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MENTAL HEALTH PROGRAMMES IN PUBLIC HEALTH PLANNING

by

Sir Samuel Manuwa
President of the Association of Surgeons of West Africa.
First Federal Public Service Commissioner and
formerly Chief Medical Adviser to the Government
of the Federation of Nigeria.

Member of the World Health Organization
Expert Panel on Public Health Administration
and of the Advisory Committee on Medical Research

The reader will perhaps forgive me for beginning this introductory address on a personal note.

I last attended these Technical Discussions four years ago. Previous to that I had attended them as a representative of my country, the Federation of Nigeria, whose Chief Delegate at the World Health Assembly I had been by virtue of my official position as Nigeria's Federal Chief Medical Adviser. I am very happy to return again to the Assembly and to this beautiful city of Geneva, to renew old and valued acquaintances, and to make new friends.

May I say at once how much I am gratified and honoured to have been selected by the Executive Board to be General Chairman on this particular occasion. In selecting me, the Executive Board has done honour not only to me, but also to the whole of the African continent, particularly Tropical Africa because this, I believe, is the first time that a true "son of the soil" of Africa has held the General Chairmanship of these important discussions.

I am particularly honoured to join the lengthening line of the many distinguished personalities from various countries who have been chairmen since this important item in the activities of the World Health Organization was first started in 1951. For, what more distinguished and erudite names can we recall in the whole field of international health than those of Professor Parisot of France, the doyen of French Public Health and Social Medicine, and a former President of the Assembly; of Professor Ferreira of Brazil; Dr Juan Salcedo of the Philipines; of another former President, the late Professor Stampar of Yugoslavia, and the late Dr Martinez-Baez of Mexico; Dame Elizabeth Cockayne of the United Kingdom and Dr Metcalfe of Australia; of our revered immediate past President of the World Health Assembly, Sir Arcot Mudaliar of India, one of the earliest members of the Organization, still going strong, and of Professor Zhdanov of the USSR, and of Dr Sauter of Switzerland, who were respectively General Chairmen in 1960 and 1961.

History and Objects of Technical Discussions

Dr Sauter in his very eloquent address when opening these Technical Discussions in India last year sketched their history and purpose, and it might perhaps be useful and interesting briefly to recapitulate them, particularly for the benefit of those who did not hear or have not read Dr Sauter's address, or those who are here for the first time.

Following a decision at the sixth session of the Executive Board which was held after the Third World Health Assembly in 1950, two years after the foundation of the World Health Organization in 1948, that provision should be made during future assemblies to enable delegates to discuss technical subjects of public health interest, the first of our series of Technical Discussions was held during the Fourth World Health Assembly in 1951. Since then, these discussions have been a regular accompaniment of each Health Assembly except the Eleventh, in 1958 when, as you will remember, we celebrated the Tenth Anniversary Commemorative Session of the Organization at Minneapolis.

Though they are held at informal meetings which are not part of the official formal business proceedings of the Assembly itself, and though delegates take part in them in their individual professional and not their official governmental capacity, nevertheless, as pointed out by Sir Arcot in his presidential address last year, these Technical Discussions have been greatly beneficial and their reports have, in Sir Arcot's words, "contributed not a little to spread the message of the World Health Organization far and wide and should receive great attention in all countries".[1] It is perhaps therefore a matter for re-consideration by the Organization whether at least a summary of the main conclusions of the Discussions should not be printed as a special supplement to the Official Records of the World Health Organization in order to ensure a wider and more permanent circulation, though I am aware that subsequent summaries do appear in the WHO Chronicle.

The importance which the Organization attaches to these Technical Discussions is indicated by the wide variety of their previous subjects. These have ranged from the problems of the education and training of medical and public health personnel, which formed the topic for discussion at the very first Technical

Discussions in 1951, to the subjects of the economic value of preventive medicine; the methodology of health protection for local areas; modern health techniques applied to the control of tuberculosis, syphilis, and the typhoid group of fevers; public health problems in rural areas; the education of nurses and their role in health programmes; health education of the public; the role of immunization in communicable disease control; and, last year, the subject of recent advances in tuberculosis control.

The World Health Organization and Mental Health

The World Health Organization has always included the promotion of mental health in its policy and programme. When the Organization was first established in 1948, mental health was even one of the five subjects to which it assigned the topmost priority, and it chose a world-renowned psychiatrist, Dr Brock Chisholm of Canada, as its first Director-General. Whether this event was accidental or occurred by design, the fact is nonetheless very significant and relevant because much of our Organization's achievement as the most outstandingly successful specialized agency of the United Nations is undoubtedly due to the skill, knowledge and devotion with which its first mentor, guide, philospher and friend nursed its destinies during its infancy and early childhood. And the psychiatrists assure us that "childhood is the golden age of mental hygiene".

Since its inception, the Organization has striven to foster the promotion of mental health among the nations, particularly in its preventive aspects and regarding the introduction of the mental health spirit into public health practice. Among its many activities designed to influence and shape international planning policy in this direction may be briefly mentioned the following:

The establishment of Expert Committees and the implementation of their recommendations.

