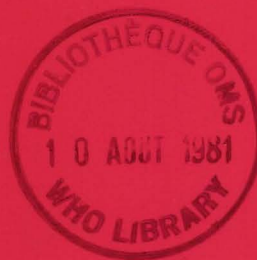


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social
dimensions
of
mental health



WORLD HEALTH ORGANIZATION

SOCIAL DIMENSIONS OF MENTAL HEALTH



WORLD HEALTH ORGANIZATION

GENEVA

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Introduction

In response to ideas and principles which determine the nature of mental health work, the WHO mental health programme over the last few years has adopted a multi-disciplinary public health approach and expanded its scope to deal with a broad spectrum of mental, psychosocial and neurological problems.

The programme needs further change and evolution and this paper presents the framework for thinking about its further development. The solid base of continuing cooperative work in some 80 countries and the mechanisms which the programme has developed to ensure full participation of countries in programme formulation and implementation will both be important parts of this framework. But there are two further elements of the framework which come from a reappraisal of fundamental health values taking place now while strategies for Health For All by the Year 2000 are being formulated.

The first springs from the nature of human life: Man is a thinking being; inner experience linked to interpersonal group experience – in other words, mental life – is what makes people's lives valuable. To be human is to think, feel, aspire, strive and achieve, and to be social. Promoting health therefore must not only be concerned with preserving the biological element of the human organism: it must also be concerned with enhancing mental life.

The second element emerges from the fact that in spite of the successes of public health and medicine the world faces a pandemic of chronic disability. Prevention of disability and promotion of wellbeing must therefore be given as much attention as the prolongation of life. Where disability is unavoidable, health workers must be able to help people to live with disability.

In its attempt to recast health thinking in general and mental health efforts in particular, WHO needs the guidance, response and support of enlightened health activists all over the world. This paper seeks to stimulate a further radical rethinking of mental health principles and to solicit widespread support for the practical work which would follow as a central theme of WHO's and countries' cooperative mental health programmes.

The paper has three main parts, resting on three basic premises:

1. Health work must recognize that mental life is what makes people's lives valuable.
2. Mental health technology can improve health care in general.
3. Mental and neurological disorders can be prevented or treated and their associated disabilities averted or diminished.

I. Mental Life Gives Value To Living

Economic growth and social change exert significant influences on the mental life of individuals and the structure and functioning of families. When insufficient attention is given to this fact the cost of progress, in terms of diminished quality of life, may be unnecessarily high. The application of mental health knowledge could help to prevent harmful psychosocial consequences of socioeconomic change and facilitate harmonious development.

Man pays a high price for the economic and administrative advantages of living in cities. The massive growth of cities and their populations, mainly in developing countries, is expected to continue until at least the end of this century. By the year 2000 more than three billion people will inhabit them and many will be first-generation urban dwellers.

***Unchecked
urbanization
and mental
life***

Overcrowded slums are the most glaring result of unplanned and unchecked urban growth. Tens of millions live in such slums in industrializing countries, with disastrous effects on the quality of life. Psychological tension, alcohol abuse and its related problems, traffic accidents, drug dependence, educational failure, violence and crime are rampant in them. In contrast to the teeming slums of developing countries, a problem in many developed countries is that up to one-third of urban households contain only one person; and small family units that find it difficult to look after a disabled member are much more common than larger households which are usually better able to buffer stress.

The nineteenth century founders of the public health movement found answers to the infectious diseases that plagued their cities in sanitation and food hygiene. Modern epidemics of psychosocial ills demand preventive measures on an even greater scale to improve today's and tomorrow's cities. A new alliance between architects, engineers, planners, health experts and behavioural scientists is needed to design or redesign them and service them to accord with people's psychosocial needs rather than with economic criteria. Above all, people must be given the conditions and the challenge to better their own lives by mutual support and self-help.

*An example
of a mental
health
initiative
in activating
a deprived
urban
community*

A striking example of the use of mental health expertise to mediate community self-help is provided by the initiative taken in 1975 by the Mental Health Section of the Ministry of Public Health and Social Assistance of Honduras. The scope of the country's mental health programme was seen as being wider than merely administering conventional mental health services. The greatest need was among the poverty-stricken inhabitants of the city *barrios*, where living conditions were extremely bad and violence, unemployment, family instability and alcoholism abounded. A community mental health project was undertaken in the *barrio* of Santa Eduvigis to better understand the social and cultural dynamics of a shantytown and to promote mutual support and self-help. Instead of applying professional technical solutions separately to each problem, the project sought to build up the community's own strength and capacity to react. It used mental health techniques to promote active participation of the people and raise their level of social consciousness so that the people came to understand the need to organize themselves and cooperate in problem-solving. People who had previously suffered resentfully their apparently hopeless predicament were persuaded to begin to work together. Thus a women's group led by the project's psychologist learned not only about hygiene, health care and household management,

but also how to deal with behaviour problems and the highly prevalent psychosocial ills of the community. It then went on to work with the community at large to improve nutrition and to set up an active democratic community organization which eventually transformed the physical environment and the way of life of the *barrio*.

The Honduras project shows the practical and concrete benefits that a community can derive from the application of mental health knowledge and skills. But this kind of technology is too rarely used, as is testified clearly by the commonly deplored predicament of migrants in host countries. Never before have there been such large migrations of people in search of work and new homes. Their economic and socio-political causes vary from one migration stream to another, but their psychosocial and health effects are similar: the acute sense of uprootedness, difficulties of adjustment, frustration of expectations and a restriction of the social field which in turn lead to increased rates of psychosomatic disease, under-use of health care and sometimes deviant behaviour. In many places migrants are subjected to discrimination and prejudice, denied human rights and exploited as cheap labour.

