THE FUTURE MENTAL HEALTH SERVICE IN DEVELOPING COUNTRIES†

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Psychiatry in the Last Fifty Years

The care and treatment of mentally ill patients has passed through various stages of development. Up to the end of the 19th century, whenever a severely ill mental patient was detected, he would be sent to a mad house or a lunatic asylum. These asylums were built at places isolated from human habitations and enclosed all round by high walls, so that the lunatics would not pollute the rest of the society. Locked doors, mechanical restraints and planned physical tortures were freely used to control mental patients. Blood-letting, heavy purging and vomiting were induced in order to make them physically weak and easily manageable.

Since the beginning of the present century, the situation has been changing for the better. Reformations in respect of management, architecture and location of mental hospitals together with developments in the method of treatment have brought about significant change in the social attitude towards mental patients. Laws relating to admission to mental hospitals have been simplified to facilitate mental patient's treatment in outpatient's departments and even in the indoors on voluntary admission without passing through a long chain of legal formalities.

In recent decades there have been certain revolutionary changes in the treatment of mental patients, creating amongst medical men a good deal of confidence and interest in psychiatry.

In 1917 Wagner-Jauregg, a Viennese physician, focused attention on the actual possibility of successful treatment of mental disease by physical means. He introduced the malaria treatment of G.P.I. and obtained encouraging results. The malaria treatment, as you know, is the method of injecting the protozoa of benign tertian into the patients of G. P. I., thus producing benign tertian malaria in them which is maintained for some time and then terminated by quinine. Though Wagner-Jauregg could not explain the mechanism involved in the process, the treatment gave clinic results which can well be considered amazing

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against a background almost of 100% of G. P. I. patients dying sooner or later. Following malaria therapy in G. P. I. various fever-therapies were tried to cure other severe mental disorders also.

Introduction of insulin shock therapy by Sakel in 1933, electro-convulsive therapy by Von Meduna in 1934, and leucotomy operation by Moniz in 1935 brought much new hopes into the hitherto rather unpromising field of therapy of mental patients. Conviction began growing that mental diseases, like other diseases, could be treated along scientific lines.

The introduction of drug-therapy in the early fifties of this century stimulated a good deal of research in different aspects of psychiatry. Probably the first landmark in psychopharmacology was the introduction of Reserpine in the treatment of mental diseases. Reserpine is an alkaloid extracted from the bark of a herb root known as *Rauwolfia Serpentina* which grows in India in great abundance. Since ancient times it has been used by traditional practitioners of Hindu medicine in the treatment of hypertension and some types of mental diseases. But it received worldwide recognition as a tranquilizer of immense promise when Ciba Pharma isolated and marketed the alkaloid as Reserpine (Seroasil). Chlorpromazine—a phenothiazine derivative, introduced almost simultaneously with Reserpine proved more efficacious as a tranquilizer; this was followed by a large number of other tranquilizers. And then came certain drugs which were used as anti-depressives. Thus a full armamentarium was developed for the successful treatment of mental diseases.

Early in this century Sigmund Freud introduced Psycho-analysis as a method of psychological treatment for comparatively mild types of mental illness. The supreme significance of psycho-analysis and Freud's works, however, lay in the profound insight they provided into the working of the abnormal and normal human behaviour, opening an altogether new vista towards scientific comprehension of the mechanisms of neurosis as well as functional psychosis. Since the revolutionary discovery of unconscious mental processes and other mental mechanisms by Freud, there have been many important developments in the science of psycho-analysis both in its theoretical frame-work and therapeutic techniques. The bearing of these developments on the successful treatment of psychosis, however, yet remains to be fully worked out.

Though of recent origin, I.P. Pavlov's theory has introduced a new method of Behaviour Therapy which, too, has stimulated much new research pertaining to aetiology, and therapy, of mental diseases.

The Present Status of Psychiatry

With outstanding developments in theories and techniques of therapy coupled with concomitant change in the social attitude and laws relating to mental patients psychiatry has today entered the era of reason and enlightenment. Yesterday's practice of restraining mental patients in prisons or asylums has today yielded place to scientific treatment in open door community hospitals. A multitude of factors have been responsible for the transformation. The law in relation to compulsory incarceration of mental patients in lunatic asylums has been liberalised to a great extent, so that there is no bar today to admit a mental

patient to a general hospital or to treat him in an outpatient's department as freely as any other patient. He is considered a human being suffering from an illness which is amenable to treatment and cure. The method of treatment, particularly physical treatment, has in recent years developed to such an extent that it is now possible to treat a case successfully in any psychiatric outpatient's department (O.P.D.) or in a doctor's clinic keeping the patient at his own home with his relatives. This way of approach to mental illness has certain definite advantages. First, it assures quick recovery. Then, there is little time-lag in rehabilitation. And finally, it helps to minimise the stigma associated with a mental hospital. As the patient stays in family, he can easily be looked after by the family doctor or the general practitioner (GP), except under unusual circumstances requiring the skill and care of the specialist in the psychiatric ward of a general hospital or in a mental hospital.