The publication of special monographs[2,3,4] some of which contain fundamental research which has greatly re-orientated modern psychiatric thinking and practice.

The convening of special regional and international conferences and seminars, and the Organization's association with other bodies in convening similar meetings.

The provision of consultants to advise on the organization of national mental health services.

Provision of Fellowships for overseas studies.

Stimulation, support, and co-ordination of special lines of research.

And lastly, active co-operation and collaboration in all appropriate activities with other international agencies particularly UNESCO, the ILO and the World Federation of Mental Health, the latter being among the first non-governmental organization admitted to official relationship with the World Health Organization on its inauguration.

The Task of the General Chairman

I should like to apologize for what is a General Chairman's introductory address of somewhat unusual length. My reason for this must be the importance and size of the subject of mental health at the present time, and its fascination for a comparative amateur like me. If I appear, as I go along, to repeat in different places certain cardinal principles, it is because of their particular relevance and significance.

I must confess at this stage that I accepted the Executive Board's invitation to preside at this meeting with considerable diffidence. This is for two main reasons. In the first place, I am not a psychiatrist but merely a retired surgeon who had dabbled for a few years in public health administration. In the second place, I considered that my qualifications as a representative of a very young and newly independent developing country which attained its majority as a full member of this august body only two short years ago really hardly justified my presuming to take anything but a very minor role in the discussion of such an important problem, of which distinguished delegates from more advanced parts of the world have had greater and longer experience.

However, as regards the first reason, I took some confidence in the fact that it might be agreed that a public health administrator, with his experience of the general administration of all the specialized elements of the machine which takes care of the public health, might possibly have a wider "bird's eye" view than a specialist would. As regards the second reason, I can only take comfort in presuming that the old saying was endorsed, that sometimes out of the mouths of babes comes forth wisdom!

Possibly this may be right, and for the following reasons. It is undoubtedly true enough that there are very many lessons yet to be learnt by young developing countries from more advanced countries. It is also true that advanced countries at some time during the span of their own cultural development have themselves passed through the evolutionary stages which developing countries are so rapidly passing through today. Advanced countries can therefore, with their more mature experience and advice, save their more backward brothers from making the same mistakes which they had made, and falling foul of those quicksands, sandbanks and breakers which they had themselves successfully navigated during their own voyage of development; and they are in a position to ensure, in the light of their experience, that the same problems are prevented in the developing countries in the best manner possible from assuming the same proportions which those problems have assumed in their own countries.

Moreover, developing countries may, and in fact do, have some useful contribution to make in the general march to progress. They are, so to speak, countries in ebullition. They are countries in ferment and, for good or ill, they are countries in a mighty hurry. They constitute an excellent giant laboratory for fundamental research in which natural phenomena, especially biological processes, such as those concerned with the problem of mental health, could be best studied and analysed while <u>in statu nascendi</u>; and I believe it will be correct to say that it is for this very reason that much of our knowledge of the etiology, pathogenesis and even management of mental illness in developed areas has in certain respects been obtained by studies carried out in relatively under-developed surroundings. As an example of some of the contributions which developing countries

can make and have made to general medicine and psychiatry may perhaps be cited the introduction by India to western pharmacotherapy of the old herbal remedy of the root of the rauwolfia serpentina and its alkaloid reserpine in the treatment of hypertension and of certain forms of mental disorder. And, in the field of mental health, the participants of the First Pan-African Psychiatric Conference[5] held in Aro in Western Nigeria at the end of last year would have observed how comparatively small resources could be employed to develop a well-integrated rural community psychiatric service into a centre for treatment, prevention, training and epidemiological research which might well produce results which could be of great benefit to other countries.

The Nature and Magnitude of the Problem of Mental Health in the World Today

In the state of the world at the present time, when tension, unrest and recurring crises make it appear as if the international mental health is not what it ought to be, the World Health Organization has acted wisely in choosing the subject of mental health for our discussions during this year's Assembly. Referring to this question during his Inaugural Address at last year's Assembly, Prime Minister Nehru of India emphasized that ". . . The world of today, which can deal with the problem of physical health satisfactorily enough . . . has still to find ways of dealing with the mental health of nations, groups and communities"; and he went on to appeal to the World Health Organization to use its resources to help those forces which are now actively labouring to enable the world to achieve a better state of mental health. Sir Arcot in his presidential address also referred to the same problem.

What, then, is the actual magnitude of this problem?

The answer to that question is not quite so easy to provide. Exact assessment of the amount of mental illness is difficult, partly owing to the lack of accurate statistical information in many countries, and partly because many minor cases of mental ill-health are not recognized. It can be said however that in countries which are still very under-developed, and where the people still live the traditional life which their forebears lived, the problem is small. The incidence of psychiatric disturbances in tribal Africans has been said to be about a tenth of

that usually found in Western Europe and North America.[6] With the development of a country, however, especially if this has been too rapidly and inharmoniously planned, and especially with urbanization, industrialization and the unregulated introduction of an alien culture when hitherto unsophisticated people become the victims of what has been described as "cross-cultural shock", the problem seems to increase rapidly. This problem is illustrated by the statement, which you will perhaps remember, made by the distinguished delegate for Thailand at last year's Assembly when he called attention to the fact that, in his country, the diagnosed cases of frank psychoses and psychoneuroses had increased from one to an estimated two per thousand of the population during the past ten years. In Nigeria, we are ourselves worried by the increasing number of cases of mental breakdown noted among our overseas students, and of cases of endogenous depression and suicide.

