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The Future of Psychiatry in Developing Countries - The Need for National Programmes of Mental Health .

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For me, today is a very special occasion and a matter of great satisfaction. I stand here to deliver the first oration in the name of Dr. Vidya Sagar for whom I had the highest respect in Indian psychiatry. I feel particularly happy that I am able to deliver this oration at the National Institute of Mental Health & Neuro Sciences, Bangalore, where I learnt my first lessons in psychiatry, more than thirty years ago. I am deeply thankful to Dr. Narayana Reddy, the Director of NIMHANS for inviting me to deliver this oration.

Dr. Vidya Sagar was a legendary figure in Indian psychiatry. Colonel Kirpal Singh, in the book "Psychiatry in India", has written about Vidya Sagar as "the saintly, devoted and noble doctor who is a household name in Punjab and Haryana" [1]. He was also a pioneer in community psychiatry, showing how modern psychiatry can be adapted to local conditions.

The broad sketch of his life is well known. After a distinguished undergraduate career at King Edward Medical College in Lahore, he joined the then British India Army and was a graded specialist in psychiatry. He worked for a while at the well-known mental hospital in Lahore. After Independence, he received his training in psychiatry in England.

His first major challenge came when he was asked to take over as medical superintendent of the mental hospital, Amritsar. It is a sad historical fact that after the partition of Punjab, even mental patients were partitioned and those unwanted patients with Indian names were sent to Amritsar where they kept in some abandoned army barracks. Dr. Vidya Sagar totally transformed that mental hospital and it became almost a place of pilgrimage for mental patients and their families. His devotion to the service of his patients was phenomenal. No sick person was ever refused or turned back from his door. He never accepted any money or gift from anybody. His outpatients clinic would begin early in the afternoon and continue, non-stop, till the last patient had been adequately attended to which would often be at two or three in the morning. After his retirement from Amritsar Dr. Vidya Sagar joined the Medical College at Rohtak where he was Professor of Psychiatry and set up a very good department. Patients would come to consult him from all over the country. The Government of Haryana requested him to continue as long as he wished but his health started falling, with kidney and heart trouble. However, he kept working almost till his death in 1978.

Perhaps the most significant contribution of Dr. Vidya Sagar to Indian psychiatry is the model of a therapeutic community which he set up in Amritsar Mental Hospital. He was a pioneer of involving families in the care of the mentally ill and introducing religious and moral teachings into psychiatric treatment. He showed the way when modern psychiatry can be

modified and adapted to Indian conditions for the maximum benefit of our patients. When he could not admit patients to the hospital due to lack of beds, or legal constraints he introduced the idea of pitching tents in the hospital compounds where patients and families could stay cheaply. Dr. Vidya Sagar would visit every family in the tent and sit with them and treat the patients. In the evening, all the patients and relatives would gather for evening prayers and Dr. Vidya Sagar would lecture and teach the principles of mental health.

I could go on talking about Dr. Vidya Sagar but time does not permit. I was neither his student nor did I work with him but, whenever I met him, he left a deep impression on me with his simplicity, integrity and devotion to his work. I feel proud to be an Indian psychiatrist because people like Dr. Vidya Sagar have lived and worked in this country.

Progress of Psychiatry during the Twentieth Century

I have chosen the title of my oration as "The future of psychiatry in developing countries -The need for national programs of mental health".

There is no doubt that during the last 100 years, psychiatry has made spectacular progress and, it has undergone many revolutionary changes. Perhaps the first major change was effected by the psychoanalysis movement about the beginning of this century. Even if one may not agree with the theories of psychoanalysis and its treatment methods, one has to admit that psychoanalysis changed the face of psychiatry, from an obscure speciality dealing with "insanity" to the branch of medicine which deals with all aspects of human behaviour. Neuroses, personality disorders and adjustment reactions were never the concern of the "alienists" of the nineteenth century. For the developing countries, perhaps the most important contribution of psychoanalysis was the intellectual stimulation it provided to a generation of growing medical men, many of whom were inspired to take up psychiatry as their career.