***Mass migration
and its psycho-
social
consequences***

Certain extreme situations, such as the depletion of the adult males of some small countries bordering on the Republic of South Africa because they live away from their families to work in South African mines, are known to have grave psychosocial and health consequences both for the migrant workers and for their families deprived of fathers and husbands for long periods of time. Similar but less severe problems are associated with other widely prevalent instances of economic migration, often in groups given least attention such as migrants' children who are torn between two cultures, or the elderly left behind in the home country.

Migration is a complex problem, and its economic and sociopolitical causes and consequences have to be dealt with by the governments and international agencies concerned. Its psychosocial and health consequences, however, are of immediate concern to health planners. Migrant families need counselling services for their psychological and day-to-day practical problems; health workers have to be trained to recognize and manage the syndromes of acute and chronic psychosocial uprootedness; and administrative arrangements must be made to help migrants to adjust to new conditions.

***Legislation
and
psychosocial
aspects of
health***

Labour laws and other legislation which deny migrants' rights do much psychological damage. But legislation can be a powerful tool also to improve the human environment and social interaction. The main emphasis of health-oriented legislation has hitherto been on the physical environment (e.g., food hygiene, pollution, housing). Laws affecting people directly have been mainly concerned with regulating contracts such as marriage, divorce, adoption and hospitalization, with little regard for their psychosocial effects. Health professionals have tended to discount the potential of law and legal action for promoting psychosocial aspects of health.

Nowadays legislation is increasingly seen as having a role in health promotion. Legal control is becoming a recognized way of limiting health hazards such as excessive use of alcohol and smoking. Mental health laws can do more than merely control mental hospital admissions and discharges. Countries such as Senegal, Trinidad and Tobago, and Algeria have shown how mental health legislation can promote services and the training of personnel, and protect the rights of the mentally ill.

The nature of the law can affect the outcome of adoption, and the quality of child care and marriage. Child care

legislation can reflect modern knowledge about the psychosocial development of children and their emotional needs. Humane divorce law and court procedures can reduce the distress associated with marital breakdown when it becomes inevitable. Legislation determines too the scope of social welfare services – whether they are concerned only with money payments or are oriented to welfare in the sense of social wellbeing.

There is enormous scope for cooperation between mental health professionals, legislators and lawyers in designing and applying laws and legal procedures that would extend mental health care, reduce the stress of personal conflicts and separations, humanize society's procedures for coping with deviance, and protect the rights and psychosocial integrity of the weak, the disabled and the rejected. Experience from a number of countries in the last decade shows, however, that the health, social welfare, justice and police sectors must work together in recommending and designing legislation and legal procedures derived from sound mental health principles.

*A mental health
input to legis-
lation and
legal
procedures*

But laws alone are not enough: the control of alcohol-related problems shows the need to combine a broad social approach (e.g., by the law) with help for individual problem-drinkers. Legislation and other social action on a national and international basis is needed to reduce or at least contain present levels of alcohol consumption because it has been shown that the prevalence of alcohol-related problems is related, at least statistically, to *per capita* consumption. Here mental health workers, epidemiologists and social scientists can be asked to provide the objective information that lawmakers and others need to analyse the problem and to help in national public debate about legal and socioeconomic measures that would curb what has become an epidemic of alcohol-related problems.

*The law and
alcohol abuse*

But this is not the only responsibility of health professionals, since problem-drinkers also need help. Because there are so many that individual therapy by professional health workers is impracticable, further efforts are needed to utilize the technology which is now being developed to enable at least certain categories of problem drinkers to be treated by general community health workers, even those with little training.

*The law and
drug dependence*

The position is somewhat different in the effort to control drug dependence. Although the use of nearly all drugs of dependence is either illegal or strictly controlled, epidemics of drug abuse occur in many parts of the world. The countries with the strictest legal controls appear to be no more immune than the others.

Opiate abuse has traditionally been the focus of concern. International efforts in the past have dwelt on controlling it by legal measures. Now more attention is being paid to other social strategies. Thus, where opium growing is an important source of income for impoverished farmers and opium is a commonly used folk medicine, there are national and international efforts to replace opium growing by an alternative cash crop and to provide primary health care to decrease use of opium for common illnesses.

*Countering the
abuse of
psychotropic
drugs*

The new drug problem of today is abuse of psychotropics. Concern about it has found international expression in the 1971 Convention on Psychotropic Substances, which has been in force since 1976. Since most of the psychotropics used are prescribed by the medical profession it has an obvious responsibility for examining critically the explosion in their use. In developed countries they are prescribed more often than any other group of drugs: one person in five takes

psychotropic medication in any one year. In developing countries their use appears to be equally widespread, often without prescriptions or health service control. Psychotropics have their legitimate uses, but clearly they are overprescribed and indiscriminately used. This gives rise to a variety of problems such as dependence on hypnotics; hazardous cross-reactions with other medicines, particularly with alcohol; drowsiness and inattention when driving or handling dangerous machinery; confusion in elderly people; and withdrawal symptoms of anxiety, insomnia, inattention and depression.

Health workers often know little about the benefits and risks of these relatively new drugs and hence they do not make the public aware of their limitations and dangers or teach their patients to deal in more constructive ways with their problems. At the same time, laws on psychotropic medicaments need to be examined if their abuse is to be controlled and they are to be used to the best effect.

Another way of protecting and promoting mental health, in which various other sectors besides health have important roles, is the maintenance of family cohesion. The family, in all its various forms in different cultures and societies, can be society's primary agent in promoting health and improving the quality of life.