In certain advanced countries, some fifty per cent. of the hospital beds are occupied by the mentally ill, and national surveys suggest that as many as or even more than ten per thousand of the population are suffering from severe mental disorder. The late Professor Sir David K. Henderson who was my own teacher in Edinburgh and a well-known psychiatrist, in 1955 wrote that "Psychiatry constitutes the other half of medicine", and that out of every one hundred children born, eight will have a nervous breakdown and three will spend part of their lives in a mental hospital. I doubt whether the situation is much more reassuring today.

Manifestly, therefore, mental health is a public health responsibility of increasing magnitude and significance, and the question which we have to answer is, in what way can we best shoulder this responsibility, i.e., bring about the incorporation into public health practice of the principles which govern mental health promotion?

Definition of Public Health and Mental Health

Before attempting to answer that question, we must define to ourselves what we actually mean by public health in this context, and what our conception of mental health itself is.

There have been many definitions of what public health connotes but, for our purpose, we shall be justified in using it in its widest sense and regarding it and public health care as the sum total of all those human activities designed to promote and protect the health of the community.

Mental health is an integral ingredient of our Organization's interpretation of total health as "a state of complete physical, mental and social well-being"; and we may describe our concept of it as one which embraces the harmonious adjustment of the human being to his fellows and to the rapidly evolving world around him, together with a consideration of the theories and techniques concerned with the development of his total personality with maximum effectiveness and happiness.

What, then, are the factors which we have to take into account in considering its promotion, achievement and maintenance, and the prevention of its disorder?

Factors affecting Mental Health

Apart from heredity, the factors which affect mental health derive basically and very largely from environmental conditions. These conditions are diverse; they touch the manifold phases of human endeavour and activity in practically all their entirety and ramifications; and they are largely inter-related. It follows, therefore, that no measures for the promotion and achievement of good mental health seem likely to be profitable or successful which do not take these facts into account; and accordingly, no progress is likely to be made except through a multi-dimensional approach in which all those branches of science and all the human agencies and forces whose task it is in all fields to prevent or alleviate suffering and enable man to enjoy a better, fuller and more abundant life, are deployed simultaneously and in concert, in a "combined operation", and on the broadest possible front, against these multi-factorial causes. Hence it is that the World Health Organization has invited distinguished representatives of so many disciplines to discuss this very complex problem.

At this juncture I should like to consider, very briefly, the history of mental ill health and of community attitudes to it; the current trends; what ideals should be aimed at in organizing a good psychiatric service; and, finally, the crux of our particular discussion here, namely, in what way could these ideals be achieved in the planning and within the framework of a national health programme?

Evolutionary Phases in Community Attitudes to Mental Health

Mental infirmity has been a social problem from the beginning of man. Biblical history records (and I hope readers who are not of the Christian faith will forgive these and subsequent biblical allusions which I shall make because they are the ones with which I am more familiar), two of perhaps the earliest famous cases, those of King Saul of Israel,[8] and King Nebuchadnezzar of Babylon.[9] Community attitudes to mental disorder had throughout the ages been much less enlightened than those towards physical disability because its causes and pathology were not until recently understood, and because the mental patient had always seemed to inspire fear rather than pity.

Broadly speaking, public attitude towards the mentally unwell passed successively through three phases during the evolution of the human race. The first one was what may be termed the "demonic or magical age"; the second, the "intramural or custodial age"; and the third, the "modern or communal age".

The demonic or magical age, which still persists among some primitive tribes, was the period from earliest antiquity, when mental ill health was supposed by some to be of divine origin or, more commonly, to be the result of possession by devils. The devils were to be cast out by magical or spiritual means, in doing which the cruellest forms of punishment or torture were employed, and the unfortunate victim was cast away from the community or even put to death. By the 12th century onwards, however, he began to be given lodgement in shrines and asylums.

The movement for the "moral treatment of the insane", as it was termed, and which was introduced by the great reformers Pinel, Charcot and Morel of France, Howard, Tuke and Shaftesbury in the United Kingdom, Chiarugi in Italy, and Dorothea Dix in the United States of America, began the second phase, the intramural or custodial age, in the 18th century, when more humane methods and less mechanical restraint began to be employed. One might almost call it the movement for the "moral rearmament of the insane". During that period, however, and even up to early this century, custodial care was practically all that psychiatry had to offer, though the work of Kraepelin, Freud, Jung, Meyer, Clouston and Maudsley, among others, led to a more scientific understanding of the pathogenesis, nosology, and

management of mental disorder. The victim was however still regarded as an alien to society, to be alienated and isolated in asylums so as to protect him from society and from himself, and placed in charge of an alienist, who was sometimes facetiously referred to as "the mad doctor" - the madder the better! Unfortunately, some undeveloped countries have not yet gone much further than this purely custodial phase.

