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THE ROLE OF PUBLIC HEALTH OFFICERS AND GENERAL PRACTITIONERS IN MENTAL HEALTH CARE

Eleventh Report of the Expert Committee on Mental Health

WORLD HEALTH ORGANIZATION

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1962

EXPERT COMMITTEE ON MENTAL HEALTH

Geneva, 31 October - 7 November 1961

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CONTENTS

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THE ROLE OF PUBLIC HEALTH OFFICERS AND GENERAL PRACTITIONERS IN MENTAL HEALTH CARE

Eleventh Report of the Expert Committee on Mental Health

The WHO Expert Committee on Mental Health met in Geneva from 31 October to 7 November 1961. The meeting was opened by Dr F. Grundy, Assistant Director-General, on behalf of the Director-General of the World Health Organization. Dr A. S. Manugian was elected Chairman and Dr J. Horwitz Vice-Chairman; Professor A. Querido and Professor P. Sivadon were elected Rapporteurs.

1. INTRODUCTION

Mental health care of a population requires different types of personnel with different training. This report deals with the roles of two professional groups — public health officers and general practitioners (or family physicians). For the sake of clarity the two are considered separately though, in practice, one person often carries out both roles.

In many parts of the world, public health personnel are still preoccupied with environmental sanitation and the control of communicable diseases, but this pattern is changing. Attention is being directed increasingly toward the role of public health personnel in discharging other health responsibilities as well, including concern with mental health programmes. This is due particularly to the decline in incidence of communicable diseases in some areas; to advances in psychiatry; and to clarification of the extent of the problem to be faced. A mental health service, indeed any medical service, should ideally be available when it is needed, where it is needed, and on an adequate scale. Public health administration is the branch of health services which has developed skills in the design and administration of health programmes to reach these ends.

Persons who are concerned about their health, including their mental health, often turn first to their general practitioner for advice. His special characteristics have always been his continuous presence in a locality over years and his personal knowledge of the patient and generally also of his

family and social group. In certain rural areas of the world the general practitioner still undertakes to perform the majority of tasks in medicine. Such attributes place him in an admirable position to collaborate in mental health care, including advising the patient and family and carrying out treatment of psychiatric cases within his capabilities. However, particularly in urban areas, his role has changed in the last hundred years. The rise of specialization has taken away many of his former tasks ; but at the same time it has increased the need for the " personal physician ", one of the most important links in the chain of medical care. Such a link has to be maintained if the dangers accompanying fragmentation of care are to be avoided.

1.1 Definition and role of public health officer

For the purposes of this report the Committee agreed to consider the public health officer as a person to whom society or a group delegates responsibility for filling the health needs of the whole of the population in the promotion of health, the prevention of disease, the treatment of the ill, or the maintenance of remaining function in persons whose health has been irreparably damaged. More concisely he could be defined as a practitioner of social and preventive medicine.

The technical direction of public health activities should be in the hands of a physician specially trained for the task, and this is the type of public health officer specifically considered in this report. The Committee recognized, however, that persons other than physicians, such as public health inspectors, nurses and midwives, are sometimes also termed public health officers and sometimes also play the above role.

Public health officers work at local, intermediate and national levels. In different places the Committee's report is concerned with their activities at all these levels.

In some countries, public health officers not only organize but personally provide medical service for diagnosis and treatment of disease, thus functioning also as general practitioners and/or hospital physicians. The parts of this report dealing with curative medicine concern such public health officers as well as general practitioners.

In some instances the public health officer in charge of mental health services may himself be a psychiatrist with additional training in public health and administration. Elsewhere the psychiatrist directing a local community hospital serves also on a community mental health board which depends on the public health authority, and he may act as a part-time public health officer. A working document from the USSR prepared for this Committee suggested that : " the public health worker responsible for the protection of the mental health of the public must be a psychiatrist, with high qualifications and wide, many-sided experience of work in psychiatric establishments, both clinics and hospitals, as well as being a

first-class administrator, with a mastery of the methods of clinical-statistical investigation of morbidity from nervous and mental diseases ".

1.2 Definition and role of general practitioner

For the purposes of this report, the Committee agreed to consider a general practitioner as a doctor in direct touch with patients, who accepts continuing responsibility for providing or arranging for their general medical care ; this includes the prevention and treatment of any illness or injury affecting the mind or any part of the body.

Over vast areas only persons with limited medical training are available to give medical care to families. Furthermore, in large parts of the world indigenous healers still perform this task. Much of what is stated in this report about the role of the general practitioner will inevitably apply to these persons, but, in general, not the remarks on training and organization.

Distinctive features of the work of the general practitioner are that much of it (in some countries one-third) is carried out in the patient's home and that he frequently gives care to the whole family.

The extent to which the general practitioner works in hospitals varies greatly in different countries. Considerable variation is shown also in the public health duties he is called upon to discharge, varying from negligible to full responsibility.[1] Thus, as already noted, the two roles—general practitioner and public health officer—may be performed by the same person. Nevertheless, the two professional groups remain functionally distinct. The " case of influenza " for the general practitioner is part of the " epidemic of influenza " for the public health officer. The general practitioner is concerned with the individual, the public health officer with the sum of individual reactions in the community.

1.3 Supply of physicians, including public health officers, general practitioners and psychiatrists

The part to be played by the above physicians in the mental health care of populations will inevitably depend to some extent on the supply. Physician/population ratios vary greatly ; some countries have fewer than one physician per ten thousand population, others more than one per thousand.

In the few countries for which information was available to the Committee [2] the percentage of physicians who are specialists ranges from 12.7 to 64.7. The percentage of neurologists and psychiatrists, taken together,

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[1] See also : World Health Organization (1957) *Conference on public health training of general practioners, Report (Wld Hlth Org. techn. Rep. Ser.*, **140**, 3).

[2] World Health Organization (1961) *Annual epidemiological and vital statistics*, Section 31, *Health personnel*, Geneva.

ranges from 0.7 to 4.2, and the percentage of general practitioners, where given, from 24.7 to 58.8. Very few data were available on numbers of physicians who are carrying out public health work. The number of psychiatrists per million population ranges from less than one to about 70.

2. NEEDS FOR MENTAL HEALTH CARE

In order to clarify the roles of public health officers and general practitioners in satisfying the needs of a population for mental health care, the Committee devoted the first part of its discussions to a consideration of these needs.[1]

2.1 Tasks comprised in mental health care

2.1.1 *Prevention of mental ill-health*

Some kinds of mental illness and pathological reaction are definitely preventable and a few have already been largely prevented in some parts of the world; examples are general paresis and delirium accompanying infectious diseases. In some instances, prevention is possible but its application is retarded by socio-economic and educational factors, as in the case of kwashiorkor and some psychoses associated with pellagra. Considerable progress has been made in the prevention of brain damage caused by industrial and home accidents, including poisonings (e.g., carbon monoxide).

There are many mental diseases of which the causes are not yet clearly known. In some cases it appears that the pathological responses are the result of accumulated stresses that have finally overcome the resistance of the organism so that symptoms appear. Preventive efforts cannot be conclusively shown to be helpful in such instances. It is believed that adequate parental care of infants and small children, relief of undue avoidable anxiety (through awareness of the more trying aspects of child development), emotional and intellectual preparation for major predictable life events, such as choice of career, marriage, etc., may well be preventive measures, albeit non-specific. Evaluative research in this field is both sorely needed and exceedingly difficult to carry out.

Although many theories have been put forward, little is known for certain about the causes of most severe and widespread mental illnesses. For this reason no consistent preventive programme can be proposed at the present time for application to these diseases, which include the schizophrenias and manic-depressive disorders. In these instances, early case-

[1] Inclusion of this section was considered by the Committee to be of particular value for those readers of the report without specialist training in psychiatry.

finding and adequate medical care probably shorten periods of disability and may prevent complications, such as personality deterioration or suicide.

Some mental illnesses, such as a limited number of cases of cerebral arteriosclerosis, may be complications of general ill-health. Certain measures in the emotional and social spheres appear able to delay or avert psychoses in these conditions, but there can be no definitive prevention of the psychiatric complications until means are found to prevent the underlying general disease process.

2.1.2 *Detection of cases and diagnosis*

For the most part, mental illnesses can be recognized only when the patients themselves suffer and complain, or when they give rise to extraordinary behaviour of one sort or another.

Patients may bring their complaints to many different persons: it is not always to the physician that they go, for they may not recognize that they are, in fact, ill. Those to whom people take their troubles, such as teachers, lawyers, police, public health nurses, social workers, religious and other community leaders, have the opportunity to suspect illness and put the patient on the path to medical care.

The diagnosis of illness is a medical function. Diagnosis involves a decision as to whether the patient is actually ill or whether he or his neighbours may have interpreted certain behaviour as illness when the full facts may show that it was not. When detection and diagnosis of mental illnesses in their early stages lead to early treatment, it may be possible to prevent the deterioration which is otherwise a factor in estranging the mentally ill from the community.

In general, where diagnosis is difficult or special advice is needed or where there is a need for skilled treatment such as certain types of psychotherapy, cases should be referred, whenever possible, to a psychiatrist.

Referral can be too early or too late. Unwarranted and indiscriminate referral can harm the patient, his physician and the psychiatrist. Suicide may be an example of failure to refer in time, but harm may also ensue where too much physical investigation and treatment are carried out when there are physical symptoms of emotional origin.

2.1.3 *Treatment of mental ill-health*

The organization of treatment services so as to ensure wider coverage of the population, early care, continuity of care, and prevention of overlap of services is an important task of health care, including mental health care.

The range of treatments in modern psychiatry is very broad. They vary from specific treatment, such as removal of a pressure-producing cranial lesion, to supportive services, such as providing jobs in sheltered workshops

or a standby service for patients subject to relapses of schizophrenia. Treatment measures may be psychotherapeutic, extending from reassurance to psychoanalysis, or somatic, including use of drugs, insulin and surgery. Adjustment of environment may be therapeutic.

Methods of relieving some of the symptoms found in recognized syndromes (depressive, paranoid, confusional, manic and anxiety syndromes) are known, but the programme of treatment has to be designed for each case. The specialized skills of the psychiatrist are required for applying some of these treatments and are frequently necessary for planning treatment programmes. Other treatments can be carried out most appropriately by the general practitioner. For a high percentage of cases of mental illness, notably the schizophrenias, no treatment is at present known which will lead to cure. Treatment applied to certain of the syndromes, however, can result in considerable relief. With continued supportive therapy patients with such disorders can be enabled to adjust to some type of community living. The aim of treatment thus includes prevention of relapse. Even where it is found necessary for certain patients to remain within an institution, treatment can be applied to limit deterioration and train for limited functioning.

Education of the public on the limitations and possibilities of available methods of treatment may help to secure early treatment and improve acceptance of treated patients.

2.1.4 *Rehabilitation*

In practice it is not possible to draw a clear line between rehabilitation, treatment, and prevention of relapse, although such a distinction is convenient for purposes of discussion. Rehabilitation of patients so that they can make the best possible adjustment to community life, even though their capacities may be limited, can in fact be said to be an important aim of treatment. Thus early and intensive treatment may assist optimum rehabilitation. As community mental health services are extended and the periods during which patients are removed from their environment are shortened, the problems of rehabilitating mental patients probably diminish in complexity, but may increase in extent because of the increasing numbers of persons receiving active therapy. Moreover, as in-patient treatment becomes better adjusted to the aim of reintegrating mental patients into ordinary life, much of the deterioration formerly seen in mental hospitals is obviated.