The psychopharamacology revolution of the 1950s was equally spectacular. It was perhaps one of the most important factors which brought psychiatry out of mental hospitals to general hospitals and into private clinics. With the development of psychotropic drugs, psychiatrists started feeling themselves to be "genuine" doctors and more comfortable in the company of their medical colleagues. The social psychiatry and community psychiatry movements of the 1960s also had a very powerful impact on the practice of psychiatry. For the first time, psychiatrists learnt to leave their hospitals and wards and tried to reach the people in the community. The recent developments in the field of computers and communications, as well as research in neurosciences, appear to be equally revolutionary and it seems reasonable to predict that these developments will also greatly modify the practice of psychiatry in the coming years.

Developing Countries, A Challenge to Modern Psychiatry

How has all this progress in psychiatry affected the developing countries? It is true that now there are more psychiatrists, more clinical psychologists, more psychotropic drugs, more psychotherapies, more computers and machines than ever before. But are we really better off in developing countries? Have we succeeded in improving the mental health of our people? Have we been able to provide the minimal psychiatric services for the most needy? Are the psychiatric services within reach of those who need them most? It is sad to record that, from the perspective of the developing countries, modern

psychiatry has so far failed to meet the mental health needs of its citizens. It has helped, only marginally, a small part of the population.

As pointed out in an earlier paper [2] there are three serious limitations of modern psychiatry in its application to developing countries. These are:

1. Its method of delivery of services, which are largely unsuited to developing countries, where specialist manpower and material resources are severely limited.
2. The focus of psychiatry, which has been much more on mental illness than on mental health. It has so far failed to develop a comprehensive model of prevention of mental illness and promotion of mental health.
3. The roots of modern psychiatry, which are too deeply embedded in Western European and North American culture. This is greatly reflected in the formulation of its aetiological theories, models of classification or treatment methods. Unless changed, modern psychiatry is in danger of becoming a "culturebound" speciality.

Let us first examine in little more detail the three limitations of modern psychiatry noted above in the context of the developing countries.

1.

Limitations of Current Psychiatric Services in the Developing Countries

The inadequacy of current psychiatric services in the developing countries is well known. The models of psychiatric services as evolved in developed industrial countries are mostly centralized, hospital-based, specialist-focused, disease-oriented and delivered in a one-to-one doctor/patient relationship [3]. Particularly in developing countries, these models have produced a form of care which is not penetrating to where it is needed most and is not consistent with the principles of social equity. Most of the developing countries are limited in both specialist manpower and economic resources, For example, in spite of the rapid increase in the number of psychiatrists in many developing countries in recent years, the ratio in most of these countries still remains about two or three psychiatrists to a million population. The number of other specialists who have become so essential in the mental health care services in the developed countries, namely clinical psychologists, psychiatric nurses, psychiatric social workers etc., are available in even much smaller numbers. The network of mental hospitals, which form the backbone of these services in developed countries, is relatively very scanty; moreover, such hospitals are usually located in isolated places, far from the community they are supposed to serve. As a result, modern psychiatric services cover only a small section of the population in developing countries, mostly in large cities and mostly available to the upper socio-economic classes who can afford such services by private means.

2.

Psychiatry versus Mental Health

Although psychiatrists repeatedly refer to the importance of mental health, very rarely do their concern and activities go beyond the treatment of the mentally ill. Of the hundreds of papers read at the last

World Congress of Psychiatry in Vienna in 1983, which are now complied in eight volumes, very few papers deal with the question of prevention of mental disorders and promotion of mental health, which are of such vital concern for all countries. As pointed out in a recent WHO document, nearly 50 per cent of mental and neurological disorders are preventable by currently known methods [4].

In developing countries, serious psychiatric illness is no doubt considered a major health problem, but there are many other competing priorities, such as nutrition, sanitation, control of infections, family planning, etc. Health planners find it difficult to allot major resources for treatment of psychiatric illness. On the other hand, both the lay public and community leaders in the developing world give great importance to problems such as drug abuse among youth, violence on the streets, stress resulting from rapid socio-technical change, break-up of the family as an institution, etc. So far psychiatry has made very little contribution in these fields which have such a very strong connection with mental health.

3.

Western European and North American Cultural Influence on Modern Psychiatry

Modern psychiatry has evolved in Europe and later in North America during the last two hundred years or so and has naturally imbibed the cultural value systems of these continents. It is debatable if any branch of science, including pure sciences such as physics or chemistry, can be totally culture-free. For psychology and psychiatry, which predominantly deal with human behaviour, it is very difficult indeed to develop without incorporating the cultural styles of thinking and belief systems of the society in which they have evolved.