Advances during the past twenty years or so, particularly in psychiatry, but also in the basic social and biological sciences (the comparative lack of knowledge in which had so long delayed progress), have produced the third and most modern phase - the age of community care of the mentally disturbed for which we are indebted to the brilliant work of authorities like André Repond of Switzerland, T. P. Rees of the United Kingdom and Paul Sivadon of France, among many others.

As regards advances in the field of African psychiatry, I would like to allude to the work of Carothers, a World Health Organization Consultant in Mental Health, whose classical monograph "The African Mind in Health and Disease"[3] has shed much light on psychiatry in a developing culture. He has helped a good deal to develop and advise on the organization of psychiatric services in Africa, and his researches and brilliant report[10] on the psychology of the Kikuyu and "Mau Mau" in Kenya is an excellent example of the assistance which a trained psychiatrist with experience of local customs and traditions could render in the field of political administration.

In this connexion I might be permitted to disobey the dictates of modesty and also mention the brilliant work, to which I had earlier referred, and which my own countryman Thomas Lambo is doing in Nigeria, particularly in developing and exploiting the system of "villagization" - a scheme of community and family care among a rural community.[11]

Contemporary Trends

As one authority has pointed out, the reminder of St Paul that "we are members one of another" seems most apt in describing the present position with regard to the care of the mentally ill. The recent trends are that we are now attaching more importance to the social aspects of psychiatry through family and community

care, and that the mentally ill or subnormal must be treated and rehabilitated, not in isolation but within and in association with the community, and particularly on a large-scale out-patient basis.

The extramural care of mental patients is, of course, not quite a new concept. It was first introduced in Gheel in Belgium as far back as the seventh century. The Amsterdam scheme in Holland[12] and those in Norway[13] are well known modern versions; and the Worthing and District Mental Health Service[14] which was established in the United Kingdom in 1957 along these modern community care lines has, by making the fullest possible use of community aid and of out-patient treatment, already shown that it is the best approach to the problem of reducing mental ill health and limiting admissions to mental hospitals.

Moreover, I think we could assert with confidence that the increasing success of psychiatry in recent times has been as much due to the spread of this new concept of regarding the mental hospital as a therapeutic community with its emphasis on socialization, rehabilitation and reintegration of the patient into and within his society, as it has also been due to the other factors of improved pharmacotherapy, newer therapeutic techniques such as group therapy, earlier treatment and shorter hospital stay.

Now, we ought to know what a good psychiatric service should be, before we could usefully discuss how to provide for it in overall national health planning.

The Good Psychiatric Service

Some criteria which a good modern psychiatric service should aim at will I think be apparent from the contemporary trends which I have just indicated. To have in a national health programme the best possible psychiatric service which local circumstances and resources will allow is essential. I know that these latter items are in many countries very important limiting factors. But, to have no service at all is perhaps less harmful to the mental health of the community than to have a bad one, because a bad psychiatric service is not only useless, but it is the worst possible advertisement for which is one of the cardinal duties of a good national general health programme, namely, that of prevention. For mental disorder, like much physical illness, is a largely preventable disease; and

preventive psychiatry should aim, like preventive medicine, at protecting and promoting that "absence of disease or infirmity" which is the irreducible minimum of a condition which can in any way be described as healthy. Treatment is expensive and can never be provided for everybody needing it. Like the many health problems of the world, mental health problems can never be adequately dealt with by therapeutic methods alone. The First World Health Organization Expert Committee on Mental Health which sat in 1949[15] strongly stessed that it is only by the preventive application of psychiatric knowledge that mental health problems can be solved. And we may define this preventive approach to embrace: primary prevention, by education in mental hygiene, and by detection and prompt treatment of early cases to prevent the necessity for admission to hospital; secondary prevention, by active and skilled treatment of established cases in order to ensure early cure and discharge, and so prevent chronicity; and tertiary prevention, by enlightened rehabilitation to prevent relapse.

To fulfil its functions the good psychiatric service should, under a capable psychiatrist as leader, first and foremost itself not only be an integrated service but should be well integrated with, and be readily accessible to the community which it serves. It should be flexible enough to follow the changes in the cultural evolution of that community. Its nerve centre should be a relatively small unit for active treatment, particularly of the acute and curable short-stay cases; for special investigations and research; and for training of staff. It should be run on open door principles. Intensive development of its extramural services, embracing provision of adequate out-patient facilities, such as out-patient clinics, day or night hospitals, mobile units and rural mental health centres, working village settlements, mental health propaganda by its trained staff who must have excellent personal relations with the local community and especially with their leaders - all these are essential qualities which a good psychiatric service must have if it is properly to perform its special functions as a centre for preventive activities, particularly, I repeat, the prevention of the necessity for in-patient admission to hospital. Geoffrey Tooth[16] has called attention to the effectiveness of the use of mobile units and rural health centres in the treatment of communicable diseases, particularly yaws and trypanosomiasis,

and has strongly advocated their similar use in the psychiatric services. It is a suggestion which one hopes all developing countries and countries with sparsely populated areas might take up.[a]

In a good service, custodial care still has to be provided for the potentially dangerous cases, which are said to constitute not more than five to ten per cent. of cases in need of psychiatric treatment (Tooth);[16] and the care of the aged and rehabilitation of the chronic and the handicapped should function in active collaboration with the local government authority.