However, many responsabilities for rehabilitation are left until the mental patient is leaving hospital. He may have to face the community after prolonged absence, fearing public attitudes derogatory to those who have had mental illnesses. Patients who, after five, ten or even twenty years in hospital can now be released—perhaps because the activity of their

illness can be controlled by drugs, perhaps as a result of other more active treatment—create a special problem. A place may have to be found for them in a community that has changed considerably in the intervening period. Continued supportive treatment may be required. Care may have to be taken that relatives, friends or other community members are not overburdened with the problems arising, and a way must be left open for return to more intensive treatment when required. Assistance may be needed in preparing the family for their homecoming ; where this has been done even before the patient enters hospital good results have been obtained. The patient may have no family or friends left in the community, but it may be possible to find and prepare a suitable foster family, and ex-patients' clubs may help him to find new friends with an understanding of his difficulties. Half-way houses, day centres, and night hospitals can assist in the gradual resumption of full community life. Occupational rehabilitation measures may be needed, such as vocational guidance and training, provision of sheltered workshops, and the co-operation of employers in the community. Of great importance in the rehabilitation of patients, and particularly in the prevention of relapse, may be the availability of some person to whom the patient can turn for support and advice at times of stress.

2.1.5 *Promotion of mental health*

Although the Committee distinguished between promotion of mental health and prevention of mental illnesses, it could draw no clear line between them. The concept of promotion of health has not matured sufficiently for clear definition in any branch of health work, and mental health is no exception. The concept includes adjustment of the stress to which a person is exposed so that his powers of resistance will not be overcome. Stress may be of many sorts ; in the context of this paper reference is made mainly to psychological and social stresses, although certain stresses that have a more direct somatic origin, such as nutritional deficiencies, are also included.

Another factor to be considered in the promotion of health is the proper stimulation of the growing person to ensure optimum intellectual and emotional development. Although there are many more factors that have not yet been investigated, the provision of parental care, or of a satisfactory substitute, in infancy and childhood appears necessary to ensure sound personality development.

2.2 Extent of need for mental health care

Several factors tend to complicate any assessment of the need for mental health care. One is the lack of comparability between most epidemiological studies made so far on mental disorders. Some studies suggest

that a minimum of 10% of any population is in need of psychiatric care at any one time, if all clear-cut cases of mental ill-health are included. At least one study, however, gives a relevant minimum figure of 1%. Percentages outside the range 1-10% have also been found, depending partly on the severity of the disturbances included in the study, and partly on the thoroughness of the investigations. In many countries little is known of the prevalence or patterns of mental disorders. Variations in incidence and prevalence appear to occur between geographic areas and between social classes of populations. In many areas, it has been found that when services are newly set up they quickly become overwhelmed with demands for assistance.

Assessment of the specific needs as related to the tasks outlined in section 2.1 is perhaps even more complex. Some estimate might be made of the need for measures against the few mental disorders known to be preventable. The need for detection of cases and diagnosis is inevitably related to the availability of treatment facilities. Needs for organized treatment and rehabilitation will depend not only on incidence and prevalence of mental disorders but also on socio-economic conditions, on community attitudes towards the mentally ill, including tolerance of their presence in the community, and possibly on the extent to which the disorders may be self-limiting or, ultimately, controllable by the patients themselves. Some surveys showed that approximately 1% of the populations investigated were psychotic, a minimum of 1-3% mentally retarded to the extent that some care and supervision were needed, and 0.2 - 0.3% epileptic, but it is not known how far these estimates are relevant outside the populations surveyed.

Estimation of the need for particular elements of mental health services presents many difficulties in the absence of comparable data from different social and cultural settings. There are still areas of the world with fewer than one psychiatric hospital bed per 10 000 population, and many with fewer than one per thousand. In some countries, on the other hand, the present proportion of psychiatric hospital beds reaches one per two hundred of the population. It is believed that this ratio could with advantage be reduced, perhaps to one bed per thousand population, if a complete system of care were in operation.

2.3 Existing patterns of mental health care

Existing patterns of mental health care vary according to, for example, the level of economic, educational and medical development of the country in which they operate, the local situation, and the size of the area served by a unit. Some but by no means all countries have within their government structure a central body for the organization of mental health services. At intermediate and local levels of administration many areas are entirely

lacking in provisions for such organization. In certain regions, psychiatric hospitals are administered by one authority and other mental health services by one or more other bodies ; there may be little liaison between them or with private practitioners. At the other extreme are areas where an attempt has been made to co-ordinate all services and to achieve adequate co-operation between all those engaged in mental health care. Some services grow through the expansion of the staff and extension of the functions of the mental hospital. Elsewhere, community mental health services are developed under local health department auspices and the mental hospital is separately organized and specialized as a treatment centre. Often, the general practitioner makes a large contribution to community mental health care, though rarely as part of an endeavour organized by the public health officer or other agent : in particular, he is often the point of entry to other services. The professional qualifications of persons assisting with domiciliary health care, such as the home visitor, are the subject of considerable experiment. In some areas the public health nurse is specially trained for domiciliary mental health care. In others the social worker takes on this task.

2.4 Unmet needs for mental health care

It is apparent that there are important gaps between what is needed and what is being or can be provided for mental health care. Before considering in greater detail the part that can be played by public health officers and general practitioners, the Committee outlined some of the most blatant needs, i.e., those that at present are being met only partially, if at all.

2.4.1 *Increased knowledge*

The greatest need in the field of mental health care is for more knowledge. Information on incidence and prevalence of mental disorders is beginning to be collected, but many more carefully controlled studies are required.

As already pointed out, knowledge on etiology, prevention and means of treatment of many of the mental disorders is limited. Something is, however, known about means of preventing deterioration from certain of the conditions. This is part of an important body of psychiatric knowledge which could be put to fuller use through better dissemination—between countries, between various categories of medical personnel and among community leaders and the general public.

2.4.2 *Adequate supply of trained personnel*

Application of the existing knowledge depends on adequately trained personnel—initially psychiatrists. Probably no area in the world has enough psychiatrists to meet the mental health needs of its population. A majority of the Committee agreed that even where there was a liberal

supply of psychiatrists, certain mental health needs might be better met by persons concerned with comprehensive health care. Thus the role of the public health officer and general practitioner in mental health care is seen to go beyond assisting with psychiatric work where there is a shortage of psychiatrists : certain mental health activities lie within their purview because of their specific functions within the community. Their need for special training to carry out such roles is only starting to be met.

2.4.3 *Adequate array of services*

Mental health services in the amount and variety needed to meet the needs of populations are nowhere available. Services designed to meet the 5 categories of need outlined in section 2.1 and sufficiently large to provide protective or therapeutic care to a proportion of the population of the size suggested under section 2.2 represent an ideal. This goal can be reached gradually; there is no cause for discouragement if only a few types of service are found to be within the realm of immediate possibility while others have to wait until they become economically feasible. Nevertheless, an adequate array of mental health services as part of the total provisions for health should be the goal of health planners.

2.4.4 *Efficient organization of services*

Recent surveys in various parts of the world have pointed to the need for better organization of services so as to increase their efficiency. It is generally agreed that mental health services are most effective when they reach the patient early in the course of the illness and are applied constantly in a planned way. When several resources for treatment are available, the health planners of the community need to co-ordinate them in such a way as to ensure optimal service.

Organization of services also implies their adaptation to the particular culture of the population to which they are to be applied. Moreover, patterns of operation of medical services must be flexible, so that they can be adapted to changing cultural needs. A mental hospital designed to serve a country with ox-cart transport cannot maintain the same pattern of operation when inter-city buses are introduced. The occupational therapy unit of a hospital serving a mainly agricultural country can suitably manufacture baskets, but when that country becomes industrialized, bicycle wheels may be a more appropriate product.

2.4.5 *Adequate statistics as basis of epidemiological studies*

Epidemiological knowledge can be gained through the daily recording of events and procedures, provided that records are kept consistently. Service statistics of mental hospitals have been the principal basis for epi-

demiological work since they were introduced by Esquirol in the 1830's, but the keeping of records of extramural types of service has not been so highly developed. An important step forward is the construction of case-registers which will make it possible to trace the natural history of the mental illnesses and to adjust services to the expressed need of the people.

* * *

In summary, to meet the needs of populations, mental health services, including adequately trained personnel, require to be increased almost everywhere. Services should be organized to be adaptable to changing needs of the culture in which they operate and should be co-ordinated to meet the needs of the patient and his social milieu. Such services should be used so as to yield maximum information about needs and demand in the population. Further knowledge is required on distribution, etiology, prevention and treatment of mental disorders, and existing knowledge needs to be better disseminated.

3. ROLES OF PUBLIC HEALTH OFFICERS AND GENERAL PRACTITIONERS IN MEETING MENTAL HEALTH NEEDS

3.1 Prevention of mental ill-health

3.1.1 *Modification of environmental factors harmful to mental health*

The mental health problems facing public health officers and general practitioners include : social and intellectual underdevelopment in children whose emotional and social stimulation has been neglected in infancy or early childhood ; poor adjustment of children at school; mental breakdown, for example in university students and factory workers ; marriage problems ; and mental disturbances in pregnancy, at the menopause and in old age. These and other disturbances may be found in combination, for instance in "problem families". There may be special problems to be faced, as where there is a rapid increase in the population or in the expectation of life. Traditional family patterns are being disrupted in some areas where there is movement of population or accelerated industrialization. Rapid spread of technological education in some cultures may have the same effect.

Some of these environmental challenges can be met. The public health officer will perhaps be more concerned with the milieu outside the family, for example the school, or factory, or working conditions in general. In so far as he works in the special protective services, such as maternal and

child health clinics, he will share those challenges of family life that particularly face the general practitioner. The events of life—puberty, marriage, childbirth, the menopause, retirement, the prospect of disease and death—are met with attitudes, and lead to decisions that may affect subsequent mental health. These events can be anticipated, healthful attitudes encouraged, and anxiety forestalled or modified.

The general practitioner dealing with illness, both mental and physical, can increase or diminish anxiety in the patient and his family by what he says or fails to say. Explanation often dispels fear of the unknown—and many ill persons are afraid.

3.1.2 *Prevention of physical illnesses with mental complications*

Public health officers and general practitioners can co-operate in campaigns against pellagra, kwashiorkor and syphilis in countries where they are still prevalent, thus lowering the incidence of the associated mental disorders. Mental disorders and brain damage can be caused by drugs and poisons. Precautions can be taken against overdosage of drugs given by physicians. Public health services can set up poison-control centres and encourage their use by general practitioners. Control of food and industrial poisoning is a community responsibility in which public health officer and general practitioner share. Programmes of accident prevention may also help to lower the incidence of mental disorders caused by head injuries. Both public health officer and general practitioner can help to prevent premature childbirth and hazards of delivery. There are good opportunities for the exercise of diagnostic skill in examining old people, who may be confused through uraemia, severe anaemia, thyroid lack, undernutrition, circulatory failure or infections. Treatment of such conditions may contribute to prevention of mental deterioration in the aged.

3.2 Detection of cases and diagnosis

Many patients with mental problems complain first of physical symptoms. The doctor himself will often be the person who detects that there is a mental problem. Detection and diagnosis thus merge into each other.

The public health officer may be directly concerned with the detection of cases of mental disorder through his work in maternal and child health centres, in schools and in public health centres engaged in prevention and treatment of certain physical disorders. He may also have a responsibility for dealing with information on cases collected by other public health personnel or by the general public.

It is an almost universal dilemma that effort put into improving case-finding tends to overwhelm the diagnostic and treatment resources available. The solution of this problem is often a matter for continuous adjustment

and planning in psychiatric consultation services. Groups in the community can be helped to assist some mental patients. They may have to be relieved of some of the severely ill, difficult cases, whose deviant behaviour is difficult to control; otherwise the constant frustration may discourage case-finding efforts.