As Stephen J. Gould in his well known book "The Mismeasure of Man" has pointed out, during the last hundred years the prevailing racial attitudes often influenced the so-called scientific studies of craniometry and certain styles of psychological testing. To quote Stephen Gould: "Science, since people must do it, is a socially embedded activity. It progresses by hunch, vision and intuition. Facts are not pure and unsullied bits of information; culture also influences what we see and how we see it. Theories, moreover, are not inexorable inductions from facts. The most creative theories are imaginative visions imposed upon facts; the source of imagination is also strongly cultural" [5].

Gunnar Myrdal had written earlier, in 1944: "Cultural influences have set up the assumptions about the mind, the body, and the universe with which we begin; pose the questions we ask, influence the facts we seek; determine the interpretation we give these facts; and direct our reaction to these interpretations and conclusions" [6].

The problem in cross-cultural psychiatry is not confined only to differences in clinical pictures or methods of psychotherapy. The problem lies at the deeper level of concept formation, in our understanding of what is normal and abnormal behaviour and what can and should be done to deal with the abnormalities of behaviour. I have earlier drawn attention to how cultural factors have influenced aetiological theories and systems of classification in psychiatry [7], [8], [9]. Science is generally supposed to have universal validity but culture places a limitation on what is accepted and put across as science. It seems that a great deal of what has been portrayed in modern psychiatry is related to only one cultural dimension and may not have equal validity in others.

Future Direction for Psychiatry in Developing Countries

In developing countries, psychiatry so far has remained a minor clinical speciality. Its activities are generally confined to the care of a small number of the chronically mentally ill in mental institutions. Benefits of modern developments in psychiatry like psychoanalysis, pychopharmacology or behaviour therapy, have been channelled to only a small number of people, mostly through private health sector. If psychiatry is to emerge as a major health discipline, then it must come out of the narrow confines of the private health sector and move into the mainstream of the public health sector in developing countries. However, to achieve that, psychiatry must undergo some major changes, on the following items:

(1) Psychiatry must change its scope from a clinical speciality to comprehensive mental health movement which is concerned not only with the treatment of mental illness but is equally involved in the prevention of mental illness and the promotion of mental health.

(2) Psychiatry must develop programmes of psychiatric care which are relevant for the needs of the majority of the population of the developing countries.

(3) Psychiatry must keep its theoretical base wide, to include both, the biological and the psychosocial sciences. Furthermore, its etiological theories, classification and treatment models must be comprehensive enough to be relevant for all cultures.

The Progress of National Programmes of Mental Health in Developing Countries

In most of the developing countries, provision of essential psychiatric services for all those who need them is possible only through a public health system. It seems unlikely that the private sector in health can provide adequate psychiatric services except for a small section of the urban population. The majority of the people who live in rural areas or inner city slums are unlikely to be benefited much by the existing specialists in psychiatry or psychology, even if the number of these professionals doubles or trebles in the near future. On the other hand, most of the developing countries do have a deep commitment to the public health system. All of them are signatories to the Alma Ata declaration of primary health care. In recent years, many developing countries such as India, Pakistan, Egypt, Iran, Thailand, Sri Lanka etc. have established a well-developed health infrastructure in the Government Sector, with a large number of primary health care centres, trained health auxiliaries and a network of referral centres. If psychiatry wants to reach the millions of currently unserved and underserved population, it should take advantage of the existing situation and move into the mainstream of public health systems in developing countries in the government sector in developing countries.

Until recently it was believed that psychiatry is too complex to be introduced at the primary health care level. During the last decade, however, a number of experiments have been done to integrate psychiatric services into the existing public health network of services in primary health care [10]. In the mid-1970s a study was started in India by National Institute of Mental Health & Neuro Sciences at the rural centre of Sakalwara near Bangalore [11], [12]. At about the same time, work started in a similar project in Raipur Rani near Chandigarh [13]. The work at Raipur Rani was part of a larger

WHO project on "Strategies for the extension of mental health services in the community " which was conducted simultaneously in India, Sudan, Senegal, Colombia, and later also in Phillippines, Brazil and Egypt [14]. Since that time similar activities have been undertaken in a number of countries in Asia and Africa and it is now well established that it would be feasible and practical to extend such psychiatric services at the primary health care level [10]. The essential strategies of such programmes of extension of mental health services in the community are:

- Integration of mental health into general health services.
- Delivery of services through the existing infrastructure of health at primary health care level.
- Short courses of mental health training for various categories of health staff.
- Provision of essential neuropsychiatric drugs.
- Adequate supervision and referral system.
- Community involvement.