Finally a good mental health service must have firm links with the other branches of public health.[17]

The question then arises: What are these links, and in what way can they be forged in order to produce a good mental health programme within the ambit of general public health planning? It would seem useful to define the cardinal principles which must govern the steps of that major operation as those of integration, assimilation, co-ordination and harmonization.

Incorporation of Mental Health into Public Health Planning

The First WHO Expert Committee on Mental Health in 1949 stressed the preventive application of psychiatric knowledge as the most important feature in a world-wide mental health programme. The Committee also emphasized with equal force that this should be done by the World Health Organization through "the encouragement of the incorporation into public health work of the responsibility for promoting the mental as well as the physical health of the community". It further recommended that preventive mental health sections should form part of the national ministry of health in all countries, which should also establish national institutes of mental hygiene.

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[a] An account of the use of Mobile Field Units in relation to general health planning in Tropical Africa is given in "The Principles and Methodology of Planning the Development of National Health Programmes in Under-developed Countries". W. Afr. med. J. 1961, Vol. X, No.2, p. 75

The National Ministry of Health

There are certain basic features which must characterize the headquarters organization of a national health ministry. The first essential principle is that the professional head of the ministry, who is variously termed the chief medical officer, or adviser, or director of medical services, and so forth, must have what may be termed as a preventive psychological outlook. In this, his political chief the Minister of Health, especially if he is himself a medical man, will no doubt lend him powerful support. It has sometimes even been humorously suggested that if they both had a slight psychiatric "kink", it would do them no harm! By the preventive psychological approach I mean that they must realize that any changes that may be planned in any sphere have their psychological repercussions among the people. The mental health implications of planning the solution of all health problems must be considered very fully at the time the planning is being done. Planning for mental health care must therefore go hand in hand with the other planning problems. Any change anywhere is inherently disturbing. However well intentioned or beneficent, changes made too rapidly, too drastically and too universally, particularly if introduced from an alien culture, and if made too far ahead of the will and capacity of the people and without the support and collaboration of their leaders, will create mental tensions and might be actively resented and even deliberately sabotaged. The Minister and his chief professional adviser must indeed ensure that a preventive psychological outlook pervades the entire hierarchy of their staff.

Next, they should if possible have on the ministry level a trained psychiatrist of wide clinical and administrative experience, and an understanding of social psychiatry who is familiar with the local culture and who is prepared to uphold, and where necessary and possible, make use of the best in the local traditions. A good administrator should always have specialist advice, if available, at his elbow. Incidentally I may confess that in preparing this address, I have relied quite heavily on the assistance of some of my psychiatrist friends, to all of whom I am very grateful. I can only hope that they consider that they have succeeded in keeping me firmly and squarely along the straight and narrow path of psychiatric rectitude, and that my affirmation of faith so far has contained no serious doctrinal or ideological deviation!

Again, the Minister and his chief advisers must realize that in their health services they are operating an apparatus of great complexity which can function with maximum efficiency only if its component parts, themselves individually complex, are fully integrated and co-ordinated. No part must be compartmentalized or encapsulated. In other words, they must keep the whole wood in full view as well as the trees. In the wise words of our Regional Director Dr Cambournac, when opening the WHO/CTTA Seminar on Mental Health in Africa South of the Sahara[18] in Brazzaville in 1958: "when planning specialized services we must never lose sight of the complete edifice we aim at constructing for the well-being of the people".

Integration

The perfect general national public health service has not yet been achieved anywhere: otherwise there would hardly be any need for the existence of our Organization! But I believe that it is the increasing awareness of the inter-dependence and interrelation of all disciplines connected with human behaviour which has led in recent years to the greater efforts that are being made in many countries to integrate the mental health and the general health of the community, and to introduce mental health principles into public health practice.

There are two major areas of public health planning in which this integration could be done. The first is the area of prevention, care, and rehabilitation; and the second, that of training and research. Some of these we have already discussed. Others we may briefly mention.

Integration in Prevention, Care and Rehabilitation

On the preventive side: Enjoying the fuller confidence of the people and having, as they do, the closest access to their homes particularly during times of illness and the emotional crises which accompany them, there is no class of workers who are better placed to spread the gospel of health education and of mental hygiene than the general medical practitioner in his capacity as the family doctor; the midwives and general nurses; the public health nurses and the health visitors; the social welfare officers; and similar field workers. In spreading the gospel of mental hygiene, their duty would be to educate the public to take a more realistic

and more humanistic attitude towards a subject which is vitally concerned with human betterment. Their services are of particular value during childhood and youth, in preventing or mitigating the incidence and effects of deviant behaviour in juveniles, because much of this could be reduced if the psychobiological development of the child was better understood and taught. The maternal and child health services are a particularly fruitful field where the mental health of both the mother and child could be fostered. The utilization of the services of a child psychiatrist in the paediatric service can be of great preventive value, as would mental health collaboration with education and other miscellaneous social service agencies.