Diagnosis is still among the most important tasks of the general practitioner in mental health care. His scope (in diagnosis) is limited chiefly by his own ability and experience; those diagnostic tools that are outside his range, such as intelligence tests or electroencephalography, would be valuable only in a small proportion of his cases.

General practitioners have great opportunities for *early* diagnosis because of their accessibility, and their existing knowledge of the patient, his home and his family. Their ability nevertheless depends on their training to recognize the symptoms of mental disorder which are offered to them, and on their attitude to mental diseases. It is the doctor who listens understandingly who holds the key to early diagnosis.

The following are the questions that many doctors will wish to consider when assessing a patient's disorder:

(*a*) Is there a mental health problem? The majority of patients still present with physical complaints, such as headache or indigestion.

(*b*) If there is, what sort of problem is it? The value of nosological classification and one-word labels in psychiatry is disputed, but some assessment of the type of problem must be made, if possible taking into account all the relevant factors of the case, not just the somatic ones.

(*c*) Is immediate action needed?

(*d*) Is the management of the case within the doctor's own power? All doctors need to be aware of their own limitations.

Three other points can be important for a full assessment: What does the patient think about his illness? What does his family think about his illness? Do the patient and family understand what the doctor thinks?

These standards of diagnosis are well within the reach of many general practitioners and public health officers, but not of all. It is, however, essential that some attempt be made to formulate a diagnosis even if only to decide whether the case is one that can be treated at home by the family doctor, one that needs some special social or environmental adjustment, or one needing specialist care.

Concerning methods of diagnosis, the Committee considered that general practitioners and, where relevant, public health officers, should have reasonable ability to conduct an interview, to construct a good medical history, and to make pertinent observations about psychological and social aspects of behaviour in patients who may or may not present obvious symptoms of psychological distress. A useful additional tool might be

some sort of psychosocial questionnaire, as developed in one country.[1] Valuable certainly in training, such a questionnaire might also be used by the general practitioner when interviewing new cases. History-taking, however, can only be a framework; at least as important is the need to let the patient talk while the doctor listens. This in turn requires a belief in the importance of mental health work: the doctor must be prepared to give his time, so that the patient is able to confide in him. Can he spare the time? Very often he can, but this depends on the supply of physicians; he is most likely to be able to do so in those cultures that are relatively free from the urgent problems of infectious diseases or under-nutrition.

3.3 Referral

Public health officers may be responsible for referring patients with mental disorders to general practitioners or psychiatrists or to facilities within the mental health service. In a few areas, public health services have set up a type of "screening" service to which all detected cases of mental disorder are referred. This service is concerned with directing patients to the most suitable source of assistance, following their progress, and arranging for further referral as necessary.

Both public health officer and general practitioner may be concerned with legal aspects of committing patients to mental hospitals or convincing them of the advantages of voluntary admission.

It is vital that the general practitioner should be aware not only of the limits of his capacity to diagnose and treat psychiatric cases, but also of the possibilities of specialist psychiatry and the particular orientation and interests of the psychiatrists to whom he refers his cases.

Although attitudes are changing, referral to a psychiatrist or mental hospital may mean loss of face for the patient. Much can be done by general practitioners and public health officers in preparing the patient and his relatives. One of the elements making for success is the patient's confidence in the physician advising his referral. The decision must be interpreted to the patient as opening a door to help and not as a conclusion that he is beyond help. The patient must also be assured that it does not mean loss of regard or rejection.

A good letter of introduction is of course essential. In a difficult case it may be helpful for the psychiatrist to go to the patient's home, preferably in the company of the family doctor.

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[1] See Weijel, J. S. (1958) *Psychiatry in general practice*, Amsterdam, London, New York & Princeton, Elsevier.

3.4 Treatment

The role of the public health officer (as defined for the purposes of this report) in the treatment of the mentally ill is largely one of concern with organization of treatment services. Where psychiatric hospitals come under the jurisdiction of the public health service he may be in a position to encourage their development according to up-to-date concepts of their role. His community influence may enable him to collaborate in alleviating public distrust when the locked doors of psychiatric wards are opened. He may help to promote changes in the psychiatric hospital so as to make it a place for active treatment in preparation for community life rather than a custodial institution. It may be possible for him to assist in modifying legislation so as to facilitate the movement of mental patients in and out of hospital in accordance with therapeutic requirements. He may be concerned with extending outpatient services and day-hospital facilities so that patients may be treated without complete removal from their community ties. The public health officer may need to organize and supervise and even carry out other means of care for stabilized chronic patients, for example, in a nursing-home or foster-home, where supportive treatment can be continued. He may have to take the initiative in setting up emergency services : various plans have been developed to provide immediate attention by a psychiatrist or other trained personnel to relieve difficulties caused by the sudden appearance of markedly deviant behaviour. In all these duties the public health officer may need the collaboration of the psychiatrist, as outlined in section 4.3.2.

The general practitioner can carry out certain types of psychiatric treatment, but not all. There are clear dangers if he takes too much on himself. Doctors vary more widely in their ability to treat mental illness than to diagnose it, because not all of them can easily reconcile themselves to dealing with mental patients. The general practitioner's competence in treating mental illness increases as he gains experience and is proportionate to his interest and training in mental health and his contact with the specialist psychiatric services.

For this reason, it is difficult to lay down rules about which cases can be treated by the general practitioner and which should be referred. The majority of his patients present minor problems requiring brief treatment, but he may meet two types of major problem : (*a*) emergencies such as attempted suicide, acute confusional states or epileptic crises ; (*b*) long-term psychoses or severe personality disorders requiring his support but not receiving psychiatric treatment at the time.

Broadly, three methods of treatment are open to the general practitioner —psychological methods, physical methods, and procedures designed to modify the patient's environment.

(*a*) *Psychological treatment*. This includes the support which is given to the anxious, ill person by the mere presence of the doctor. All general practitioners take histories, discuss problems with patients, give reassurance, advice and suggestions, whether they realise it or not. They all need to be aware of the importance of attempting to understand the patient and to use this understanding so that it can have a therapeutic effect. They are usually concerned with immediate situations rather than with attempts to modify lifelong patterns of behaviour. But even with limited aims they can help their patients to discharge emotion and acquire insight. Some general practitioners, with or without special training or experience, do attempt to uncover unconscious conflicts in certain patients and help them to make an adjustment in the light of newly gained insight. However, a general practitioner cannot undertake formal psychoanalysis.

(*b*) *Physical methods*. The physical methods suitable for use by general practitioners include drug treatment, relaxation methods, and the prescribing of rest or activity. General practitioners can and do prescribe psychotropic drugs. Although there is a real danger that they are used too often, there are, in fact, no reliable data on how much they are being used or whether they are given for the right or wrong indications. General practitioners need to be aware of the results of any well-controlled therapeutic trials.

(*c*) *Modification of environment*. The general practitioner can achieve this in several ways, e.g., by giving a certificate prescribing sick-leave or by recommending a convalescent holiday. In some countries there are as many as 30 to 50 different agencies on which general practitioners can call for social and economic help for their patients. If he is conversant with the scope and limitations of these agencies, the general practitioner can act as an important link connecting his patient with the required assistance. This is, of course, a task which he shares with the public health officer and others, and the public health officer may have the responsibility for informing the general practitioner of the availability of sources of help.

Transcending in importance these three broad methods of treatment, there are certain general needs, such as a tolerant attitude, dependability, continuity, an interest that allows the doctor to take even minor disorders seriously, and attention to the needs of close relatives of the patient.

The Committee again emphasized the importance of the general practitioner's daily task in assessing and, where indicated, attempting to relieve the anxieties of sick persons. The general practitioner can also play an important part in treatment by co-operating with specialists (see also section 4.3.2)

3.5 Rehabilitation and long-term follow-up

If rehabilitation is to be looked upon as part of the whole process of adapting the mentally ill person to a place in society where he can function

optimally, the public health officer and general practitioner have an important role to play. Both will be concerned in preserving the continuity of care and interest that are basic to rehabilitation.

The public health officer will be particularly concerned to ensure that his community provides for rehabilitation to meet psychiatric as well as other medical demands. This may include vocational and re-educational services, job-finding, provision of sheltered employment, and influencing employers' attitudes. Special opportunities may arise through maternal and child health centres and school medical services. He may have a responsibility for organizing services so that continuity of care is possible (see section 3.7). He can fulfil an important function by organizing the preservation and availability of case-records where large numbers of patients are followed. In some areas, there is also an elaborate system of outpatient psychiatric clinics for each district from which staff carry out domiciliary care and follow-up. This has been a successful way of securing continuity of care, at least in the large cities. In other parts of the world, the general practitioner is the agent who arranges for such continuity; this may be a good solution, especially for rural areas, provided he can call on psychiatric advice.

The general practitioner is frequently the person to provide continuity in human relations. Reference has already been made to the advantage of his knowledge of the patient's background. This puts him in a position not only to assist in the choice of place and type of treatment, but also to influence the attitude of the family toward the patient by explaining the nature of the illness as well as methods of treatment and what can be expected from them. This may enable the patient to be treated at home, or to enter hospital without undue fear and be accepted back again by the family. The patient's return may be smoothed if the general practitioner visits him in hospital, encourages the family to do so, and visits the family during this period: this may support the family in carrying what may be a heavy burden. Later, the general practitioner may help the patient to become re-established by referring him to social agencies, the vocational guidance centre, and industrial and other rehabilitation services. He may assist in finding foster homes for patients without families. In all these activities the physician's aim will be to help the patient to find his own place in the community and to be as self-reliant as possible, knowing that he has an adviser to whom he can turn at times of stress.

The public health officer and general practitioner are needed to assist with the tasks involved in rehabilitating patients who are returning to the community after a long stay in hospital. They may need to take steps to prevent members of the community from being overburdened with the tasks of caring for discharged patients who are not free from symptoms.

Long-term follow-up gives a chance to prevent relapse and to watch the natural history of illnesses. It may completely alter the doctor's con-

ception of long-term psychoses. It can show, for instance, what happens by the time he is 40 to a patient who developed schizophrenia at the age of 20. It permits the doctor to see how the family bears up under the strain and may reveal, for example, that a schizophrenic in the home is less disturbing to the family than a hysterical patient.

The doctor will have to decide how long follow-up should continue. To some extent this problem solves itself, since patients cease to seek support after a certain length of time. If they are visited, it is frequently found that they are managing without outside help. Experience in one area showed that when a patient had not contacted the service for 2 or 3 years, in general the case could be considered closed.

3.6 Promotion of mental health

The Committee considered that it might be feasible for public health officers and general practitioners to assist the promotion of mental health through education of the public as individuals, in meetings, and through mass media. The content of such education will vary from place to place and time to time. It will be determined by local culture, local problems, and the particular audience addressed. It was not possible for the Committee to make precise recommendations.

Attemps can be made to improve public attitudes towards mental illness. It should be made clear that there are many different sorts of mental illness and no attempt should be made to cover up ignorance about the cause of some of them. Encouragement of contact with the mentally ill and support of voluntary visiting and community activities to assist the mentally ill may lead to improved attitudes. This in turn may promote better overall mental health of the community.

Public health officers and general practitioners may have opportunities through observation and research to help clarify what factors do promote mental health. Much more information on this topic is required.

