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MENTAL HEALTH SERVICES IN EASTERN MEDITERRANEAN COUNTRIES *

by

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I INTRODUCTION

The term "mental health services" as used in this paper refers to all preventive, treatment and rehabilitative services related to psychiatric disorders, including special categories such as mental retardation, drug dependent persons and mentally abnormal offenders.

This paper is mainly based on the available data collected from twenty countries which provide relevant information in response to a structured questionnaire, supplemented by visits to twelve countries to verify the data.

II EXTENT AND NATURE OF MENTAL HEALTH PROBLEMS

1. Psychiatric morbidity and the increasing needs

Until very recently two striking features characterized the mental health activities in the countries of the Eastern Mediterranean Region (EMR), principally isolation and lack of information. Not only the geographical isolation of the mental hospitals, but professional aloofness as well, kept psychiatry away from the mainstream of medicine and created serious lacunae in scientific knowledge on mental health problems. However, with increasing interest in psychiatric disorders, and the burgeoning epidemiological studies, more and more information is now becoming available on the extent of mental health problems.

It is of particular importance to note that the conclusion which could be made from the field surveys,[1 - 4] and from studies in general out-patients' clinics,[5 - 6] though limited, is that a significantly higher psychiatric morbidity exists than has hitherto been known. An interesting example is the recent investigations carried out at Pahlavi Hospital, Iran, on physically ill patients, which showed that 64 per cent of these patients were found to be suffering from mild to severe psychiatric disorders.[7]

A pertinent question which may be raised here is that these surveys were rather limited to a few countries; how about the others? It is true to say that in several countries, for example Kuwait, Libyan Arab Republic, Saudi Arabia and Somalia, no systematic field surveys were conducted, and hence no accurate data were available regarding the prevalence rate of mental illness. Despite the lack of important statistical data, the need for mental health services can be clearly seen from the contact rates of the various psychiatric institutions, the mounting pressure on the existing services and the relatively high bed occupancy of psychiatric hospitals. A common finding is that the bed occupancy is more than 100 per cent.[8,9]

A different picture prevails in countries where there are no psychiatric institutions as such, no qualified psychiatrists or trained mental health workers, who could provide the necessary information, which is so essential for planning and decision-making. Naturally there is a desire to know, under such circumstances, where the people go, and who attends to them, whenever they are psychiatrically disturbed. In the United Arab Emirates (UAE), for example, it was found that there were six possibilities open to them.[10] They may be :

- attended to in the general health services, as ambulatory patients,
- admitted into a special in-patient unit in a general hospital,
- admitted into a general hospital for the care of chronics,
- sent abroad for treatment on the recommendation of a general Medical Board,
- housed at a special Detention Centre if they are dangerous to themselves or others or have committed offences and been found mentally ill,
- or they may resort to traditional healing.

The information which was gleaned from these different sources was generally helpful in the delineation of the mental health problems and the development of future programming.

2. Mental health features in EMR

While experience everywhere shows that the basic core of mental illness is the same, and that no country, developed or developing, is immune from universally known psychiatric disorders, there are certain features which present themselves, and which should be taken into consideration, when discussing the extent and nature of mental health problems in EMR. In brief, they can be summarized as follows:

(a) As a result of the rapid cultural and socio-economic changes, which certain traditional societies are currently undergoing, such as in the oil-rich countries, problems of adjustment and adaptation constitute central issues in the mental health field. Inter-generational conflicts, youth problems, migration, disorderly living conditions and other psycho-social problems of urbanization are but a few examples which are worthy of consideration.

(b) The illness behaviour, as a "culture-bound phenomenon", under the stress of rapid change, has been found to constitute an intricate mental health problem for the general medical services. Over-utilization of the medical services, as commonly seen for example in the Libyan Arab Republic, Qatar and UAE, could be partly due to the elusive psychological disturbances, which generally escape the notice of poorly psychiatrically-trained health workers, who are generally oblivious to the psychological needs of those communities which they are striving to serve.

(c) The majority of neurotic disorders, which commonly report to out-patient services, are mostly anxiety and depressive epidodes and schizophrenic reactions constitute from 40 to 70 per cent of psychiatric hospital admissions. In general, half the mental hospital population has been found to be formed of schizophrenic reactions and the other half of a heterogeneous group of manic-depressive states, organic psychoses, mental retardation, epilepsy, psychogeriatric conditions and a few personality and neurotic disorders. Psychogeriatric conditions, which were not regarded in the past as the foremost of the mental health problems in countries of EMR, have been found recently to form as much as 23 per cent of the mental hospital inmates in the Libyan Arab Republic (LAR).