The contemporary trend of community care of the mentally ill to which I have referred earlier is an encouraging example of integration on the curative side, because all forms of community care require well-integrated team work between public health personnel, general practitioners, mental health workers, and the public. Another step in the same direction is the increasing recognition of the value of the provision of psychiatric wards and out-patient clinics in general hospitals. It has been suggested that about ten per cent. of the beds in general hospitals should be reserved for psychiatric cases. In the United Kingdom, where a new ten-year reconstruction programme[19] of the hospital services is being planned along these lines, it is expected because of this and of the success of new methods of treatment, combined with changed social attitudes to mental illness, that the recent decline in the number of hospital beds required for mental cases will continue, decreasing from the present 3.3 beds per thousand population to 1.8 by about 1975. The prospects are unfortunately not so clear, however, as regards cases of severe mental sub-normality in children.

The curative area, I think, is that in which integration should not only be done but, like justice, be manifestly seen to be done. The mental hospital should be brought within the ambience of the general hospital, for the mutual benefit of both; and indeed a principal feature of the new United Kingdom plan to which I have just referred envisages encouraging more vigorously the modern trend towards greater interdependence of the various branches of medicine by bringing together within the same hospital curtilage those forms of treatment and care which have

hitherto often been provided in separate hospitals. This would doubtless be more economical, as certain common services and facilities such as staff training could be shared.

The American National Council for Rehabilitation has defined rehabilitation as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable". It therefore follows that in this field all available resources must be used. The human resources include the nurse who, in carrying out the treatment of the ill patient, must be taught not to overlook its rehabilitatory aspects. They also include the occupational therapist, the psychologist, the psychiatric social worker, the health visitor, and again the public health nurse, the general practitioner, and others. Socio-psychological factors could affect the recovery of patients from injuries, and a mental health programme in public health planning should provide for the physically handicapped as well as for the mentally disabled. The rehabilitation programme should be flexible and continuous; and, as on the preventive side, it is a field in which the fullest collaboration between the hospital services and the local authority services could yield the most rewarding results, as I had also pointed out when discussing integration with the maternal and child welfare services.

Integration in Training and Research

Now, a few words about integration in training and research. Although priorities must differ in different countries and among different cultures owing especially to variation in needs and in the availability of resources, I believe that, next after prevention, training should receive the highest priority in considering the various aspects of integration. I think it can be established as a first principle that trained staff should be available before the services which they are intended to operate can be considered as being functionally ready.

Reciprocity is the basic principle which should underlie the training of the entire national health team, from the psychiatrist and general medical practitioner down to the humblest allied workers. All public health workers, particularly the doctors, nurses and midwives, public health nurses and field workers, should receive some training in the broad principles of mental hygiene. Vice versa, instruction

in public health principles should form part of the training of the psychiatric staff. The new trend of incorporating a psychiatric wing in general hospitals should facilitate this by means of joint seminars, clinical meetings, reciprocal posting of staff, and other combined training programmes. Particular attention should be paid to the joint training of the nurses (general, psychiatric and public health), who are in fact the buttress of the whole health service.

The psychiatrist himself should have had some experience in public health work or in general practice, and might with great advantage add a diploma in public health to his own specialist qualification in psychiatry. Also, the language barrier alone makes it desirable that, wherever possible, the psychiatrist should himself be a native of the culture of the people among whom he works and should also where possible, have received his preliminary psychiatric training within that culture. If a foreigner, he should of course make himself quickly familiar with the local language, traditions, and customs.

For the training of the medical student as a future general practitioner and family doctor, the teaching of psychiatry should be well integrated into the curriculum of medical schools which should, wherever possible, have a university chair in psychiatry, the professorial incumbent of which might profitably be closely associated with the national institute of mental hygiene. The professional examinations of the medical student should include one in public health and in psychiatry, as is for example the practice in the Scottish medical schools. It is essential that it should be impressed on the medical student at all stages of his clinicial training that his ultimate success as a general practitioner depends very largely on his ability to understand and sense out the psychological background of his patients' illnesses.

The principles which should underlie the teaching of psychiatry particularly to medical students have been very well put by Tsung-yi Lin and Matte-Blanco in a very recent WHO monograph by various authors entitled "Teaching of Psychiatry and Mental Health".[20] Lin considers that it should be taught, not only as a specialty of medicine for the mentally ill but as an introduction to psychosomatic medicine and the psychology of the physically ill and part of the basic philosophy of medical

education, presenting the concept of the "whole man" and of sound doctor-patient relationships. It should, he continues, be a decisive factor in community health programmes through its presentation of the individual as a member of a family, society and culture. Matte-Blanco, another contributor, agrees, and emphasises that the aim of the teaching of psychiatry should be for the student to reach an adequate understanding of man as a person, of his needs, conflicts and complex relations with his environment; to acquire the attitudes necessary to deal with these needs and conflicts in patients and their families, especially with regard to the anxieties and problems aroused by illness; to acquire the ability to recognize the psychiatric aspects of any illness, especially those termed psychosomatic, and to identify the main psychiatric disturbances; to be able to carry out simple psychotherapy; to refer appropriate cases early to the psychiatrist; and to realize the possibilities and importance of promoting mental health.