The success of such experiments towards extension of psychiatric services in primary health care has encouraged many countries to think in terms of more comprehensive mental health programmes at the national level, usually organized by ministries of health in the public health sector. The World Health Organisation has greatly encouraged and supported this development.

A comprehensive national mental health programme in a country should consist of a number of other activities as listed below: [15].

1. Promotion of mental health.
2. Prevention of mental and neurological disorders.
3. Treatment and rehabilitation of the mentally ill, including problems related to alcohol and drugs.
4. Improvement of functioning of general health services.
5. Contributions to overall socio-economic development.
6. Enhancing and improving the quality of life.

During the last decade, national planners in a number of developing countries have become aware of the need for national programmes of mental health. With the support of WHO, many countries of Asia and Africa have taken steps to develop such programmes. India was one of the first countries to develop such programmes, at a series of multisectoral national workshops in 1981-1982 [16]. Subsequently, the programme was adopted and incorporated into the national Five Year Plan. In south east Asia, similar programmes have been initiated in Bangladesh, Nepal and Bhutan, Africa, Tanzania and a number of other countries have also started such programmes.

In the WHO Eastern Mediterranean Region, there has been rapid progress in the development of these national programmes. Between 1984 and 1988, almost half the countries of the region, i.e. eleven out of twenty-three, have taken steps to formulate such programmes and have prepared the related documents. A number of countries, including Afghanistan, Democratic Yemen, Pakistan, Sudan and Yemen have followed it by organising multisectoral national workshops, at which these programmes were discussed and adopted as part of the national health plans. These workshops were attended by representatives from various ministries, including those of education, social welfare, law, justice, planning, finance and religious affairs, as well as experts from health and mental health. The progress of the National Programme of Mental Health in Pakistan has been very good during the last three years; it has now been included in the National Five-Year Plan [18]. As part of the national programme, more than 500 doctors and 1000 health workers have received mental health training in Pakistan where the mental health services at primary care level have spread to the four provinces of Punjab, Sind,

Baluchistan and North-West Frontier Province. Good progress has also been made in the extension of services in primary health care in Afghanistan, Democratic Yemen, Egypt, Sudan and Yemen. A summary of the progress of the national programmes of mental health in the Eastern Mediterranean and South-East Asia and Regions of WHO is shown in Tables 1 and 2.

Table 1 - National programmes of mental health in the south-east Asia region of WHO

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National Mental Health Programme in India and the Role of NIMHANS

During the last four years, the National Mental Health Programme in India has made very good progress, particularly in the field of extension of mental health services in the community, mental health training of health personnel, integration of mental health with general health services, and in development of appropriate technology for such programmes. A number of countries of Asia and Africa have benefited from the models and technology developed in India. The National Institute of Mental Health & Neuro Sciences (NIMHANS) has been a pioneer in these developments and deserve congratulations on this outstanding achievement. However, although the programme related to delivery of mental health services has moved forward rapidly, progress has been relatively modest in the field of prevention of mental illness and promotion of mental health. It is hoped that NIMHANS will also provide leadership in this very important area which is so vital for the mental health movement in developing countries.

While on this subject of national programmes, I might also touch on the role of different professional groups such as psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, etc. In Europe and North America, professional rivalries among mental health professionals have already become very prominent and are giving rise to difficulties for the services. It will be very unfortunate if the same pattern were to be repeated in developing countries. The signs of professional strains are indeed already visible in many developing countries. Clinical psychologists in India are probably the largest such group outside Europe, North America and possibly Japan; the leadership provided by the clinical psychologists of India, will therefore be watched by colleagues in other developing countries. The same is perhaps true of psychiatric social workers. The American or European models for these professions were developed for psychiatric institution or private clinics and thus are not appropriate for the needs of national programmes based in the public health sector. In this connection, it is important to emphasize that, for the developing countries, the concept of the mental health team, as envisaged in national mental health programmes, is not a hierarchical structure but as multisectoral group. This approach seems to be very important for the future role of various professionals in the national mental health programme. In some ways it resembles the game of cricket where the whole team plays and any good player can be the captain; he may be a batsman or a bowler or even the wicket-keeper.