***Maintaining
family
cohesion***

Families vary in size and form and function, but everywhere two kinds of family are especially prone to behavioural and mental health problems: the incomplete family and the family under stress. The incomplete family, with either one parent or no children, lacks some of the requisites for the normal rearing of children or the gratification of basic psychosocial needs of adults. Family stress can arise also from the burden of chronic illness or disability of

***Families
at risk***

one of its members, which may restrict it to no more than coping with daily tasks, and from parental separation or divorce, bereavement, unemployment and migration.

A number of current trends – falling birth-rates and the aging of populations, rapid urbanization and its effects of splitting and dispersing the traditional large family, the rising prevalence of chronic disability, and the increasing frequency of divorce – suggest that high-risk families will become more numerous. Developing countries are unlikely to be spared the social costs of similar trends as industrialization advances.

Rural/urban migration is a case in point. Young people move from villages and towns to large cities to find work and social stimulation. They often live in extremely bad social and material conditions. They are likely to marry early and have children early and to lack the support that young families in rural communities obtain from the older generations. Too often they think that to enter into the new exciting life of the city they must turn their backs completely on their parents and siblings in the villages. While they are incorporating new values and adapting themselves to new lifestyles they discard socially beneficial traditional values they will not have time to rediscover. More opportunities for maintaining ties with the family of origin – which the modern technology of communication and transport could easily mediate – would lead to less homesickness, less sense of being lost, and less dependence on new acquaintances who exploit them.

The stimulus needed to harness technology to the maintenance of family cohesion, as to other determinants of mental and social wellbeing, could very well come from the health sector because of its responsibility to raise awareness in the other sectors, and in society as a whole, of the

psychosocial hazards to which the family is being increasingly exposed.

Normal psychosocial functioning of the family and the strengthening of its role as the basic social unit requires measures on three levels: social policies, community organization, and focused interventions in risk situations.

*Strengthening
the family*

Family-oriented social policy may be implemented in legislation and economic reform which would prevent family breakdown and reduce the burdens of families. Many countries have taken or are considering measures to assist the family, but too often these measures are concerned only with demographic and economic matters and they lack the psychosocial dimension which would protect the integrity and evolution of the family.

*Social policy
and the family*

Of the various aspects of community organization that affect family functioning one of the most important in the present context is community development. Development projects in general would benefit from a psychosocial screening of their objectives and methods with regard to their effects on family functioning, the degree to which they promote the participation of the family group, and the possible openings that various health programmes offer for extending preventive and supportive psychosocial care to families at risk. A very small proportion of the total cost and effort of a large development project could be invested in forecasting or ascertaining its psychosocial effects on those it is designed to serve.

*Effects of
community
development
projects on
family
functioning*

The health and social welfare services need to give particular care to high-risk families, especially incomplete families, those with chronically sick members, and those that

*Family-oriented
health care*

are underprivileged or stigmatized for one reason or another. Family-oriented health care means a significant shift from the medical approach which concentrates mainly on a patient and a disease. Even the whole-hearted adoption of the concept of primary health care would not automatically ensure that the single disease or the single sanitation measure would not continue to be the norm. Health service research should be strengthened by the wider participation of behavioural scientists and mental health specialists in order to elucidate better the psychosocial needs of the family group and how they can best be met.

Technology for daily living

Lack of cooperation among different sectors and disregard of psychosocial needs can also be seen in the failure of social organization to harness the achievements of the scientific and technological revolution to the improvement of people's daily lives. People with sensory and physical disabilities are often deprived of appliances or products that are easily and cheaply produced and could improve their lives and productivity. Old people compensating precariously for a disability may break down because of apparently minor frustration, physical irritation, or discomfort which could be avoided if they had easy access to simple products. Thus, books or newspapers with large print that can be read by the elderly are available in very few countries; loose cotton underwear that does not cause skin irritation in the old is practically unavailable even in countries where cotton is a main national product; food which is particularly suitable for the elderly is difficult to find.

The scope of technology and inventiveness in the service of the aged and disabled is almost unlimited but, for reasons that are not entirely economic, millions are forced to be dependent and helpless, and their social isolation is compounded.

II. Mental Health Technology can Improve Health Care in General

Mental health skills can be used in developing positive attitudes towards community participation in health programmes. They can also help in persuading social sectors to adopt health as a motivating value for action. A mental health perspective in general health care can counter the dehumanization of medicine, and make health services more effective and less costly.

Health is a value, formed in the interaction of man and his surroundings. The health sector can influence the status of health as a value but it does not determine it. Action in other sectors such as education, social welfare and socioeconomic planning also influences it, and is in turn influenced by it.

Participation of communities and of the various social sectors in achieving health is the greatest single challenge to health care and the primary health care effort of today. Neither individuals nor communities will participate in health efforts if they do not hold health as a precious value. Mental health disciplines have the skills necessary to bring about the change of attitudes which would make health a highly valued state. They can apply purposefully to this aim their knowledge about the psychology of the individual and the functioning of communities.

Health workers often assume that their own values are shared by the communities they serve, become frustrated

when they find that people do not give priority to health, and are apathetic about what they can do to help people to improve their lives. This often reflects their failure to bring about change in attitude and an acceptance of new values. Proper training, in which mental health has been adequately represented, would help health workers to deal adequately with communities' pre-existing beliefs, habits of thought and value systems. Skill in applying mental health principles would prevent them from being discouraged and could result in the liberation of the enormous energy and resourcefulness which lies untapped in communities and which could be harnessed to the bettering of people's health.