One of the essential points in the planning of a national health programme is the stimulation, fostering and co-ordination of research generally into the nature and effects of disease. Just as the realization of sin must precede repentance, forgiveness and rehabilitation, so must the knowledge of the etiology, epidemiology and ecology of disease precede its prevention and cure. Without research, there cannot be much real progress in scientific knowledge.

The question however arises: who precisely should carry out research in mental health in an integrated national health programme? I suggest the answer is: everybody! Everyone in the medical and allied fields should be involved in research as members of a well-balanced and integrated team, with differential emphasis on job assignment in the light of particular needs and circumstances. As our Director-General, Dr Candau, said with particular reference to epidemiological research in his address[21] at the International Congress on Mental Health in Paris last year on the subject of mental health as a public health responsibility: "Psychiatrists and a variety of public health officers must work together. Without effective team-work the facts cannot be ascertained. The public health officer needs the advice and technical guidance of the psychiatrist, and the psychiatrist on his side depends upon organized public health services to collect much of the information he requires for a complete statement of psychiatric problems".

The various needs for further research in mental health and the lines along which the World Health Organization should foster them are indicated in the 1961 report[22] of the WHO Expert Committee on Mental Health. They require no recapitulation here.

Coming as I do from a developing country, there are one or two aspects of research to which I would like to call attention. The first is the need for more intensive epidemiological and ecological research, particularly on the effects of rapid changes on mental health and the means of preventing and mitigating such effects, with special reference to health and social studies of rural communities undergoing the "cross-culture" problems of rapid urbanization and industrialization, as many developing countries are now doing. Much research still remains to be done in developing countries into the effects of mental health of nutritional deficiencies, a common condition there; and research into different community attitudes to mental health and into variations in "normal" behaviour patterns - for example what may be "normal" in Kano may not be quite so "normal" in Karachi or Kansas City! Further investigations are also needed into better techniques of the organization and administration of an integrated psychiatric service in a developing culture.

I would add my support to the plea of the Ghana delegate to least year's Assembly[1] for more research into the pharmacological properties and efficacy of native herbal remedies. To this I would also add the need for research into how the therapeutic techniques of native healers, whose methods are sometimes so outstandingly successful, can be improved upon by trained psychiatrists.

More research is also needed into the increasing incidence of mental breakdown among students pursuing studies in foreign lands. The cause is certainly not always due to "much learning making them mad", as Porcius Festus said of St Paul.[23]

I would also mention the Expert Committee's recommendation for the need for more international co-operation in the field of mental research. Despite the difficulty of setting up standards which would permit results to be compared between countries with different cultural backgrounds, nevertheless internationally co-ordinated research in mental health would provide much useful knowledge of benefit to all.

Finally, I should like to draw attention to the document A15/Technical Discussions/1, which is a background document for reference and use at these discussions. This paper has been most competently drawn up by Dr Ari Querido, Professor of Social Medicine at the University of Amsterdam, Netherlands, an internationally known and admired figure in psychiatry and public health, with practical achievements in the integration of the two disciplines.

This background document is largely based on reports of discussions in Member States in response to an outline document prepared in WHO and circulated in July 1961. Professor Querido has considered in greater detail many of the points on which I have merely touched. A final section, on pages 50 and 51, is devoted to suggestions for points of discussion.

Conclusion

It will be recalled that I began, as I again now wish to end, by referring to the present state of international mental health. I would of course not go so far as to agree with the cynic who said that the present world would seem to be like one gigantic lunatic asylum some of whose inmates might well be allowed to depart in peace, without benefit of clergy or of psychiatry! But, as a United Nations delegate recently lamented, the world today lives in a pall of fear. There are constant threats to peace; constant threats to, or actual deprivation of human dignity and freedom; frequent revolutions and counter-revolutions, coups and counter-coups; plots and counter-plots; pacts and counter-pacts for the formation of blocs and counter-blocs; espionage and counter-espionage. And the old pastime of sabre-rattling has now been replaced in this terrifying technological age by the serious business of nuclear blasts and counter-blasts, with their implied threat of the possible annihilation of the human race itself in the event of a nuclear war. Disarmament talks have followed disarmament talks in an unending and so far abortive succession, though at long last a ray of hope may perhaps soon be discernible on the horizon. In short, we are all today in the grip of a mass neurosis on an almost unprecedented global scale, engendered by universal and mutual fear and distrust.