3.7 Integration of services into a comprehensive system of care

Various stages in patient care are frequently dealt with by different bodies within different organizational structures. For instance, care by general practitioners, hospital treatment and after-care facilities may each belong to a different organizational system and be financed in a different way. Only in the last few decades has the necessity been clearly recognized for linking mental health services to provide an integrated, comprehensive system for treatment and rehabilitation. Such a chain of services would provide for each type of psychiatric case according to its needs. Systematic consideration of the application of services gives an opportunity to countries developing systems of psychiatric care to make long-range plans and to

determine priorities in the establishment of new services. The health officer at national and provincial levels has the responsibility for the development of mental health care as an integral part of health services generally; he must usually deal with the problems of priority. Where he has the overall responsibility for health planning, he may also have psychiatric responsibilities as the administrator or co-administrator of local mental health services. Because of his position he has a comprehensive view of the community's health requirements and is therefore able to make the various organizations aware of each other's activities and to establish new lines of communication. He is often in a unique position to bring the various personnel and their governing bodies together to exchange views of mutual interest on the practical level as well as on questions of organization and policy-making. These activities may lead to organization of more comprehensive health work.

3.8 Research and collection of data

The public health officer and general practitioner also play a part in the collection of data and research on mental health and mental illness which is considered under section 6.

4. REQUIREMENTS FOR PUBLIC HEALTH OFFICERS AND GENERAL PRACTITIONERS TO CARRY OUT THEIR TASKS IN MENTAL HEALTH CARE

For the public health officer and general practitioner to fulfil their roles in a specific field of health care there are certain prerequisites. They need motivation, interest and training. Organizational factors are important: the framework of health care, the financing of services, staffing levels, and time available. Good communication and co-operation are required between those concerned with carrying out health tasks. Each of these factors as related to mental health care is considered below.

4.1 Motivation, interest and training

4.1.1 *Public attitudes to mental illness*

Much has been made of the evidence that in some cultures the mentally ill are peculiarly unpopular and feared and that the public tends strongly to reject them. This attitude is sometimes found among the medical profession as well, so that great efforts may be necessary to maintain interest in and recruit personnel for programmes of mental health work. However, experience has shown that patients may be well received in communities, even when they still show severe symptoms, provided that emotional support

and practical advice are available to the family, and that the emotional burden is not too heavy, the economic drain on the family not too great, and a reasonable activity schedule can be provided for the patient: in regular employment, in sheltered workshops or in day-care or hospital centres. There are indications that patterns of rejection are changing towards increased understanding and acceptance of the mentally ill. Increased efforts in public education, both through direct activities and through the indirect effect of volunteer programmes in psychiatric hospitals, as well as increased frequency of contact with treated patients in the community, are probably largely responsible for this change.

Greater interest means that mental illness is less an unknown quantity and therefore less frightening; this fosters tolerance and favours community care. It may also bring encouragement for the doctor and with it possibly more money for research and treatment. Particularly is this so where the interest of key people in the community is stimulated.

4.1.2 *Motivation and interest of public health officers and general practitioners*

There are a number of reasons why, for a practising physician, psychiatry may be an almost unknown territory. One is that his interest may have been insufficiently stimulated. Students who have brought from their home life an interest in people may develop during their training an interest mainly confined to "cases". It cannot be said that undergraduate teaching, as practised in many medical schools and universities, directs the interest of the student to the mental health field. Medical teaching reflects the development of medicine, in the sense that it is broken up into small sections of specialization. As a result of this fragmentation, there is a danger that the patient may be viewed as a number of seemingly unrelated technical problems. In this situation there is little room for consideration of his human problems and of the whole person.

For the general practitioner, physical illnesses that cause pain or threaten life have a traditional priority over mental disorders. Thus, when he is confronted by patients with urgent mental health problems he frequently first makes a prolonged search for physical causes and tends to postpone diagnosis of mental illnesses because he feels inadequate to deal with them. This is due to some extent to insufficient undergraduate training in psychiatry which in turn may result from lack of interest or motivation or inadequate training among teachers of medicine. Another reason for lack of interest in psychiatry is that it tends to appear as a less exact science than certain other medical disciplines. These problems were considered by the Expert Committee on the Undergraduate Teaching of Psychiatry and Mental Health Promotion which was convened in 1960. The report[1] of this

[1] *Wld Hlth Org. techn. Rep. Ser.*, 1961, **208**.

Committee indicates that there is an important movement in many parts of the world toward the improvement of undergraduate training in this respect.

There are at present indications of reviving interest in the person of the patient, resulting in increased realization of the need for a "personal doctor" who will deal with the mental as well as the somatic health of his patient. A willingness is being shown, too, by the public health officer to accept responsibility for mental health care as part of total health care in his community. At the same time there is apparent a growing desire for further education and training to meet these responsibilities.

Public health theory and practice have developed primarily under the stimulus of the problems of infectious and parasitic diseases. Psychiatric theory and practice have been faced with other types of illness where etiological agents external to the host are much less common or apparent. This difference in type of problem poses certain conceptual difficulties for the health officer as a planner and administrator of programmes for mental health care. Among these difficulties are the lack of clear-cut end-points distinguishing the healthy from the ill, the problems of nomenclature and classification of psychiatric disorders, and the fact that in psychiatric illnesses the assumed cause of the reaction is often remote in time from the resulting symptoms. The demonstration of the extent of the need of populations for mental health care has, on the other hand, promoted interest and acceptance of responsibility in this field by health officers. Another factor promoting interest has probably been increase in effectiveness of control of psychiatric illnesses in recent decades.

4.1.3 *Special training needs*

Many general practitioners are now recognizing more mental health problems in their practice than formerly—partly because of increased awareness of their existence and partly because many serious somatic conditions, especially in the younger generations, are demanding less time and attention. At the same time, there are more resources at the disposal of the general practitioner for dealing with mental health problems. Every advance in psychiatry increases his responsibilities. In order to meet them he needs further training, much of which can be best carried out over a period of years while his own personality is maturing and his experience widening. General practitioners in the more remote areas have greater responsibility for making decisions on the diagnosis and treatment of mental disorders in their patients. One method of bringing postgraduate training to these practitioners is considered under section 5.

For the public health officer there are special needs for instruction in recent advances in the use of psychiatric facilities, so that he may more adequately fulfil his responsibility for the organization of mental health services.

The Committee therefore wished to underline the need for increase and improvement in undergraduate training in mental health and psychiatry, as pointed out by the Expert Committee on the Undergraduate Teaching of Psychiatry and Mental Health Promotion,[1] and also the necessity for differentiated postgraduate training for general practitioners and public health officers. This is further considered in section 5.

4.2 Organizational factors

Some kind of organizational framework is needed if more people in need of mental health care are to be reached. Existing methods of organizing health operations range from a unified and comprehensive government programme, including all forms of medical aid and health protection, to varying degrees of limited organizational and economic responsibility of the central government. They may be combined with independent activities on lower governmental levels and voluntary activity by private bodies. Furthermore, large parts of the activities may be carried out by governmental, semi-governmental or private insurance systems. Apart from the organizational differences, variation may be found in the amount of attention paid to mental health in any of the systems mentioned.

In some countries, the first step in setting up programmes has been to create a department of mental health at a national level. If the public health officer is to be concerned in all the tasks outlined in section 2.1, the care of the mentally ill has to become part of the general programme of preventive and curative medicine and its planning integrated into the total health programme. This may need to be stated as a policy at national level. On the other hand, a measure of freedom of organization at the local level may enable the public health officer better to fulfil his role, as the plans for regionalization of mental health care in some countries suggest. It is recognized that in some countries voluntary bodies are playing a very important role in mental health care. The public health officer has to be aware of this and may need special provisions, such as the possibility of making grants or of inspecting the operation of voluntary programmes, so that he can integrate their efforts into the work of other medical programmes.

Whether health facilities are united in a comprehensive system or not, a constant flow of information on the patient from one facility to another is needed. The Committee emphasizes the importance of this interchange of information for continuity of care. It is understood that, in order to safeguard the interests of the patient, guarantees must be given that the information will be limited strictly to persons acting under medical responsibility.

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1961, 208.

Originally the general practitioner did not work in any organizational frame. Various factors have brought about a change. In many countries doctors have formed group-practices ; the institution of colleges of general physicians aims at systematizing and organizing their work ; some general practitioners are becoming more actively concerned with public health organization. Some such organizational factors are needed if the general practitioner's scope in mental health care is to be extended.

Dealing with mental health problems can be very costly. Several countries have concluded that the financial burden is too great for individual patients and that an organized system of covering the cost of care is essential. Moreover, if adequate services are to be provided adequate budgets must be forthcoming. It is being realised that in view of the problems to be faced, financial provisions for mental health care have been disproportionately low.

The general practitioner frequently states that he has no time to deal with the emotional problems of his patients. It has, however, been argued that dealing with mental health problems in their early stages can save time later. Methods of effective psychiatric care are needed that are less time-consuming than the classical methods ; some are being tried out or are already established.

If public health officers and general practitioners are to undertake all the responsibilities for mental health care referred to in the report, the size of the population they can serve is limited. Obviously, then, adequate numbers of personnel are needed for performing these roles. However, there are possibilitities for trained physicians to extend their roles in mental health care by utilizing and supervising other persons in the community. In some areas, the indigenous therapists are being used in this way. In others, social workers or nurses assist with this work. Further investigation of the roles of the various members of the mental health team may make for a more efficient use of the special contribution of the more highly trained members of the team.

4.3 Communication and co-operation

4.3.1 *Between public health officer and general practitioner*

The public health officer functions as an adviser to or executive of the government, and sometimes acts in a similar capacity on behalf of industrial or insurance undertakings, be they governmental, private or semi-governmental. He receives directives, information and requests for advice from the governmental body and returns information, advice and proposals, but he functions on the basis of direct experience only to a limited extent. He is mainly dependent on the people who meet health needs and health

problems : in the first place, the general practitioners and other doctors. This is true for the gathering of information as well as for carrying out activities. A second system of interaction develops between the public health officer and the family physicians.

When data pass through these systems they undergo a certain processing. When the flow is from periphery towards centre, i.e., from the general practitioner to the public health officer, their quantitative significance is assessed by relating the observations of a single general practitioner to those of others. In the second place a qualitative assessment is made : what is the significance of the observation related to the health condition of the population ? In the third place the data gathered in medical practice must be translated into planning and policy decisions : a complaint from a general practitioner may indicate defects in a particular service, the need for new provisions or new legislation. Translation is also necessary in the opposite direction : funds have to be translated into provisions, legislation into action, policy into directives, suggestions, or requests for data.

Another line of communication needed is between the authorities—including the medical profession—and the general public. The public health officer may play an important role by seeking the means which may be most effective in a given community to reach the right persons. Here, consultation and co-operation with the general practitioner, who may help to bring information to the public, is essential.

Such co-operation and communication have been found essential for satisfactory deployment of physical health activities and have been made possible by the common elements in the training of the two types of physician concerned.

Communication is affected by attitudes, which may be influenced by training and education. It depends also on the use of a common language, which again is partly a matter of education. For good co-operation in the mental health field, the public health officer and general practitioner require a common field of knowledge about psychology and human relations and a common field of interest.

In order to promote the integration of mental health care into general medicine, it would seem desirable for the public health officer to have some experience of the work of the general practitioner and of the conditions under which it is carried out, Some members of the Committee recommended that a few years of experience as a general practitioner should be required for the appointment of public health officer. Other members regarded this as desirable but not obligatory. The general practitioner is likely to show more understanding of public health problems if they have been considered in his undergraduate training. Good professional relations between public health officer and general practitioner are the most important factor in enabling them to co-operate in fulfilling the roles outlined in section 3. Such professional co-operation may be fostered by a common

training in the psychology of interpersonal relations, but it may also be necessary to carry out studies on the "power structures" within the community, and particularly on the relationships between the authority of the health officer and of the rest of the organized medical profession.