General health workers themselves must be helped to become more aware of the importance of the psychosocial components of health programmes and other development programmes. But being aware does not suffice: they will have to acquire psychosocial skills that today are the province of specialists. They will need more relevant practical training, and special training to recognize and work with human motivation and sociocultural patterns in matters of health and disease. Some part of this competence will come from broadened formal education and training; but at least as much has to come from organized supervised experience in settings where different sectors cooperate in relating programmes and techniques to people's needs and values.

*The community
health
self-study*

One especially useful way to mobilize people's energies and concern for health programmes and initiatives is the community health self-study. It helps them to learn that conventional medical care cannot solve all health problems, and can stimulate them to cooperate in finding new ways to improve health. Also it can identify unmet health needs and reveal obsolete and harmful health practices that tend to be overlooked by professional health workers, especially in communities where medical services are highly technical,

specialized and fragmented. It can uncover wrong forms of care and identify people whose disabilities can be reduced by means that the community itself – and its members – can afford.

Epidemiological studies have shown that at least one-fifth of all patients who attend general health services present with mainly psychosocial problems. Even more present with a combination of psychosocial and somatic problems. This is so in industrialized and developing countries alike. The notion that psychological illness occurs only in people exposed to the stresses of urban living in industrialized countries is unfounded. Psychological ill-health is known to be widely prevalent in quite varied cultures: only a few of its manifestations are culture-specific. Mental health problems are strikingly similar across cultures, and there is now sufficient evidence to show that their management along similar lines helps patients regardless of culture. It requires knowledge and skills that can be learned by various categories of health staff; and the rules for action, from first contact to diagnosis and management, can be operationalized to a considerable degree so that health auxiliaries can apply them. There is now indisputable evidence that this approach is effective; it permits extensive coverage and is much less costly than the usual way of dealing with the 20% of general outpatients who use health services primarily because of mental health problems.

***Mental health
in general
health care
services***

The hundreds of millions of people who attend health services mainly because of emotional problems illustrate an important truth about health care: it is an essentially human endeavour in which interaction between people should be paramount. However, most training for health workers, and medical and nursing textbooks and journals, give a different picture, in which machines, drugs and technical procedures, rather than human interaction, predominate.

***Countering
dehumanization
of medicine***

The self-help movement

The self-help lay group movement is more a reaction of dissatisfied people than an expression of the health system's commitment to self-help as a positive health care strategy. Either people find professional technology ineffective or they seek autonomy and control over their own health and reject reliance on the medical establishment. Mutual help groups sometimes reflect the lack or breakdown of families as social support systems in distress or disability; usually, however, they indicate that the health system has failed to fulfil hopes.

Nor are the providers of health care satisfied with their work and achievements. Often, services are organized in such a way that patients do not receive care continuously from the same health worker. This prevents the establishment of bonds between those who need help and those who provide it, and affects both the patients' health and the health workers' feelings of achievement and self-confidence.

The family's part in institutional care

The family's role in care and support during illness is eroded by modern forms of institutional care. All families have experience of caring for sick people at home and have their own ways of doing so more or less adequately. They turn to the hospital when the illness is beyond their capacity. But there is no need to discard the emotional investment and skill of families. When this happens, patients are isolated from those with whom they are most familiar and best able to communicate. The participation of families and friends in hospital care helps them to learn about caring for the ill at home and alleviates patients' distress. The hospital staff can benefit by learning simple ways of making patients more comfortable which they were not taught during their training and which are part of the tradition of society.

Just as families can help in caring for patients in hospitals, so the hospital staff and the public health staff can help families care for chronic patients at home. The extension of specialized services into the home, by combining health care technology with family care, can reduce the need for hospital care and enhance the quality of life of the chronically ill. People with chronic disorders that cannot be cured by today's techniques particularly need this kind of home-care help. They include the retarded who are either too handicapped to go to school or too old for school day-care programmes, old people immobilized by musculoskeletal or neurological impairments, and people with permanent brain damage whose mental lives are so disordered that they cannot look after themselves or take part in the social programmes that are available.

Home-care help

The psychosocial dimension is equally neglected in other institutions. It is well known that large orphanages and special schools cannot provide the best environment for orphans and retarded children. Children cared for in small units, with continuing personal contacts with one another and with a house-mother, mature better and have less disturbed function than children cared for in large highly-organized institutions; yet health professionals still advocate, and governments still approve, the building of large institutions.

*Advantages of
small local
facilities for
child care*

The same is true of other child-care facilities including day-care centres, nursery schools and, particularly, hospitals. Small facilities set in local communities, and with continuity of staff and adequate opportunities for play, learning and personal interaction, are known to be much more suitable for their purposes than large facilities. When children are admitted to hospital parents should have easy access to them, they should be nursed by as few different nurses as possible, and in the case of young children there should be facilities for

mothers to stay with them. Yet, too often such rules, which would improve child care and diminish unnecessary stress, are not adopted or enforced. Financial reasons are sometimes invoked, although most of these measures cost little and can reduce the length of stay in hospital.

*Health workers
and the commun-
ity in partner-
ship*

Acknowledging that patients are people with their own rights, autonomy and power of making choices could lead to a very different atmosphere in hospitals and clinics. It could also stimulate a more active role for the community in health care. Psychosocial analyses of health systems find regularly that services are disease-oriented and patients are processed like passive objects. A new partnership between health workers and the community will depend on fundamental and lasting shifts in attitude. In some countries such shifts have accompanied or followed radical political change. Other countries may opt for different ways of stimulating community commitment to promote health and an improved quality of life for all, including the sick.