It will be remembered that I referred to the "demonic age" of psychiatry, when mental ill health was supposed to be caused by possession with devils; and the reader will recall the biblical story of the accusation by the Pharisees that the

Lord Jesus Christ cast out devils from possessed victims by the power of Beelzebub, the prince of the devils. This reminds me of the incident recently, when a certain politician arrived at a certain capital city to take part in constitutional talks. He was "welcomed" to the entrance to the Conference Hall by some of his political opponents by missiles of eggs and garbage, whose vintage was as somewhat doubtful as the orbit of their launching was devastatingly accurate. He exclaimed somewhat ruefully "there are too many beelzebubs in this place". Now, is that not perhaps equally true of the world itself today?

The Apostle Mark tells us also the story of how the Lord cured an insane person at Gadara by expelling the devils into the neighbouring swine, which fled down the slopes and perished in the sea[25] and how, thereupon, the Gadarenes, infuriated at the loss of their swine, asked the Lord forthwith to leave their town. Now, the world today is mentally sick. Would it not be stupendous if a Master like the Lord were again to arise, to perform a similar miracle and cast out the many legions of beelzebubs which appear to stalk at will around the world today? I am sure our present generation will be far more appreciative than the ungrateful Gadarenes were, because there are I believe many of us in the world today who would welcome such a miraculous deliverance with pleasure and great relief, if the mere price to pay is our good riddance of all the available pork!

Coming as we all do from countries of varying degrees of technical advancement; from countries which may be predominantly rural or predominantly urban; from countries at all levels of social literacy and of a variety of religious faiths; from countries where physical ill health in the form of infectious illnesses or malnutrition still plays a major role, and countries where they do not; from countries where mental health programmes are already highly developed and others where they are still rudimentary or non-existent; in short, coming as we do from countries with such a wide variety of cultural development, problems, needs, and resources, our discussions should prove to be an exercise in comparative psychiatry of exceptionally absorbing interest. In our combined examination of the problems of mental health, let us therefore hope that we shall be able to discover useful common denominators which will serve as finger posts to psychiatry and to all its

practitioners. The road to the attainment of our goal is still long. But let us go forth to discover sign posts which will shorten and ease the journey towards that goal. Our special task is to go forward to search for those guide posts which will better enhance the contribution that our national health programmes could make to the promotion of mental health, in order to enable each and every one of us in our various countries throughout the world to achieve the enjoyment of the highest attainable degree of health which, in the words of our Constitution, "is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

REFERENCES

1. Off. Rec. Wld Hlth Org. 111, 42 (Part II. Fourteenth World Health Assembly, New Delhi, 7-24 February 1961)

2. Bowlby, J. (1952) Maternal care and mental health, World Health Organization: Monograph Series, No. 2

3. Carothers, J. C. (1953) The African mind in health and disease, World Health Organization: Monograph Series, No. 17

4. Bovet, L. (1951) Psychiatric aspects of juvenile delinquency, World Health Organization: Monograph Series, No. 1

5. Brit. med. J. 16 December 1961, p. 1637 (The First Pan-African Psychiatric Conference)

6. Wld Hlth Org. techn. Rep. Ser. 73 (Third Report of WHO Expert Committee on Mental Health)

7. Henderson, Sir David (1955) Why psychiatry, Brit. med. J.

8. King Saul of Israel, The Holy Bible, I Samuel, ch. 16, v. 14

9. King Nebuchadnezzar of Babylon, The Holy Bible, The Book of Daniel, ch. 4, v. 33

10. Carothers, J. C. (1955) The psychology of Mau Mau, Government White Paper. Government Printer, Nairobi, Kenya

11. Wld Hlth Org. techn. Rep. Ser. 177 (Seventh Report of WHO Expert Committee on Mental Health)

12. Ling, T. M. (1954) The prevention of mental illness (some lessons from Holland) Lancet, pp. 1127-8

13. Wing, J. K. (1957) Family care systems in Norway and Holland, Lancet, pp. 884-6

14. The mentally ill in our midst. Special article by Medical Correspondent of the London Times, February 1962

15. Wld Hlth Org. techn. Rep. Ser. 9 (First Report of WHO Expert Committee on Mental Health)

16. Tooth, Geoffrey (1958) The psychiatric hospital and its place in the mental health service, Bull. Wld Hlth Org. 19, 363-387

17. Wld Hlth Org. techn. Rep. Ser. 134 (Fifth Report of WHO Expert Committee on Mental Health)

18. Final Report on WHO/CCTA Seminar on Mental Health in Africa South of the Sahara, WHO Regional Office for Africa, Brazzaville

19. A Hospital Plan for England and Wales, Government White Paper, 1962, 1604, Her Majesty's Stationery Office, London. Also Brit. med. J. 27 January 1962

20. Teaching of psychiatry and mental health by various authors, World Health Organization Public Health Papers No. 9, 1961, Geneva. Also Review article in Chron. Wld Hlth Org. 15, No. 10, 392-3

21. Candau, M. (1961) Mental health as a public health responsibility, Geneva (WHO paper)

22. Wld Hlth Org. techn. Rep. Ser. 223 (Tenth Report of WHO Expert Committee on Mental Health)

23. The Holy Bible, Acts of the Apostles, ch. 26, vv. 24-25

24. The Holy Bible, St Matthew, ch. 12, vv. 22-27

25. The Holy Bible, St Mark, ch. 5, vv. 1-20