General practitioners can help public health officers by supplying information on problem-people and problem-families, and they can co-operate in schemes for mental health education. Public health officers can supply general practitioners with information on the community as a whole and can facilitate access to services such as nursing, provision of home-help, assistance by social workers, convalescent homes, night hospitals, and nurseries. In some countries, public health officers arrange admission to hospital. It is important that the general practitioner should be informed when a mental disorder is detected in his patient by a member of the public health staff, due regard being paid, of course, to preservation of professional secrecy.

The public health officer may be in a position to encourage co-operation between the public health nurse and the general practitioner. Shared knowledge of a patient's family background may assist them both in their mental health tasks.

It should, of course, be kept in mind that the functions of public health officer and general practitioner are in some areas carried out by one person, as mentioned on page 5.

4.3.2 *Co-operation between public health officer, general practitioner and psychiatrist*

The need for public health officers and general practitioners to collaborate closely with psychiatrists has been stressed several times in this report. As pointed out in the introduction, a few public health services are now provided with a psychiatrist who has had a public health training and is in charge of the organization of partial or comprehensive mental health services. Where these responsibilities devolve upon the public health officer who is not himself a psychiatrist, there may be psychiatrists in the public health service with whom he can collaborate. He may need to take steps to secure the advisory services of specialists in the community or even from another country. Engagement of psychiatrists in the community as consultants in the public health service can permit the public health officer to extend psychiatric consultation services to other agencies. The public health officer may be influential in extending the services of privately practising psychiatrists to larger numbers of persons in need, for example by arranging for their part-time engagement in outpatient clinics. In order to collaborate effectively in the planning of treatment services, the public health officer needs to get to know the specialists of his district and to become acquainted with their day-to-day activities and problems.

Mutual assistance is required when cases are referred to the psychiatrist or when his advice is requested for cases treated by the non-specialist. His help may be sought in deciding whether the patient needs specialist care. If he does, the public health officer or general practitioner can provide valuable background information about the patient and his relatives. Many people look on psychiatric treatment as a blow to their self-esteem; the physician can help to lessen this feeling if he has himself acquired a positive attitude towards psychiatrists.

When a patient is referred, continuity of care can be improved if the psychiatrist keeps the general practitioner informed on the progress of the case. If a patient is admitted to a mental hospital, the general practitioner's visit may afford an opportunity of exchanging information with the psychiatrist. On discharge of the patient, a report to the general practitioner may help to revive his interest in the case so that he resumes responsibility without delay.

When the patient is receiving outpatient treatment, the general practitioner should be aware of the proposed treatment programme so that he can help to maintain the patient's confidence in it and be in a position to advise the patient's family. He should not interfere in the specific treatment without the knowledge of the psychiatrist.

It is important that public health officers and general practitioners should know psychiatrists personally. Where there are enough of these specialists, choice of psychiatrist for the particular patient may be important, since they vary considerably in interest and orientation.

Once psychiatrist, public health officer and general practitioner know each other personally and have worked together, the psychiatrist can develop an important role as adviser. It is a great help to be able to telephone a psychiatrist and discuss a problem even though the general practitioner or public health officer is carrying out or arranging the treatment.

Other valuable methods of co-operation are clinical assistantships of general practitioners in mental hospitals and in psychiatric departments of general hospitals, attendance at psychiatric outpatient clinics, attendance by the psychiatrist as observer at the practitioner's consulting room, and case-discussions in a general practitioner's practice, in a public health group, in hospitals or in outpatient clinics.

In some developing countries, the roles of public health officers and general practitioners are not specific, i.e., these categories are both regarded as medical (health) workers. In the same way, psychiatrists are considered "doctors" first before anything else. Disease, its prevention and healing, may play a tremendous social role, necessitating communication and co-operation at all levels—family, practitioner, patient and community. In these countries specialization has less influence on comprehensive medicine than in more highly developed areas: there tends to be a more unitary concept of psychosomatic interrelationship. Because of this, a

psychiatrist working in certain developing countries should perhaps ideally be able to assume the role of a general practitioner. Vice versa, general practitioners and public health officers are expected to cope with emotional problems and major psychiatric problems within the community, especially in those areas where there are no psychiatrists or other trained mental health workers. In one African area, for example, it is now being proposed that remand homes and allied institutions should be run by a joint professional board consisting of one or two general practitioners, public health officers, psychiatric personnel, and welfare officers.

In those developing countries where communication and co-operation between all types of medical and health workers have traditionally been integrated, the question arises of how to preserve, or even improve, this state of affairs when other methods, technologies and specializations are introduced. This problem is a fair example of the need to preserve advantages inherent in the culture of developing countries. Before achievements of other cultures are accepted, their possible value in a new setting has to be critically reviewed.

4.3.3. *Co-operation with community bodies*

Education is often one of the largest and most expensive government services. In some areas where education is not highly organized, it may be concerned more with the practical matters of communication and skills in work and may be carried out only in the home or in small groups. Education has important effects on personality formation and is thus a matter of concern to the mental health programme.

An educational system, however informal, is in effect a test of whether or not, and to what extent, the child is able to perform at the level expected of it. When difficulties of behaviour become too great they attract attention, thus making the educational system an effective case-finding agency. Its effectiveness as an agency for promoting mental health has not been as conclusively demonstrated, though many believe it to be so and have attempted to show how to improve this function.

The provision of sustenance for those unable to provide for themselves is, like education, to be found in every community in one form or another, and in certain countries has become a complex social institution. In other countries it is more a matter of individual charity or of family care. This basic welfare function is frequently accompanied by help or advice as to how to end the need for assistance. This has become formalized as social case work, which has the double function of giving relief and of trying to make the support unnecessary through adjustments of the mental or physical health of the individuals concerned or of the circumstances under which they live.

It can be shown, furthermore, that social distress, either in amount or kind, is not evenly distributed in the population. Health, educational,

and social problems have been shown in certain communities to occur together and all in a relatively small segment of the population.

The various types of welfare functions will bring to light cases to be dealt with in mental health programmes. Preventive or promotional schemes have not been as thoroughly worked out as is the case in education, but progress in theory and in practice is being made in this area.

Health organizations, both governmental and voluntary, also exist in all cultures, whether as highly structured national health insurance programmes, or as more direct service by one or another type of health agent to the person in need.

These three large social institutions—education, social welfare, and health services—are obviously of great concern to the health officer in discharging his mental health responsibilities. Religious observances, police functions, recreational institutions, and many other aspects of organized society have also to be considered in this connexion.

4.3.4 *Communication and co-operation with the general public*

In much of the foregoing it is implicit that the public health officer and general practitioner need the co-operation of the general public in carrying out their mental health tasks.

Reference has been made to differences between cultures in community attitudes to the mentally ill. Attitudes of rejection will inevitably hinder the development of community programmes. Being in close contact with the community, public health officers and general practitioners are particularly well placed to attempt modification of reactions to the mentally ill through education of the general public and leaders of public opinion. To do this they themselves require understanding of sociological and anthropological facts and need to be well acquainted with the subcultures of the community to be approached. They need grounding in the techniques of health education and need preparation for and understanding of the possible adverse reactions of the persons involved. Attention was given to these questions in the seventh report of the Expert Committee on Mental Health, devoted to social psychiatry and community attitudes.[1]

It is important for physicians to be aware of the extent to which relatives and friends of mental patients, as well as voluntary bodies are taking upon themselves the care of the mentally ill. Recent research in some areas showed that families were willing and eager to maintain responsibility for the care of aged relatives—a finding that came as a surprise to some administrators who were faced with a possibility of large-scale organizational measures for geriatric care.

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1958, **177**.

5. TRAINING OF PUBLIC HEALTH OFFICERS AND GENERAL PRACTITIONERS IN MENTAL HEALTH

Since the question of undergraduate medical training in mental health has been studied by an earlier expert committee [1] consideration is here limited to the postgraduate training of public health officers and general practitioners.

However, as the recommendations of that Committee are not yet being implemented everywhere, this Committee felt the need to include in the postgraduate training certain subjects which may also appear in undergraduate programmes.

Public health officers and general practitioners have an equal need to be familiar with the principles regarding interaction between the individual and the environment, so that they may later easily use the same technical language, but in the field of the practical application of these principles their professional interests diverge. The Committee therefore suggested a programme comprising a basic theoretical part suitable for both the public health officer and the general practitioner, with the subsequent training adapted to the specific needs of each. This should, nevertheless, be considered only as a pattern to be modified according to the needs, possibilities, and cultural characteristics of the country.

To accomplish his public health tasks, the health officer needs to know how to work with specialists in many other fields: nursing, engineering, orthopaedics, pulmonary diseases, building inspection, psychiatry, health education, etc. It is probable that at present the health officer is not everywhere prepared to "use" the psychiatrist as well as he is other medical specialists. One reason for this may be that the psychiatrist has been, in many cases, rather slow to realize his public health responsibilities. Another reason may be that there has been a tendency for the psychiatrist, realizing the desirability of continuous therapeutic relationships and the difficulties of establishing rapport, not to tolerate the inclusion of other persons in that relationship. Whatever the causes, it seems clear that if the health officer is to carry out his responsibilities for mental health care efficiently he will need not only to know more about the field, but also to study the particular problems of bringing mental health personnel into the health organization of the community.

This probably entails a certain amount of "emotional desensitization" on the part of both the health officer and the psychiatric specialist and

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1961, **208.**

familiarization with each other's attitudes and fields. Such desensitization and familiarization are perhaps best accomplished in courses in public health practice led by persons equally well educated in mental health and in other special programmes. When the special mental health care programme is under discussion, faculty members should be expert in that field or, if such experts are not available, a public health specialist should if possible be associated with a psychiatric specialist in the teaching. When the desensitization and familiarization process has to be effected through in-service training programmes, planning sessions will be required where the psychiatrist and the public health specialist can work together at the solution of the problem. Interchange between the two specialists of ideas relating to the practice of mental health care appears to be one of the best means to such education. Each profession can help the other and each learn to appreciate both the problems and the opportunities of the other. It is obviously the responsibility of local health officers and psychiatrists to arrange the necessary contact for themselves. Where they do not do so, because of ignorance or lack of appreciation of the one field by the other, it is the educational responsibility of the next higher level in the health organizational structure to attempt to facilitate suitable contact.

The general practitioner is presumed to have learnt during his undergraduate courses the essential principles for carrying out his profession. However, the "personal doctor", functioning in the midst of a multitude of medical specialists, might be regarded as requiring certain additional knowledge and skills not common to other physicians. In that case, undergraduate training would become the laying of a foundation from which further training branches off. The postgraduate training of the general practitioner, as considered in this paper, would then have to be regarded as a special training required before he takes up his function, as in the case of the public health officer. The Committee strongly recommended that the consequences of such a proposal be the subject of further studies.

For the general practitioner a practical training is desirable, aimed at enabling him to become aware of his own attitudes, increase his capacity for therapy with the mentally ill and handle the emotional aspects of his patients' complaints.

On the other hand, broad information relating to populations is more necessary for the public health officer. His training must be developed with particular emphasis on ensuring his capacity for communication and coordination.

For purposes of clarification, three aspects of training are considered separately : the content of the programme, methods of training, and facilities required. These are obviously interdependent.

5.1 Content of training courses

5.1.1 *Common training for public health officers and general practitioners*

The Committee considered that both public health officer and general practitioner should have an adequate knowledge of the following factors influencing behaviour :

(*a*) personality development, including emotional, intellectual, psychosexual and psychomotor development, in childhood, adolescence, adult life and old age ;

(*b*) the emotions and their relation to motor activity, thought, etc. ;

(*c*) processes of conditioning and learning ;

(*d*) defence mechanisms ;

(*e*) principles of social psychology (interaction of person with family, society and culture ; group behaviour).