In all instances, however, since the people's health is a matter for the people themselves, the health sector must avoid the temptation to take over people's own responsibilities for achieving the highest quality of life consistent with their abilities, values and needs.

*Reducing
chronic ill-
health and
disability*

Public health measures – including immunization programmes, a clean water supply, nutrition, and other components of primary health care – have proved highly effective in controlling many killing diseases. It is an urgent matter to apply these measures as widely and as equitably as possible. At the same time there is a pressing need to deal with the consequences of continuing high birth rates, falling death rates in early life, and increasing expectancy of life at birth;

these, paradoxically, contribute to an increase in the prevalence of certain health problems that could prove to be major obstacles to achieving health for all by the year 2000. Among the most important of these consequences is the rising pandemic of chronic ill-health and disability, for which there seem to be three reasons.

The first is that the life expectancy of people with chronic diseases is now increasing faster than that of the population as a whole. In the past, people with chronic diseases died of secondary infections; now since infections can be treated successfully they live long lives.

*The three causes
of the pandemic
of disability*

The second reason, only in part linked to the first, is the changing demographic structure. The proportion of older people is increasing in many societies, and they have more chronic diseases than the young. What is less often recognized is that some younger people are at high risk of specific chronic diseases, and their numbers are also increasing faster than the population as a whole. For example, because the 20-35-year age-group, that at highest risk for schizophrenia, is increasing in many countries, more people will suffer from schizophrenia even if there is no rise in its age-specific incidence rate.

The third reason is the relatively slow progress in finding methods to combat non-fatal diseases. Techniques for preventing chronic illness have advanced much less rapidly than techniques for delaying death.

The pandemic of disability and chronic ill-health is most apparent in the wealthy industrialized countries where material conditions of life and medical care have been improving longest. In the developing countries the picture appears to be different, at least on the surface. Acute

*Double burden
on developing
countries*

infections, parasitic diseases, malnutrition, and other killing diseases continue to produce a low average life expectancy at birth. But there, too, death-postponing medical technology is already resulting in increased rates of chronic non-communicable disorders as well as diseases of modern life. The expectation of life at birth in Nigeria is only 37 years compared with 72 in the United Kingdom, but for those who have survived to age 65 the expectation of life in both countries is 75 years. Hence public health planners have to battle on two fronts simultaneously: saving lives and providing services for the growing number of chronically ill and disabled.

*Harmful
separation
between health
and other
social services*

Clearly, chronic disability will remain a problem for a very long time and, short of spectacular advances in the prevention and cure of the diseases that cause it, present medical technology can do little to help the great majority of the disabled. Even in the most advanced countries the health care and social welfare systems function in relative isolation from each other and do not share common values. Medicine is oriented towards treatment of disease, often without regard to the total person and his social environment. The social welfare services tend to be passive recipients of invalids for whom medicine can do little and whose basic needs have to be provided. Although in some countries social workers take an active part in therapy, this is not enough to offset the negative effects of the split between health and social welfare services, which rests on tradition, obsolete mechanistic concepts of disease, and bureaucratic inertia. Indeed, it may well be asked whether the separation of medical care and social welfare does not itself contribute to the prevalence of disability.

*Psychosocial
inputs to
long-term
care*

The behavioural sciences reveal the intricate network of social relations, roles and perceptions of the individual that form the matrix of the personality. Long-term disease disrupts this matrix and interferes with social functioning; and the

disability that ensues is more a manifestation of this disturbance of social function than of the original disease. This means that prevailing concepts of long-term care, rehabilitation and social assistance to people with chronic illness must be re-examined and the psychosocial nature of their disability reflected in more suitable forms of care. Long-term care requires a significant mental health component which at present it too often lacks.

Two courses of action need to be pursued simultaneously. The first is a far-reaching reorientation of long-term care services, requiring a considerable reallocation of resources, for example from hospital to community outpatient services; the mobilization of lay initiative and self-help action; and the introduction of a mental health perspective in the work of those dealing with diseases and disability.

The second course of action is investment in disability prevention research to unravel the behavioural consequences of disease, which clinical studies in the past have largely ignored. Recent mental health research has shown that very specific measures and programmes can be designed for particular groups of disabled people, which if routinely provided could reduce substantially the psychosocial handicaps of disease.

The content of primary health care specified in the fifth recommendation of the Alma-Ata Conference on Primary Health Care¹ includes among its essential elements the promotion of mental health; this should give added impetus to the necessary reappraisal of the concepts and values that underlie the management of chronic disease and disability.

¹ Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata, 1978. World Health Organization, 1978.

III. Mental and Neurological Disorders and Associated Disabilities can be Prevented or Treated

There is a mass of neglected mental and neurological disorders, and associated social malfunction, which specialized mental health services can never reach. Many of them can be managed by community health and other social sector workers, trained, supervised and supported by mental health professionals, in a primary health care setting. Although much improvement could be achieved if available knowledge were to be applied there are significant gaps in our understanding of mental and neurological functioning and disease. The research effort needs much more support.

At least 40 million people suffer from severe forms of mental and neurological disorders such as schizophrenia, brain damage and dementia; and 200 million are incapacitated by less grave mental and neurological conditions such as severe neuroses, mental retardation and peripheral neuropathy. When to these are added the numbers affected by alcohol – and drug-related problems, and by mental disorders secondary to physical disease (such as the 20% of all patients with chronic gastrointestinal disorders who suffer from depression), the magnitude of the problem, in terms of individual suffering, burden to families and losses to communities, becomes staggering. Clearly, conventional medical or mental health care alone can make no significant impact on a problem of such dimensions.