Furthermore, in the public mental health sector, there is likely to be greater scope for preventive and promotive health work which will probably to be the focus for the future. Social scientists seem to be better equipped for such roles than medically trained doctors. By evolving appropriate roles and training programmes for different professionals groups, NIMHANS can show the way and set the pace for the implementation of the national programme not only for India but for many other developing countries.

In closing I may mention that the movement towards the development of national programmes of mental health in developing countries is still in its infancy. There is still considerable scepticism in many sectors. Some people argue that the medical model of psychiatry as a clinical speciality cannot be changed and that psychiatry cannot become a public health discipline. They may turn out to be right but I am not willing to give up my optimism because I have seen so many changes in psychiatry in my own lifetime. When I was a medical student, nobody thought that psychiatry would ever reach the general hospitals. When I was a young Assistant Professor in Chandigarh in the 1960s, nobody thought that psychiatric services could be brought into primary health care. All this has happened, in three or four decades. Hence I am confident that this new development of comprehensive national programmes of mental health can also be brought about provided we all work together for it. The future of psychiatry in developing countries lies in it.

1.Singh Kirpal, Evolution of Indian Psychiatric Society
In: De Sousa Allan and De Sousa D.A (Eds): Psychiatry in India Bombay: Bhalani Book Depot Page: 453-490, 1984

2.Wig N N, Anthropology and mental health /A view from the third world
In: Rosenberg R, Schulsinger F (Eds): Psychiatry and its Related Disciplines, The Next 25 Years, WF Page: 169-178, 1986

3WHO, *The Introduction of Mental Health Component in Primary Health Care. Division of Mental Health, WHO, Geneva (In press)*

4WHO, *Prevention of Mental, Neurological and Psychological Disorders. WHO/MNH/EVA/88. World Health Organisation, Geneva*1988

5Gould S J, *The Mismeasure of Man New York. W W Norton* Page: 21, 1981

6Mydral G, *An American Dilemna: The Negro Problem and Modern Democracy. New York, Harper an* Page: 1483, 1944

7Wig N N, *Diagnostic et classification en psychiatrie. Aspects transculturels en Confrontations Psychi* Page: No. 24 Paris, 1984

8.Wig N N, Kusumanto S, Shen Yu Cun & Sell H, Problems of psychiatric diagnosis and classification in the third world in mental disorders, alcohol- and drug-related problems.
Excerpta Medica. International Congress Series 669, Amsterdam Excerpta Medica Page: 50-60, 1985

9.Wig N N, Psychiatric classification - A view from the third world
In : Pichot P, Berner P, Wolf R and Thau K (Eds): Psychiatry, State of the Art, Proceedings of the Sev Page: pp 45-50, New York, Plenum Press, 1985

10.WHO, Mental Health Care in Developing Countries: A critical appraisal of research findings
*Tech Rep Series 698. WHO, Geneva*1984

11.Kalyanasundaram S, Issac M & Kapur R L, Introducing elements of psychiatry in primary health care in south India
Indian Journal of Psychology Page: 3: 91-94, 1980

12.Chandra Sekhar C R, Issac M & Kapur R L & Parthasarathy R, Management of priority mental

disorders in the community
Indian Journal of Psychiatry Page: 23: 186-187, 1981
13.Wig N N, Srinivasa Murthy R & Harding T N, A model for rural psychiatric services - The Raipur Rani Experience
Indian Journal of Psychiatry Page: 23: 275, 1981
14.Sartorius N & Harding T W, The WHO study on strategies for extending mental health care. I. The Genesis of the study
American Journal of Psychiatry Page: 140: 1470-1473, 1983
15.WHO/EMRO, *Intercountry Meeting on National Programmes of Mental Health, Damascus, November 1985. WHO-EM/MENT/113/E. WHO, EMRO, Alexandria*1986
16.Narayana Reddy G N, Channabasavanna S M & Srinivasa Murthy R., [Implementation of national mental health programme for India]
NIMHANS Journal Page: 4: 77-84, 1986
17.WHO/EMRO, *Promotion and Protection of Mental Health, Technical paper for the thirty fifth session of the Regional Committee, Eastern Mediterranean Region. EM/RC35/15, WHO, EMRO, Alexandria*1988
18.Planning Commission, Government of Pakistan, Seventh Five Year Plan (1988/1993) and Perspective Plan (1988-2003), *Report of the Sub-working Group on Mental Health Care in Pakistan, Islamabad*1987