5.1.2 *Training of the public health officer*

In the training of the public health officer the above basic information would be applied to the human environment and community facilities.

The principles of *personality development* and of family psychology would be applied, for instance, to school health services, health education methods, the organization of maternity clinics, crêches, family help and domiciliary care, housing problems, hospitalization of children, adoption and foster-care for young people.

The principles of *social psychology* would be applied to the mental health aspects of various forms of collective living on which the public health officer must be prepared to give his advice :

(*a*) the school and university : size of classes, work-load, organization of leisure activities and clubs for adolescents ;

(*b*) the hospital : site, role, size ; psychological importance of space, timetables, feeding, reduction of noise, shorter waiting times for examinations, keeping patients occupied, relations with the outside world, etc ; pathological consequences of prolonged hospitalization (hospitalism, institutional neurosis) ;

(*c*) the factory : human relations in factories ; significance of work, timetables and rhythms of work ; possible signs of emotional stress : absenteeism, alcoholism, accidents, occupational neuroses ;

(*d*) urban and regional planning ;

(*e*) psychological mass reactions to exceptional social events : catastrophes, epidemics, food poisoning, strikes, riots, and threats of war ; reactions of migrant population groups.

Subject matter taught under the head of social psychology would include the methodology for studying the cultural practices of societies with particular attention to those facets that may be touched upon or altered by the introduction of a proposed programme. There is now sufficient experience in this field to show that no change in a culture can be isolated, that proposed desirable changes may be resisted because at some unforeseen point they come into conflict with an important fixed pattern, or that a change that appears desirable is found to have side effects so disruptive of the way of life that the social instability introduced outweighs the benefits of the change.

The Committee considered that study of these problems should have a place in the training of all public health officers including those in countries undergoing rapid change.

Information given to the public health officer on *mental pathology* should, in the view of the Committee, be as extensive as that given on all other aspects of pathology with social repercussions. On the other hand, he does not need to be trained to use examination techniques and therapeutic methods.

The subjects concerning mental health and illnesses requiring special consideration are, in the Committee's opinion :

(*a*) epidemiology of mental illnesses, including collection of statistics as for physical illnesses ;

(*b*) development of methods of psychiatric assistance ;

(*c*) rights and responsibilities of society toward mental patients (legislative problems concerning the liberty of the individual, the protection of society, the safeguarding of property, and the right to prolonged care, etc.)

(*d*) facilities for case-finding and treatment :

community leaders and agencies, e.g., clergy, educationists, police ; outpatient clinics, day hospitals, domiciliary care, hospital treatment, half-way houses, sheltered workshops, social and professional rehabilitation, social assistance for the mental patient, etc ;

(*e*) the principal psychiatric therapies ;

(*f*) recruitment, training, qualifications and status of psychiatric personnel (doctors, psychologists, social workers, nurses, re-educators) : the Committee considered that this question should be treated in detail because it affects all other aspects of activities carried out against mental illnesses.

The aim of the teaching of *interviewing technique* is to increase communication when two or more people work together to solve a problem. Many of the basic principles in this field stem from the clinical experience of the

psychiatrist, particularly the psychoanalyst, in the peculiarly intensive situation of the therapeutic interview. These principles have been further extended, simplified, and made more easily teachable by other professions, particularly psychology, social work, and nursing. Again, interviewing is perhaps most important in the mental health care programme. An appreciation of its techniques and principles will enable the health officer better to co-operate with specialists in that field. It has far wider significance, however, since almost all the health officer's professional work involves influencing people towards proposed patterns of action.

One of the major responsibilities of the public health officer has been stated above to be the *co-ordination of health services* in his community so that services are available when needed and to the extent that they are needed. The development of programmes for services to accomplish these aims is thus a primary part of the education of the public health officer. Such subjects as collection of statistics, theory and techniques of communication, social psychology, personnel management and principles of administration are pertinent as background for the design of health programmes, but the specific application to the mental health field must also be included in the health officer's education.

Study of the detailed application of these principles and techniques to various kinds of local conditions will also be necessary. This will entail examination of the way different communities finance their health and social welfare services, since in some countries continuity of programme involves the co-ordination of the expenditure of funds which may come from many different sources.

The Committee recommended that WHO support the inclusion of training in mental health and the mental illnesses as a part of the curriculum in all public health training centres, and that this training be compulsory, in amounts appropriate to the needs of all persons taking postgraduate courses in public health.

5.1.3 *Training of the general practitioner*

This involves the application of the theoretical knowledge listed in section 5.1.1 to the various situations met by the general practitioner in his practice :

(*a*) techniques of clinical examination of patients with psychological symptoms or with physical symptoms of psychological origin : limits of general practitioner's technique ;

(*b*) mental hygiene : the study of important life-events and preparation for them (attitude and knowledge) to enable the general practitioner to lessen anxiety which might otherwise constitute considerable stress for the patient ;

(*c*) the impact of illness on patient's attitudes;

(*d*) psychosomatic medicine: study of various types of disorders where the emotional mechanism seems important (cardiovascular, digestive, pulmonary, cutaneous disturbances, etc.);

(*e*) minor neurotic manifestations;

(*f*) major neurotic manifestations;

(*g*) the warning symptomatology of mental disturbances — changes from previous behaviour;

(*h*) diagnosis and management of the most common syndromes in mental disorders (depressive, paranoid, confusional, stuporous, manic, intellectual deterioration, and anxiety syndromes);

(*i*) diagnosis and management of mental retardation, lesions of the central nervous system, including those causing aphasia, agnosia and apraxia;

(*j*) measures to be taken in cases of acute mental episodes: emergency treatment, hospitalization, possible administrative measures;

(*k*) methods of treatment: scope and limits of psychotherapy carried out by the general practitioner, drugs used in the treatment of mental disorders, physiotherapy and functional re-education: relaxation, exercise, work, etc.; rest and its indications and contra-indications; management of patient's environment — liaison with social services.

Some of the above programme would be necessary to enable the general practitioner to make early diagnoses and refer the patients to specialists. Other subjects should be covered more completely because they concern the treatment of patients whose disorders are within the general practitioner's competence (see section 3). Both the limitations and the opportunities of general practitioners should be the subject of active consideration during their mental health training. It will become easier to do this as they gain knowledge of the therapeutic possibilities of psychiatry and the facilities to which they can refer their patients (outpatient clinics, hospitals, sheltered workshops, etc.).

As the term "psychotherapy" has different meanings according to different schools of thought, the Committee wished to specify that it is used here in its traditional sense, i.e., a psychological attitude combined with action of a therapeutic or preventive nature. The question arose of the possible danger of initiating the general practitioner into the principles of a method which, in certain forms (for example, psychoanalysis) should be reserved for specialists. The Committee considered that ignorance is no safeguard, and that the risk is greater when the general practitioner is left to invent his own techniques than when he is given enough training to enable him to participate in the treatment of mental disorders and to appreciate

the limits of his competence. These limits were formulated with reference to medical students in the ninth report of the Expert Committee on Mental Health as follows:

"The Committee felt that to instruct a student in existing psychotherapeutic methods was useful only in so far as he would know what can be expected from them and in which cases they might be indicated. The Committee believed that the medical student should not be given systematic teaching in psychotherapy but that he should be made aware of the plasticity of the human personality and behaviour and of the necessity for a psychotherapeutic attitude." [1]

Postgraduate training should aim at enabling the general practitioner to go further: that is, to assist in modifying attitudes and behaviour in patients, especially with reference to the treatment of certain psychosomatic disorders and minor neurotic disturbances. This involves understanding of both the patient's and his own personality. The Committee did not consider it possible to define the limits of the general practitioner's psychotherapeutic activity. It agreed that his instruction should be sufficient to enable him to recognize the limitations of his own training.

The Committee paid attention to the problem of the use of psychotropic drugs by general practitioners. It recommended that the general practitioner be fully warned of the disadvantages of undue recourse to these drugs. They are of great therapeutic value but the ease of application leads to abuse. Some of them have dangerous side-effects. The same reserves apply to drug therapy as to psychotherapy.[2]

As set out, the above subjects represent initial postgraduate training for young doctors. Many of them can also be selected for use in refresher courses given to public health officers and general practitioners.

5.2 Methods of training

In the absence of organized teaching there are various means of enabling public health officers and general practitioners to improve their knowledge in mental health. Besides what is inevitably picked up by experience, much is, of course, learnt by physicians from printed matter. Discussion with partners in a group practice may be helpful: intellectual isolation may be a serious problem for doctors who work alone. During their daily activities, there are many opportunities for the public health officer and general practitioner to communicate with and learn from psychiatrists. When the public health officer has to take a decision of a social nature

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[1] *Wld Hlth Org. techn. Rep. Ser.*, 1961, **208**, 14.

[2] These problems have been considered by a WHO Study Group on Ataractic and Hallucinogenic Drugs in Psychiatry (*Wld Hlth Org. techn. Rep. Ser.*, 1958, **152**).

concerning a mental patient (rest, return to work, etc.) he frequently confers with the psychiatrist. He often has recourse to the latter's advice when he must himself advise the administrative authorities on a measure concerning the welfare of mental patients. The general practitioner may meet the psychiatrist during consultation concerning one of his clients. The psychiatrist usually sends the general practitioner a report on the diagnosis and treatment of the patient referred to him.

Personal research conducted by the general practitioner may also have decided educational value.

However many these occasions, they do not provide training which the Committee considered sufficient. Various types of planned training will be needed, a number of which are discussed below. Each is valuable and can be used in variable proportion depending on whether the general practitioner or the public health officer is to be reached, the stage of training which the doctor has already attained, and local conditions, for instance, availability of teachers.

In the training methods aimed at inculcating a proper psychotherapeutic relationship between doctor and patient, it is important that the trainee should maintain a continuous therapeutic relationship with his patient, should be given ample opportunity for checking the validity and efficiency of his technique, with recourse to a supervisor when necessary, and should be able to observe the techniques used by experienced physicians.

5.2.1 *Trainee assistantships*

The training value of an assistantship lies in the fact that on the one hand there may be an identification with the teacher and on the other hand collaboration with the other members of the therapeutic team during concrete situations which do not unduly involve the personal responsibility of the assistant.

There has been some experience of the use of the general practitioner as an " integrator " in general hospitals. He can develop an important function by studying the psychological and social relationships of the patient and interpreting the patient as a person to specialists. This assists in the understanding of the conditions under which the illness developed and how they may affect cure. Supervision of the integrator's work can be established by his taking part in team discussions with the social worker or sociologist, the psychiatrist, the psychologist, and the patient's family doctor, where these are available.

In a few areas, clinical assistantships in psychiatric departments of general hospitals and in psychiatric outpatient departments have proved a valuable training device for general practitioners. A period of training within the mental health service is required of some public health officers before they take up their administrative duties.

A few countries provide one- or two-year periods for trainee-assistantships in general practice. The young doctor is attached to an experienced general practitioner as apprentice. He is partly trainee, partly assistant, accepting increasing responsibility for cases as the year proceeds. This is an important opportunity for learning the art of patient-management by example and the long period of association with a single teacher has its special value, providing the teacher is good. It is important that the teacher should regularly discuss the trainee's own cases with him. This may be the first time that the young doctor has had personal responsibility for psychiatric problems and he may ask for much help. The trainee assistant period usually leaves freedom to attend short courses in psychiatry.