Although the causes of many mental and neurological disorders are still unknown, the application of already available knowledge could significantly decrease their incidence and prevalence and the impairments and suffering they cause. Common disorders such as psychosis, epilepsy and mental retardation, which cause widespread disability, can be dealt with simply, cheaply and effectively. Many epileptics can be treated with drugs that cost as little as two US dollars each a year; but ignorance, prejudice and the low priority given to the condition result in only a fraction of an estimated 10 million people with epilepsy receiving any treatment at all.

These disorders can be managed largely without specialists. The highly trained professional can contribute by being an advocate of urgent preventive measures; taking part in the training, supervision and support of community-health and other social-sector workers; and developing appropriate technologies for the care of the mentally and neurologically ill.

Many mental and neurological disorders caused by damage to the brain by infection, infestation, injury, dietary insufficiencies and intoxication can be prevented by simple medical and nonmedical measures, and the neurologist and psychiatrist can be forceful advocates of such primary prevention. Syphilis of the nervous system can be prevented by early detection of primary syphilis; severe mental retardation in children can be diminished by preventing rubella in their mothers early in pregnancy; and dementia as a manifestation of pellagra, which is still endemic in some countries, can be prevented by simple agricultural and dietary measures. Many infections and parasitic disorders of the brain, perinatal brain injury and toxic brain lesions can be prevented by public health measures such as immunization, good perinatal care and adequate protection at work or in traffic. The epidemiolo-

***Prevention of
mental and
neurological
disorders***

gical mapping and monitoring of drug-dependence and alcohol-related problems indicate specific possibilities for primary prevention. The prevention of traffic accidents reduces significantly the number of brain injuries; and a better control of air pollution can reduce certain forms of encephalopathy of children in city slums.

*Preventing
mental impair-
ments
associated with
sensory defects*

In some countries it is reported that one child in ten suffers from dyslexia, which can impair mental development and educational progress; teachers in those countries can be taught to recognize dyslexia or to deal with it. Uncorrected errors of refraction can lead to slower mental development, school failure, neurotic disorders and accidents which are very expensive to treat, but glasses to correct a refractory error need cost no more than a few US dollars. The same is true of hearing problems and specific learning disabilities, many of which could be identified by teachers, community workers and families. Perhaps because of the low value placed on mental life and psychosocial development, few countries have included these subjects in the curricula of child health workers or primary school teachers.

*Treating
mentally
disturbed
children*

Similarly, with limited training and adequate supervision, various categories of workers can help mentally disordered children. Health workers already giving other services can be trained in brief focused counselling, behaviour modification methods, and the use of psychoactive drugs; volunteers, social workers, police and probation officers, and teachers can improve mental health care at little cost and with the least disturbance of traditional child-rearing practices. With adequate referral and support facilities, it should be possible to treat most children with mental disorders quickly and in their own homes and schools.

While, clearly, much can be done for children, even more can be done for the elderly. Absolute numbers and relative proportions of the aged are rising steadily in both industrialized and developing countries. At the same time their social roles are shrinking everywhere under the relentless pressure of the economic logic that does not see the aged as contributing to the national wealth. Although humanitarian traditions, family bonds, and the helping instinct of human beings do something to reduce the alienation of the elderly from the mainstream of social life, some highly industrialized societies are realizing that they face a continual moral and social crisis because their predominant values attribute no intrinsic utility and meaning to old age.

*Maintaining
social
function in
old age*

Old age brings normal wear and tear of functions, increased risk of multiple morbidity, and a particularly high incidence of mental impairment of varying degree. However, many of the health problems of old age are intertwined with the psychological effects of isolation and lack of social roles of the elderly. Mental deterioration is not an inevitable concomitant of aging. Societies everywhere urgently need to rethink their social philosophy with regard to the elderly and their place in development. Two kinds of action can be undertaken now to stimulate this process.

First, by imaginative and socially constructive approaches new roles can be found for elderly and retired citizens. In one country a large number of retired school-teachers have been trained to work as interviewers in a major social survey. In other countries elderly people have been invited to function as volunteer social workers. Such pilot schemes should be evaluated without delay and their results widely disseminated. Successful experiments of this type may stimulate policy-makers to design programmes and legislation that go beyond the provision of food and shelter to the

aged and contribute to restoring the social value and dignity of old age.

Second, much more active support can be given to research on the functioning of the aging brain, which promises an early significant advance in the scientific understanding and prevention of common disorders of old age. Collaborative research combining psychological, epidemiological and biological approaches in the study of senile and pre-senile dementia, cerebrovascular degeneration, depression in old age, and the various psychiatric complications of physical disease, should have high priority. It needs to be complemented by health services research which should define the most effective ways of providing preventive and curative care to the elderly, limiting as far as possible the role of the nursing home and the geriatric ward (still the only forms of care available to the aged in many countries), and developing community services capable of maintaining the social functioning of the person far beyond the sixth decade of life.

*The chronic
social
breakdown
syndrome*

Many serious mental disorders such as schizophrenia, mental deterioration associated with epilepsy or degenerative disease of the nervous system produce a secondary syndrome of deterioration in social functioning known as the chronic social breakdown syndrome. Its symptoms are very similar regardless of the underlying mental illness: normal everyday behaviour, attitudes and habits required for social interaction and communication are lost. The conditions in which the social breakdown syndrome arises have now been extensively studied and a number of simple measures are known that can prevent it. However, they require a considerable reorientation of the functioning of the mental health services, which are still too often fashioned on the obsolete model of the mental hospital which treats symptoms in a social vacuum and ignores the psychosocial needs of the patient.

