS FOR POINTS OF DISCUSSION

1. **Coverage**

   Public health services are intended to provide full coverage for the population deemed in need of the service; would the same be true of mental health programmes? If so, what steps can be taken to increase mental health coverage: (a) within an existing organizational framework; (b) by merging with other health activities; (c) by echelon formation?

2. **Organization**

   If it is proposed to include mental health programmes in public health planning, in what order of priority should activities be merged? If a choice as to priority has to be made, will it be more effective to have the psychiatrist concentrate on direct treatment or act as consultant to other physicians? To merge in-patient or out-patient arrangements? To develop long-stay or short-stay facilities?

3. **Training and delegation of functions**

   What steps are to be taken in regard to personnel training when merging of public health care and mental health care is proposed? Is it possible to follow the echelon principle in training? How far and to what limits can diagnostic and therapeutic procedures be delegated to personnel without medical training?

4. **Initiating a mental health service**

   What should be the first step to be taken in a country virtually without mental health services? What should be the general plan of campaign? Could it be agreed that health care services should use as much as possible traditional and cultural patterns and resources? If so, in what way and to what extent could assistance from international and other agencies be utilized to start a mental health nucleus? (Surveys, advisory experts, training abroad.) What should be the function of this mental health nucleus, how should it be staffed, what should be its place in the over-all health organization?
5. Developing a mental health programme

What steps should be taken to develop the initial nucleus into a mental health service? (Training at various levels; priorities of training; expanding activities at various levels by increase of personnel and echelon formation; assimilation of mental health principles in general health activities; using general health activities to carry out mental health programmes; evaluation of activities; operational and other research.)