Voluntary admissions to mental hospitals or to the mental wards of general hospitals have removed fears and prejudices attached to mental illness and employers are becoming more accommodative in respect of employing mental patients who have recovered from their illness.

It is obvious from the foregoing that the present status of psychiatry is brighter today. People are looking to psychiatry with greater expectation and psychiatrists are handling cases with greater confidence.

Though there is no evidence to believe that the incidence of mental illness has increased in recent years, it has been observed that attendance in psychiatric outpatient departments is increasing rapidly; larger number of patients, even the milder types, are freely seeking admission and the number of actual admissions to mental hospitals has gone up—one of the redeeming features being a much shorter average period of stay in the hospital.

The only conclusion that we can draw from these trends is that there has been a tremendous change in the attitude towards mental patients and in the outlook of modern psychiatric treatment. In short, what the people think of the mental patients has changed, what the mental patients expect from the psychiatrist has changed and what the psychiatrist with his modern scientific knowledge and skill can do for the mental patients in particular and the community at large has also changed. All these changes are epitomized today in what is known as Community Psychiatry.

Before we embark upon the discussion of what the psychiatrists with Community Psychiatry can do for the society, we are to assess what he has to do, what are the mental health problems the society is riddled with today and how the psychiatrist seeks to solve them.

Certain facts collected from records of more developed countries will show how enormous the problem of mental health is.

Approximately 50% of total number of beds available in most of the western countries are occupied by mental patients. About 30% of sickness in industry is due to psychic illness. It might appear to be an eye-opener to many that one out of every 10 persons born in the U.S.A. will at some time during his life require hospitalization for mental illness and 30%

of the population require treatment for mental illness, even though their illness may not be so severe as to require hospitalization. (Gold Haumer et al 1953; Reunic 1955).

According to a recommendation of the Expert Committee appointed by the W.H.O. (1953), most of the Asian countries will require 5 beds per 10,000 population (the comparable figure being 1 per 1,000 in the western countries) for treatment of mental patients.

The assessment has taken into account the needs of those who are mentally so ill that they are a danger to themselves or to others, or that their disturbed behaviour creates a grave social problem in the community in which they live. There are others who also require active hospital treatment, though they are not aggressive to themselves or to others. It must be noted that patients requiring indoor hospital treatment make only a small fraction of the total number of mentally ill persons. Basing our calculation on the standard set by the W.H.O. (5 beds per 10,000 of population), it may be shown that a country having a population of one crore will require 5000 beds for the treatment of mentally ill patients who require immediate hospitalization as an emergency case. How enormous this figure is, may be judged by the fact that the strength of beds available today in any developing country for treatment of mental patients is far less than 5,000. This comparison, of course, is based on the scrappy surveys made so far in some of the Asian countries. However, I believe I have given you an idea of the size of the mental health problem we face today. The task before us, needless to say, is to tackle this problem by making a three pronged attack on it, namely, the elimination, as far as possible, of the causes of mental illness, early diagnosis of mental illness and promotion of positive mental health in the society at large. It is in this context that the vital importance of the concept of mental health becomes obvious. What does mental health actually stand for? Just freedom from illness is not sufficient evidence of sound health. This is true for both physical and mental health. It has been said that a mentally sound person is one who can adjust himself well to the environment without much disturbance and is in pleasant mood. A well adjusted person can realise his own limitations and also the limitations of others and he can make full use of his talents in creative activities. He is realistic in his outlook, confident in his own capacity and can find meaning in living. He can enjoy his work without much fatigue and can enjoy marital and other social relationships. He has the ability to love some body other than himself.

To promote and maintain the mental health of the community according to this standard and to prevent and cure mental illness whenever it is detected, is not a mere medical problem. It is medical and social at the same time and must be tackled on a comprehensive scale with active participation of the Governments.

In the advanced countries of the west, such as Britain, the U.S.A. and the U.S.S.R. the State is taking greater and greater part in the organisation of mental health service.

The main development of psychiatry in Britain is in social psychiatry with particular reference to psychotics, whereas in America the development has been largely in respect of the dynamic aspect of ambulant neurotic patients. In America mental cases are dealt with from the very outset by the psychiatrists, but in tune with Britain this trend is now changing

action towards psychiatry in general hospital, managed by GPs under the guidance

psychiatrists.

Under the National Health Service scheme in Britain, the GPs as a rule, deal with patients and their case-load of mental patients can be guessed from the fact that 10% of their total referrals are made to psychiatrists (Skottowe 1966). In this connection it

while to consider the state of mental health service in the U.S.S.R. It is considered of Soviet psychiatrists that prolonged hospitalization retards ultimate recovery and this is

alized by the fact that in the U.S.S.R. relatively small number of mentally sick patients are given domiciliary treatment when the State pays

amount of money to the family for caring for the patient (Ziffersteen 1966).