Experience in many countries has already shown that mental health services can be decentralized to the level of district general hospitals by establishing small psychiatric units with daily outpatient clinics. Often these small units are under the day-to-day charge of a psychiatric nurse. Brief periods of care for mentally ill patients away from their homes can be provided also by psychiatric rehabilitation village communities, which have proved their worth in developed countries as well as in developing countries. In them patients can receive active pharmacotherapy and social therapy; they can be accompanied by close relatives and remain in a familiar environment.

***Primary
mental health
care***

Recently, a WHO collaborative study has shown that effective techniques and approaches can be applied to providing care for mental and neurological disorders in the community as part of primary health care. The basic principles of this approach are:

1. Efforts are concentrated on only a few priority conditions, and these must be selected in each country according to criteria of prevalence, harmful consequences, community concern, and the availability of simple effective treatment.
2. Detection of cases and their management is carried out in the community by local health staff, including primary health care workers, after brief training in practical skills; and a very few drugs, known to be effective and safe, are made available in health centres and dispensaries.
3. The community participates actively in assessing its own mental health needs, in deciding on action to be taken and in providing care.

Cooperation between countries is needed to speed up the wide application of this new approach, which over the next few years could result in exponential growth in the number of communities where patients with serious mental illness would receive prompt effective treatment that would prevent long-term disability.

*Overcoming
obstacles to
mental health
care*

The wide application of new approaches to mental health care can improve significantly the lives of patients and families. Ignorance, old stereotypes and prejudices about mental disorder (also held by many health workers), and public apathy are the main obstacles to humane and more effective mental health care. They can be overcome in the foreseeable future by various means which include the training in mental health skills of various categories of health and social welfare personnel, education of the public and a clear policy backed by appropriate administrative, legislative and financial provisions.

*Psychotropic
drugs in mental
health care*

Modern pharmacology and chemistry have produced a range of psychotropic drugs which have already made an impact on the treatment and management of severe mental disorders. The phenothiazines, butyrophenones and other similar drugs have enabled most people with chronic psychoses to be free of troublesome symptoms and out of hospital. This has had a considerable social effect in alleviating the invisible burden and suffering of families and relatives of people with mental disorders. Nevertheless, the therapeutic potential of modern psychotropic drugs is largely unrealized for, among others, social, economic and educational reasons. Many of these drugs are too expensive; medical and other health workers are not trained to prescribe them rationally or to monitor treatment; and many of them are manufactured in such a form that it is a daily ordeal for patients to take them for long periods.

More research is necessary to improve the pharmacological tools for the management of mental diseases; but, more important, research into causes of mental and neurological disorders needs major support. Although much of mental disorder and psychosocial handicap can be prevented or managed by today's technologies, there are still important gaps in knowledge. Mental disorder has complex causes, and until recently research was not considered likely to yield early or important practical results. But today, advances in the basic and clinical sciences have uncovered fundamental mechanisms of mental and nervous functioning.

***The need to
support
research***

The coming decades are likely to witness a scientific revolution in the understanding of the human brain in health and disease. Never before have so many solutions to central problems of mental functioning appeared so close. Yet they risk not being discovered for a long time because the necessary research has low priority in most countries and there is a scarcity of funds for international cooperation in research.

IV. The Role of the World Health Organization in an Expanded Mental Health Programme

Forms of WHO collaboration with countries

Because of WHO's unique position in health care it can facilitate the exchange of information and other forms of technical collaboration among countries, stimulate and promote programmes in which countries can pool resources and share the results, and take action on problems of concern to several countries which none of them can resolve alone. In cooperating with countries committed to developing their health programmes, WHO has been able to accumulate experience and develop an infrastructure on which it can use resources for international health work efficiently and imaginatively.

National and regional coordinating groups

Over the last few years the mental health programme of WHO has developed mechanisms which can be used by countries in their efforts to deal with the psychosocial problems discussed in this paper. One example is the establishment in some 20 countries of national mental health coordinating groups composed of representatives of health, education, welfare, labour and other sectors. Their task is to discuss mental health needs, agree on priorities for action, and ensure that the efforts of the different sectors are coordinated. Regional coordinating groups comprise representatives of different countries and disciplines; their chairmen participate with WHO staff in developing specific plans for WHO's global mental health programmes.

Collaborating centres

The national coordinating groups are supported by technical advice from WHO-designated collaborating centres.

Some of these centres deal with a specific matter, e.g., the collection and analysis of information about the effects of psychotropic drugs and their use.

Others are designated for research and training in such fields as drug and alcohol abuse, psychosocial influences on health, neurosciences, and biological and epidemiological psychiatry.

Over the years they have engaged in projects to develop technology for action in the fields described in this paper. In many countries groups of individuals or institutions cooperate with WHO without being formally designated as centres. Their participation in WHO collaborative projects has benefited their countries' and international mental health efforts. There are in all some 40 designated centres and at least twice as many non-designated groups, in more than 40 countries. In epidemiology and public health aspects of mental health alone, 22 centres in 18 countries are engaged in collaborative projects.

In addition to information exchange and research, the centres train staff for mental health and other social services, and groups of centres have undertaken to prepare complementary curricula which will provide a unique training facility for professionals in developing countries. In these ways the centres supplement and reinforce the conventional WHO training activities such as fellowships and training courses.

The multisectoral orientation of the mental health programme has another important aspect: WHO staff and collaborating centres have direct access – through nongovernmental organizations, congresses, meetings and other means – to scientists in fields other than health such as psychology, sociology and anthropology. These, as well as the expert panels of leading professionals from some 60 countries, provide an invaluable channel for information exchange.