5.2.2 *Lectures*

The lecture has been maligned as a mental health teaching device because it does not directly involve the student but allows him to sit more or less passively and listen to the presentation. As already noted, however, there is much mental health knowledge that does not involve the personality of the student any more than does the study of mathematics. Such material can be taught by lecture, provided the student is motivated to listen. Probably more material can be presented in a lecture session than in any other form of teaching. Also, the lecture method of teaching ensures that a logical sequence of material will be presented and that the student will have a framework around which to organize facts available to him. It does not, except in the hands of very gifted lecturers, provide for the emotional involvement of the student agreed to be necessary for the best learning in this field. However, the value of the lecture can be increased if it is followed by a question period. Lectures (and discussions) can reach doctors in remote areas through tape-recordings which can be circulated by post.

5.2.3 *Seminars*

Seminars, as understood here, are working groups of limited size devoted to the study of a definite problem with the collaboration through mutual instruction of participants and one or more teachers. This form of instruction enables the students to participate actively and forces them to make some preparation and to make an effort at expressing themselves. It also permits discussion to be carried on. For this reason, it is preferable to lectures, but it is a more time-consuming method of dealing with the same subject. It has the advantage of giving training in teaching which may be needed more by the public health officer than by the general practitioner. Seminars for small groups of public health officers are valuable for free discussion of the detailed application of principles to local conditions. For this training, seminars can usefully be combined with observation of units in operation.

Where psychiatrists are receiving postgraduate training in public health, their interaction with other public health trainees during seminars may assist in giving adequate emphasis to mental health aspects of other medical problems discussed.

5.2.4 *Case conferences*

Case conferences may afford the opportunity for doing the work of diagnosis and management of a case vicariously through listening to the story of how another physician experienced the procedure, or may throw new light on a case the general practitioner has been trying to manage alone. Like the seminar they give an opportunity for raising questions and hearing them discussed by the group. As much theoretical discussion can be included as desired, but the necessity of deciding on a plan of action helps to keep the practical aspects in the forefront. On the other hand, small clinical services may not afford the range of diagnostic and therapeutic challenges necessary to the comprehensive study of the field, and the experience obtainable will then be incomplete. Also, unless case conferences are skillfully led they can degenerate into mere label-attaching sessions, serving administrative purposes rather than the needs of the patient or the education of the participants.

5.2.5 *Discussion groups*

The techniques of group dynamics for postgraduate training of physicians have been used with success during recent years by particularly qualified specialists. Free discussion in such groups aims at drawing out and influencing emotional attitudes more than at increasing intellectual knowledge.

A method introduced in Great Britain and now being employed elsewhere, often with modifications, is based on regular weekly discussion meetings of a group of 6 to 10 general practitioners under the guidance of a psychiatrist. Each session lasts about two hours and the meetings continue for about 36 to 40 weeks per year. The total length of the course is 2-3 years (or even longer), the length of training depending on the degree of proficiency that the doctor wants to attain. The meetings are quite informal and have no fixed agenda. The doctors are asked to report about the emotional problems of patients they are treating, especially about complicated or difficult patients ; these reports are then discussed by the various members of the group with special emphasis on what sort of therapy each patient might require, and how the patient will respond to that particular therapy. There are always some differences of opinion, and in this way the doctor learns to see himself and his professional behaviour constantly in contrast to others. The succeeding discussion groups demonstrate the immense variations in possible therapeutic approaches, and since an attempt is

made to follow up the cases reported, the efficiency and the limitations of the various therapeutic approaches can be considered. The doctor is encouraged to understand the meaning for the person of the complaints and illnesses which he offers to the doctor. Moreover, while the doctor reports himself or listens to the reports of his colleagues, he not only understands but also becomes aware of his feelings, that is, he realizes his own contributions and his own emotional involvement in each case. As during the whole time he is under the constant pressure of his therapeutic responsibility towards his patient he cannot help—sooner or later—but experiment with one or the other therapeutic attitude that he has heard reported in the discussion groups. Patients are quick to sense any such change and their changed reaction cannot fail to impress the doctor. Not every new line of treatment adopted by the doctor will be successful, and not every changed reaction in the patient will be in a therapeutic direction. Still, failures as well as successes leave their mark and in turn teach the doctor something about the better use of his own personality in the psychotherapeutic relationship. This training method can, however, be used only under the guidance of a competent leader and it may be difficult to apply for general practitioners in outlying areas. Nevertheless, the Committee considered that this method is one of the best at present in use for enabling the general practitioner to handle emotional problems in his patients.

On the other hand, participation in this form of discussion group does not seem a useful training method for the public health officer. He can, however, benefit considerably from similar methods which also use group dynamics, but where the discussion centres on current problems of social medicine. Staff discussions on actual cases with representatives of various professions are also valuable. The public health officer should be particularly well-versed in the art of chairmanship for multiprofessional meetings.

5.2.6 *Community study*

Complementing the methods of studying the situation of the individual in his particular environmental setting, there may be opportunities for studying the community itself. When the study is extensive and elaborate it is likely to be described under the title " survey ". What is being discussed here, however, is something much less pretentious, though it is often included in a survey-type study.

Communities take care of their problems in various ways, some of which are rational, clear and highly organized, others unorganized, rather hidden or secret, and quite irrational. Sometimes, they are simply traditions that had real meaning when established but persist for reasons no longer apparent. Those studying mental health care in public health courses should have the opportunity to go into the community to observe how such problems as the hospitalization of the severely mentally ill, the

management of the juvenile delinquent, welfare services, and the rehabilitation of prisoners and the crippled are managed. The diagnosis of the retarded child, the attempts to resolve marital difficulties, the legal consequences of child or family abandonments are all types of issues suitable for such study, which may occasionally result in genuine contributions to knowledge. This sort of work is sometimes called field observation, which is too often a passive type of watching, whereas what is implied here is a more penetrating study of what is happening and, to some extent, why it so happens. When carried out by a group, each taking a different subject for investigation, considerable breadth as well as depth of understanding of the community operations can be gained in a relatively short period. So far as is known no such plan has been used in in-service education but it is a feature in some types of institutional teaching.

5.2.7 *Family study*

Study of the health problems of families over several years has been incorporated into teaching programmes of a number of medical schools. The objective is to furnish the student with the opportunity to observe the life of the family as it copes with various major and minor crises. Most public health training courses are too short to make use of this sort of pattern, but some of its features may be incorporated in short-term teaching contacts through the use of cumulative records to which the student has access.

The method of long-term observation is also ideal for the study of child development and of the changing patterns of parent- and sibling-child relationships. Record-keeping in this area has proved a particularly difficult problem, though much can be learned from series of drawings produced over periods of years and from other samples of the child's creative activity.

5.2.8 *Inclusion of mental health aspects in other public health courses*

One of the difficulties in the teaching of mental health is the pervasiveness of mental health issues, which enter into almost every kind of health problem. This has not been recognized in many areas of health activity as fully as it might be. The mental health group is thus left with the obligation to attempt to see that consideration is given to the mental health aspects in other relevant health teaching.

The basic statistics regarding serious mental illness and loss of social productivity, the cost of disease to populations, etc., have been available for a long time in some countries. Because they are unfamiliar to most statisticians, however, these data are rarely used in teaching statistics at the present time. They must therefore be incorporated in the mental health education curriculum in most schools and in in-service educational pro-

grammes. Similar statements could suitably be made about chronic disease problems in general ; as these problems expand they tend to lead to statistical studies of the mental diseases being included in the basic teaching of biostatistics. Likewise, the epidemiology of the mental diseases should be included in the teaching sequences in epidemiology rather than as special courses in a mental health sequence. For the present, however, it will probably have to be taught by those particularly interested in this speciality. The teaching of communicable diseases and of the microbiology underlying them should include the study of the psychiatric symptoms and complications that occur. There is a considerable literature on psychological selection of employees, on mental health aspects of working conditions, and on the evaluation of absenteeism in industry. These topics should have a place in the teaching of industrial hygiene and will, in many instances, have to be taught by mental health experts co-operating with industrial hygienists whose interests and experience do not include this field.

The implication of much of the above is that the mental health aspect should be simply a part of teaching on relevant medical subjects. This is an ideal, and probably is nowhere in operation. Under existing conditions the mental health educational group is likely to be called upon to teach in different courses of study. This situation presents very real problems for the mental health teacher who must adapt himself to many different teaching situations and whose knowledge must be very broad. Most schools of public health do not have large mental health faculty groups ; this will often mean that experts working in the various fields will be asked to become part-time faculty members in order that specific aspects may be adequately presented. The pedagogic principles of this sort of teaching are reasonably firmly established, but require constant attention if genuine integration, not merely presentation in juxtaposition, is to be accomplished.

5.2.9 *Duration of initial training*

Here again, the requirements differ, depending on whether the public health officer or general practitioner is being considered.

Public health officers in particular need complementary training giving broad information. The Committee considered that the part of the training concerning mental health can be included in the public health curriculum, as it is now in many schools.

In order to modify the emotional attitudes of general practitioners so that they can handle mental problems in their patients, a longer period of training is required. Such training can be carried out through working sessions held, for example, at weekly intervals. It must, however, be noted that the spacing of these sessions is not unimportant and varies according to the technique used, while the total duration is rarely less than two years. Refresher courses at more or less frequent intervals are necessary.

5.2.10 *Encouragement to undertake postgraduate training*

In those countries where postgraduate training for general practitioners is not compulsory—that is, the majority of countries—few doctors at present attend courses in mental health care. The Committee therefore considered methods of reaching large numbers of general practitioners.

The increased attention which is being given in many countries to mental health in the undergraduate curriculum is likely to stimulate the desire for postgraduate study. More general practitioners are becoming aware of their need for training, both from their own experience of inadequacy and from the pressure of their patients' expectation.

Section 4.1 of this report is also relevant to this problem.

5.3 Facilities for training

5.3.1 *Accommodation for postgraduate study*

A simple solution to this problem can usually be found. In the case of the public health officer, training is given either in a university building or in a separate school of public health. The teaching of mental health at this level does not necessitate any special technical installations and any meeting room can be used. Moreover, assistantships are carried out in hospitals which, if they are equipped to receive the assistants, always have meeting rooms.

In permanent educational institutions the mental health teaching group should have its offices and library situated adjacent to the other elements of the school. This is important in order that the integration of mental health into public health practice should be obvious even at this simple level. Such juxtaposition of the offices has not only the advantages of easy consultation across departmental lines and informal friendly contacts that can break down any tendency to isolate mental health interests, but it also has symbolic significance, emphasizing the unity of the field of public health.

5.3.2 *Teaching personnel*

This problem is much more difficult to solve because of the dearth of psychiatrists in general and particularly of psychiatrists capable of giving this type of training. Mental health is not taught in some schools of public health simply because there are not enough competent psychiatrists available for teaching.

As mentioned above, there are great advantages in the incorporation of mental health aspects into basic health courses. The Committee recommended that the administration of mental health programmes should be included in courses on public health administration, the epidemiology

of the mental illnesses in general courses on epidemiology, and so forth. The mental health faculty may be involved in teaching in these courses or may furnish material for them.

As regards assistantships (see section 5.2.1) a good teacher is indispensable; particularly for discussion groups an experienced leader is difficult to find. However, the experience required does not necessarily imply classical psychiatric training. It is to be hoped that some general practitioners will become sufficiently well-trained in these techniques and be able to act as leaders, perhaps in collaboration with a psychiatrist.

All these problems are linked together and this is one reason the Committee wished to refer to the need for recruiting and training psychiatrists who are able to give this kind of advice and support.

5.3.3 *Teaching material*

No special equipment is essential for instruction in mental health, but extensive use can be made of tape-recordings and films, as for some other medical teaching. The Committee pointed to the need for suitable handbooks of medical psychology for the use of general practitioners, and for more articles on problems of mental health in journals of general and social medicine.