The Soviet psychiatrists believe that work therapy has a major role in the treatment of patients, as work helps to keep the patients in contact with reality and in the realization of their personal worth. (Ziffersteen 1966)

It is therefore, evident that the advanced countries are focussing their attention on community psychiatry with its base in psychiatric O.P.D. as against hospital psychiatry. This

advantageous for several reasons. It gives better results, it costs less, it is free from the

of segregation in mental hospitals, and it minimizes loss of man-hours to the industry. it goes without saying that the developing countries having limited resources in

money and material should accept community psychiatry as the most suitable type of mental health service.

To develop such a scheme, our first step should be the introduction of teaching of psychiatry in under-graduate schools and colleges, so that our GPs will be sufficiently trained

to diagnose cases early, can manage psychiatric emergencies and can take the responsibility of follow-up. Short orientation courses in psychiatry for GPs may be arranged to make them

aware of the present position and to equip them to serve the changing needs of the society. GPs will, therefore, be the main prop of the community mental health service. They

diagnose early cases, treat emergency cases and follow up the recovered cases in the home surroundings or psychiatric O.P.D.

The next step should be the establishment of psychiatric units in every teaching hospital. The unit should have a well-organised O.P.D. and an in-patient ward having

more than 50-100 beds. There are many advantages of such psychiatric units in a teaching hospital. The students, who are the future GPs, learn and gain confidence

to practise psychiatry. People will be less prejudiced to accept the facilities of treatment for mental patients, as it will remove the unwanted and artificial boundaries between physical

and mental illness. Last but not the least, the psychiatrists working together with their non-psychiatric colleagues will help to develop a mutually beneficial relationship among

members of different medical disciplines. Another worth while effort will be to give them training to certain groups of persons who, in their professional work, come in

contact with persons of different age-groups and can detect early signs of craziness in them. Teachers, starting from the primary to the university level form one such group. If they

are given a good background knowledge of the essentials of clinical psychology and child

guidance, they can act as a useful link in the chain of preventive psychiatry by detecting early cases of mental illness and psychopathy in children and adolescents. The clergy or their equivalents in different societies such as priests, fortune-tellers, voluntary social workers (like members of panchayat *samitis* in the rural areas) and even legal practitioners are those groups of persons who can be of immense help in promoting mental health of the community, provided they are given the proper guidance and orientation in this field. The primary health centres situated in each community development block should have a trained psychiatric social worker who will extensively tour in his area and detect early cases of mental illness and bring them for treatment to a Primary Health Centre which is headed by a GP who has been trained to take care of such patients. Every industrial unit, every school and college and every unit of rural and urban areas will be served by trained psychiatric social workers, who will constitute the agency through which the scheme of community psychiatry will deliver its goods to the periphery of the community.

Over and above this, every developing country should make arrangements for a centralised epidemiological study of the mental health of the community in order to assess the extent and nature of the problem. This study will be of much use in chalking out the plan of mental health service more realistically.

When we consider the enormous wastage of national wealth and manpower caused by mental diseases, we cannot turn a deaf ear to the problem of mental health.

The adverse effect of mental illness on the youth, on the economy of the family, and on the productivity of industries and above all the miserable personal sufferings and the wretched condition of the chronically ill sufferers should move every human heart. If we can feel the need of the hour, it will give us the impetus to go ahead—nothing will stand in our way. However modest the beginning may be, our success is sure to come.

We must remember that mental health is not a purchasable commodity. Nevertheless means are required to promote it; and means require money—money for hospitals, for trained personnel, for research. To obtain psychiatric services on a private basis is costly and for most people it is impossible to get such an individualistic private service. It is, therefore, imperative that in the interest of widest service to the suffering humanity, we should endeavour to develop by all possible means a scheme for community mental service.

In this scheme we need not build big hospitals with a large number of in-patient beds; such hospitals cost so much that they are considered prohibitive even in advanced countries like the U. K. or the U. S. A. The keystone should be the psychiatric O. P. D. attached to general hospitals and domiciliary treatment where patients will flow in from all sources guided by teachers, clergy and psychiatric social workers. The GP will handle them as far as practicable and will get the specialist's advice as and when necessary. This will ensure treatment at low cost, (without dislocation of the patient from his surroundings), less wastage of man-hours and an easy rehabilitation. If we consider the

pros and cons of this system, it will be evident that this is the most suitable pattern of mental health service for a developing country.

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NMA Academics

FAMILY PLANNING FOR THE INDIVIDUALS*

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The title of to-day's Symposium reads Social & Medical Aspect of Family Planning. There is no doubt that we achieve improvement in our standard of living if we plan our family. The benefits we receive, as I understand, are social (i.e. happiness in the home) and medical (which means health to the family). The topic I chose to speak upon to-day is the *relation of the individual to family planning*.

It is fascinating to hear and know many varying aspects of family planning. We learn about it from radio, learned people, newspapers and posters. But it means different things to different people. To a mother who had troubles during repeated deliveries, family planning means an escape from it all. To a working mother, to have fewer children is to find it easier to manage. To other people the truth is that children can have a better education and standard of living when they are fewer in number. Some newly married and other couples may wish not to have children for a length of time till they are well settled. But to the people dealing with the family planning service (the organiser and medical and para-medical personnel) there is much more, to it because in addition to achieving fertility control for medical

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