*Access to the
world's
scientific
community*

***Technical
cooperation
with countries
and United
Nations
agencies***

A variety of models of technical cooperation in mental health have been set up over the past few years. Thus, for example, a group of southern African countries that share numerous psychosocial problems have formed the African Mental Health Action Group, for which WHO serves as a secretariat and source of technical expertise. In all participating countries, coordinating groups have elaborated mental health programmes usually in cooperation with WHO; and bilateral collaboration resources have been used to implement agreed-upon country programmes. WHO has established and briefed a group of consultants with African experience who can take part in programme development as necessary. The countries have direct access to technologies from a series of other WHO-coordinated projects. Other intercountry activities, e.g., bulk purchase of drugs, joint training, exchange of personnel, are also handled in close collaboration with WHO.

Some mental health programmes, such as prevention and control of drug dependence, require particularly close collaboration with other United Nations agencies. This has proved very effective for the control of problems with multiple causes. UNESCO's¹ interest in special education, ILO's² concern for migrant workers, and UNICEF's³ recent policy decision on the inclusion of mental health in child programmes are examples of the common interest of UN agencies in national and international cooperation. Some 20 nongovernmental organizations complement these activities in very valuable ways.

***Indicators for
programme
monitoring
and evaluation***

One task for WHO is to cooperate with governments in establishing indicators that will help them to steer their

¹ United Nations Educational, Scientific and Cultural Organization.

² International Labour Organisation.

³ United Nations Children's Fund.

programmes. If wellbeing and quality of life is the central target of health and other development efforts there must be valid psychosocial indicators to assess the current position and trends in this respect. No indicators have yet been agreed on that would reflect in a sufficiently sensitive way changes in quality of life or psychosocial state. With such indicators it would be easier for countries to monitor the psychosocial effects of resettlement projects, of industrial and agricultural development and of special programmes for the aged, in order to ensure that they contribute, rather than detract from, the true welfare of those they are meant to help.

Undoubtedly, useful information available from routine sources could be analysed by study groups or centres to evaluate situations and trends. But such an approach would have limited usefulness. A systematic study which will coordinate research work in different countries and socio-cultural settings will have to be undertaken to discover techniques to select, collect, analyse and interpret psychosocial information. This technology can then be used by governments to monitor trends, and plan and evaluate joint action so as to use scarce resources to best effect.

But it is not enough to produce knowledge. The array of mental health technology now available has been assembled piecemeal from a variety of disciplines, including pharmacology, sociology, psychology, neurophysiology and clinical psychiatry. Different disciplines may advocate certain techniques strongly; also national authorities may be subjected to commercial pressures to purchase particular drugs or equipment. Some mental health techniques are expensive; others demand highly trained personnel; and their efficacy varies considerably. Countries therefore need a highly selective approach to mental health technology. Decisions should be based on programme needs established in the countries.

*An information
service to
countries*

Working together to devise guidelines for the evaluation of systems and methods of treatment and care, and of equipment and techniques, will assist countries in this task and enable them to benefit promptly from scientific and industrial advances while eschewing unnecessarily complex and costly technology. A close working relation between WHO and national authorities will also allow WHO to identify priority needs for new technology and to stimulate the necessary research.

*Coordinating
neuro-
psychiatric
and
psychosocial
research*

WHO's coordinating role in neuropsychiatric and psychosocial research is likely to be more than ever essential in the coming years. The WHO programme must act as a platform for the exchange of scientific information and collaboration; it must continue to stimulate and initiate joint studies by disciplines which up to now have acted largely in isolation from one another: epidemiology of mental disorders, the biochemistry and immunology of the nervous system, neurophysiology, genetics and the psychosocial sciences. Operational research can complement these efforts, prepare the ground for the application of findings, and help to ensure the social relevance of research and administrative action. A programme of coordinated interdisciplinary research on priority problems in the mental health and psychosocial fields could be the key to unprecedented progress and have multiplier effects on countries' capacities to deal with the problems that are the concern of this paper.

*Appropriate
technology
for daily
living*

A systematic approach is needed to the psychosocial surveillance of 'activities of daily living' to improve the quality of life of the disabled or the chronically sick. WHO could stimulate action and cooperate with countries by means of a programme on 'appropriate technology for daily living', which would seek to harness local enterprise and industry to improving the mental life of hundreds of thousands of people

at present frustrated and demoralized because they cannot perform the tasks of daily living.

Principles and guidelines are needed also for the application of knowledge about aspects of health care in institutions. Few of the important conclusions of sociological studies of institutions have been applied to the organization and management of these institutions. The unfavourable psychosocial and mental-health effects of large, impersonal institutions on both patients and staff are well documented. Institutions can have positive effects too, and it is at least equally important to discover and promote the factors that produce these effects as to dwell on their well-known dehumanizing features. Collaboration between WHO, behavioural scientists, government agencies and nongovernmental organizations could produce the information needed to formulate guiding principles for the planning and management of health institutions which would give due attention to the psychosocial aspects of treatment or care.

*Psychosocial
aspects of
institutional
care*

In sum, the WHO mental health programme through its established infrastructure could help to bridge the gap that exists between political and scientific action, between the scientific and academic worlds, and between those who work with concepts and those who work with people. It could help to ensure that social action takes account of the best available knowledge and technology. But to fulfil all these functions WHO needs much more resources. They are at present lacking because decision-makers and the public are not sufficiently aware of the enormous size and pervasiveness of the problems to be dealt with, or of the pressing need for concerted action to prevent or remedy them.

*WHO's need for
further
resources*

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