The mental health library for in-service training should contain, in addition to standard reference works on public health, basic texts and collections of readings in sociology, anthropology, child development, psychology, and social work, as well as books dealing directly with mental health in public health.

5.3.4 *Access to clinical facilities and to community agencies*

In-service teaching programmes often have the advantage of having mental health agencies directly under their control or the control of the health department in which they take place. These agencies will rarely if ever comprise the full range of mental health activities, however. The educator will need to use operating community mental health agency personnel for some teaching, and the agencies themselves for opportunities for observation and for research. It is thus incumbent upon the mental health group to maintain the closest possible relationship with schools, welfare services, mental hospitals, etc. Such relationships are best sustained on a *quid pro quo* basis; this means that the teaching group will need to make some contribution to the reciprocating agency, such as consultative services, either clinical or on research projects, in offering training courses, in sharing research results, in serving on Boards of Directors or in direct or indirect financial subsidy to the agencies concerned. The opportunity for those taking courses to observe the work of an agency, or to use the

research opportunities offered by an agency, must be paid for by a responsible attitude toward the agency. Only thus can a continuous, mutually productive relationship of co-operative teaching and research, be sustained over the years. When clinical psychiatric teaching is a part of public health officer training, the arrangements must usually be planned far in advance so that the clinician may introduce the student at a convenient time in relation to the programme of work.

5.3.5 *Financial resources*

In some countries there are official budgetary provisions or private resources which usually enable public health officers and general practitioners who so desire to undergo further training. As regards the public health officer, if the training in mental health is incorporated into the teaching of the specialization of public health, no separate problem will be involved. The Committee supports recommendations that all public health officers be enabled to follow refresher courses lasting a few months every 3 to 5 years. As regards the general practitioner, often he can give a little time to training only by extending his hours of work. For all attempts to increase his training, the general practitioner in many countries not only must bear the cost, but he also incurs loss of income. The Committee suggested that means of organizing the postgraduate training of the general practitioner be considered, as well as means of covering the cost not only of instruction but also of loss of time entailed.

6. RESEARCH ON MENTAL HEALTH CARE IN RELATION TO PUBLIC HEALTH OFFICERS AND GENERAL PRACTITIONERS

Research, by definition, works at the advancing edge of knowledge where the unpredictable curiosity of the researcher is the guiding factor. In many countries, mental health research appears destined for some time yet to be centred on the curiosity and hard work of an individual or small group, rather than to be a function of a large organization directing a number of researchers toward the solution of a particular problem or group of problems. There are, however, areas of the world where funds now provided for mental health research are more commensurate with the social loss incurred by the ravages of the mental diseases and disorders. It may be expected that the near future will see the multiplication of psychiatric and mental health research institutes. Such a desirable development would not make unnecessary the devoted research of a curious clinician or the stringent evaluation efforts of a health administrator in the field.

There are certain kinds of research for which public health officers and general practitioners are particularly well suited. Research in mental health carried out by the public health officer will, in general, deal with data on groups of people rather than on particular, identified individuals. The health officer has the opportunity to view the total population in all its variety of social, economic, cultural, ecological and religious diversity, whereas the general practitioner's viewpoint will, of necessity, be limited by the location of his practice and the constitution of his clientele.

6.1 Research by public health officers

As the horizon of mental health care widens and the older static concepts change into more dynamic ones, prospects for treatment and prevention increase. This makes valid and reliable information imperative as the basis for present and future planning.

Methods for dealing with large bodies of data, for organizing these to yield information and for determining the significance of differences have been developed by statisticians. The application of statistical methods to health data is one of the basic tools of public health research generally. Biostatistics is a tool available to the public health officer for application to research problems regarding mental health and ill health in the community.

The quality of the statistics depends, of course, on the completeness and accuracy of the basic data. Also, clearly stated objectives of the investigation, definitions for the collection of the data, and appropriate classification procedures are needed for obtaining adequate statistics.

Mental health is not easily reduced to clearly definable items, and classification of the mental illnesses is notoriously difficult. Nevertheless, much can be done with existing systems and further work in the public health setting will undoubtedly help, along with other types of research, to improve the methods by which basic data are gathered in order to improve the quality of the information.

6.1.1 *Collection and analysis of service statistics*

(*a*) Statistics should be included from all types of relevant services, such as : hospitals, general and special ; outpatient services for children and adults ; patients seen privately by specialists and general practitioners ; others.

(*b*) Roster-type data collection : the register or roster of persons receiving or who have received mental health care : this method avoids the problem of duplication of cases, but presents certain problems in regard to the confidential nature of medical information.

Research questions that can be asked of such collections of data are very numerous. The following are a few examples:

(*a*) How are mental health services distributed according to segments of the population (age-group, sex, economic group, geographic area, etc.)?

Obvious over-usage or under-usage calls for further study to discover any reasons for the differences. The material may also be used for planning location of facilities or selecting areas for special preventive efforts. The distribution of mental diseases in the population, a problem in epidemiology, is approachable through such data-collecting systems. Some segments of the population may be subject to specific diseases more than others.

(*b*) What is the natural history of the mental illnesses? This problem can be approached through the register system suggested. There are a large number of unkowns in this area, for example, the relation of behaviour disturbances in childhood to later mental illnesses and movements of patients in and out of various treatment facilities.

6.1.2 *Special-survey studies*

Examples might be the determination of the distribution of an item of behaviour (e.g., rigid as against permissive patterns of feeding infants) in a sample of the population, using trained interviewers or health department personnel to collect the material.

Attitude studies, such as estimating public acceptance of a change in service, also come into this category.

6.1.3 *Evaluation of services*

Methods for the evaluation of mental health services are not as yet very well developed; indeed, this applies to most fields of public health. The Committee suggested that WHO consider stimulating special projects or studies on methods of evaluative research.

It may be pointed out that there are many questions that can be answered only on the basis of large amounts of data. This is true particularly when the expected change is small.

An example of evaluative research would be studies of whether supportive care for psychiatric patients after their discharge from hospital affects rates of re-admission. Studies of the effectiveness of drugs could also be included in this category. Another large and pressing problem suitable for this type of research is the effectiveness of various types of personnel in performing specific health tasks.

The Committee recommended that WHO take further steps to promote communication between workers in different parts of the world concerning

research methods and results in the area of mental health and illness. Workers engaged in parallel research might thereby gain from each others' experience, avoid unnecessary duplication, and make comparisons as far as this is possible. The mechanics of communicating such information have been the subject of considerable study and it is generally agreed that the task may be both difficult and expensive.

6.1.4 *Financing of research*

The Committee considered that research should be an integral part of health service activities, and work in training institutions. The budgets of such services and institutions should therefore include allocations for research; staff should receive recognition and, where appropriate, emolument for carrying out research projects.

6.2 Research concerning general practitioners

The work of general practitioners in mental health will gain from most of the important advances in psychiatry and public health. It is possible, however, to identify certain areas of knowledge where difficulties are greatest and where an advance would be of particular value to the general practitioner. The Committee suggested the following subjects for research designed specifically with this aim in view:

(*a*) Meanings of words current in psychiatry. Agreement is needed on the meaning of such words as "anxiety" and "depression".

(*b*) Classification. This major contemporary problem of psychiatry also troubles the general practitioner. Systems of classification need extension to cover the minor and less easily defined cases that he sees.

(*c*) Epidemiology of mental illnesses. What kinds of illness does the general practitioner meet?

(*d*) Which cases can a general practitioner treat himself? What are the results of his treatment?

(*e*) How does he decide that a patient is cured?

(*f*) What are the indications for formal psychotherapy and what are the results?

(*g*) Controlled trials on psychotropic drugs.

(*h*) Evaluation of training methods for general practitioners in mental health subjects.

Some of the subjects listed above might be studied by general practitioners themselves, either by collaborating in studies organized by others, or by organizing their own studies.

There are certain guiding principles for research carried out by general practitioners and these apply also to research in the mental health field :

1. Experts should preferably be consulted at the planning stage. In many instances the public health officer may be contacted first. He may give advice on scope, design and technique, and may be in a position to bring in other experts : the biostatistician, epidemiologist, social psychiatrist, sociologist, anthropologist.

2. The subject must appeal to the general practitioner as important. It must be clearly defined and not too ambitious. The difficulty of processing complex and extensive data is often not at first realized.

3. The research task should fit as easily as possible into his routine work.

4. A systematic periodic review of the course of the investigation with the participation of all concerned is often valuable.

5. The research should have a clear end-point.

6. Negative results and carefully analysed failures should be reported as well as positive results and successful investigations.

These principles apply whoever is organizing the research. In recent years, a considerable volume of research has been initiated by general practitioners, either individually or in groups. Central bodies to co-ordinate such efforts regionally and nationally could be of value.

There are innumerable subjects for study in the mental health aspects of general practice and there is no need for general practitioners to choose subjects which lend themselves better to the skills of the psychiatrist or public health officer. Subjects particularly suitable for study by general practitioners will vary in different cultures. Here are some examples :

1. Descriptive studies of cases or groups of cases, particularly if they are unlikely to be seen by other doctors or if they require long follow-up. The general practitioner may be particularly well placed to assist with longitudinal studies and to collect data on the course of untreated diseases.

2. Epidemiological studies to determine what sort of cases the general practitioner sees. Such studies become valuable if they are based on an agreed classification.

3. Family studies—mental illnesses affecting several members or generations of a family. The effect of one or more ill persons on the rest of the family.

4. Studies of people who do not come to the doctor. Here the doctor might receive assistance from the public health officer or public health nurse.

5. Study of the emotional reactions of patients who are physically ill or have surgical operations.

6. Studies of the doctor himself and his work. How is his time spent? How does he deal, for instance, with night calls? How can he evaluate his results?

The work of the general practitioner may also be the subject of investigation by others. Relevant subjects for study would include his role in the chain of available facilities for mental health care.

In sampling populations for mental health research, general practitioners may co-operate by providing data from their files on members of the sample. When multi-disciplinary research is being carried out, the general practitioner can usually be included in the working party at the planning stage.

7. RECOMMENDATIONS

7.1 Training

1. The Committee recommended that WHO lend support to the inclusion of training in mental health and the mental illnesses as a part of the curriculum in all public health training centres, and that such courses be compulsory, in amounts appropriate to the needs of all those training in public health.

2. The Committee has regarded the general practitioner as a person who requires knowledge and skills that other doctors do not possess and that cannot be adequately provided in an undergraduate course. He needs a special further training. The Committee recommended that the training of the general practitioner, both in mental health and other subjects, should be further studied on an international level. It suggested that when this is done a reassessment should be made of the distribution of studies between undergraduate and graduate training.

The Committee's discussions in its particular field have led it to recognize that the role of the general practitioner is changing. His future role deserves further study by an international organization.

3. The Committee recommended that WHO should encourage countries to consider means of organizing the post-graduate instruction of the general practitioner and to provide funds so that both cost of instruction and loss of income during instruction can be defrayed.

7.2 Research

The Committee recommended that WHO should stimulate :

(1) investigation into systems of classification better adapted than present systems to the needs of the general practitioner in the mental health field ;

(2) study of the methods of evaluating the training and work of public health officers and general practitioners concerning mental health care ;

(3) studies using research survey methods of attitudes of public health officers and general practitioners to mental illness and mental health ;

(4) study of the role of other trained personnel in mental health care ;

(5) study of cultural differences in choice of person approached for help with mental problems ;

(6) communication between workers in different parts of the world, giving information about research (methods and results) on the role of public health officers and general practitioners in mental health care.

(7) the formation of central organizations within countries or in groups of countries to co-ordinate the individual and group research efforts of general practitioners : these would vary in structure, function and composition according to regional and national conditions.

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