(d) There is an increasing tendency to send more mentally retarded children to institutions, and in some countries one psychiatric bed out of four was found to be occupied by moderately or severely retarded children.

(e) Drug dependence constitutes a special problem in the mental health field. Opium-dependence, hashish smoking, Khat-chewing, alcoholism and the abuse of chemical drugs are found in varying degree in the countries of EMR.

Preliminary studies on opium-dependence, for example, estimate the incidence as one per cent in Iran [12,13] and show that 25 - 33 thousand persons in Cairo and major cities in Egypt depend on the chronic use of opium. Further information on the characteristics of the drug-dependent population in these two countries can be obtained from recent WHO reports.[14,15] In Pakistan, a United Nations Mission [16] reported that a "preliminary check in certain villages within the opium producing area suggests that more than 20 per cent of the male population are dependent".

The WHO document on "The Question of Khat"[17] submitted in 1959 to the Regional Committee, gives an all-round statement from the international and national viewpoint and covers the attempts at control made in this field. Furthermore, preliminary studies on the socio-cultural aspects and the extent of Khat-chewing in the Arab Republic of Yemen were initiated in 1973.[18] More elaborate data were collected by an interdisciplinary team who visited this country for three weeks.[19] Significantly the findings gave rough estimates of the magnitude of the problem and demonstrated that the prevalence of Khat-chewing among adult males may reach 80 per cent in major cities and 90 per cent in the villages where Khat is produced. It is clear that such studies open the way for more organized epidemiological research which should lead to realistic and practical approaches to the prevention and management of the multi-sided problems of Khat-chewing.

On the whole, there is increasing concern regarding the mental health problems of drug abuse, and systematic epidemiological studies are indicated for more accurate information on which future planning and relevant programming should be based.

III RESPONSE TO MENTAL HEALTH PROBLEMS

1. Community attitude

Though the community attitude towards mental disorders is generally changing under the accelerated rate of socio-economic developments and rapid means of communication, it is generally influenced by the socio-cultural levels of the population, and this can be broadly divided into three groups.

There is at one extreme the literate urban patient, who is knowledgeable and seeks modern psychiatric treatment, and at the other the traditional illiterate rural-dweller, who adheres faithfully to folk practices and attends modern psychiatric services, if available, half-heartedly until he is convinced of their efficacy. In between the two

extremes, there is a certain group who is caught in the grip of change, is uncertain in attitude and generally divided between the centuries-old indigenous remedies and the vaguely known modern therapies. Indeed, among some of the laity, diseases in general are divided into two: the hospital treatable and the non-hospital treatable. By the non-hospital treatable is meant that they are amenable to folk healing, and within this context mental disorders commonly fall. The isolation of mental hospitals from the general health services, the professional poverty of psychiatric knowledge and the general lack of interest in the care of mentally ill persons, which are still observed in some countries, seem to have perpetuated this community attitude. Naturally, this has changed within communities where better psychotherapeutic alternatives have been provided.

As a general rule it can be stated that the more psychiatric services are provided, the more attendants are reported. As a matter of fact, there is a significant increase in the number of patients attending psychiatric services in all the countries of this Region, which is due to several factors, including attitudinal changes towards modern psychiatric treatment.

An important development, however, which has to be considered when discussing the mental health services is the community attitude towards treating the mentally ill patient at home. It is now quite clear that with the current socio-economic changes and the increasing engagement of family members in the growing urban centres, the past tendency to keep the mentally ill patients in the community and within the family's care has been generally reversed. Thus, more and more psychiatric patients, mentally retarded, epileptics and psychogeriatrics etc., are finding their way into the mental institutions. It is, therefore, important that the mental health services should be more effectively developed to meet these changing needs.

2. Professional attitude

A basic issue which seems relevant to this point is that, while infectious diseases, due to advancement of health technology and socio-economic development, are continuously receding from the medical scene, non-communicable diseases including mental disorders are coming more and more to the forefront. Yet the attention given to mental health problems is far less than it should deserve. This is well demonstrated, for instance in LAR, which has become almost a malaria-free country since 1960, and where the incidence of pulmonary tuberculosis has dropped from 10.1 per 1 000 population in 1969 to 0.6 per 1 000 in 1973.[20] Again, other endemic diseases such as trachoma, schistosomiasis and leprosy are continuously on the decrease. In contrast to this, the mental health problems under the strong impact of socio-economic changes are increasingly felt, while the existing facilities are far from being adequate to cope with them.

The most serious disparity, which reflects the general professional attitude, is in the number of health workers in mental health services, compared with the workload and their counterparts in other health services. In this regard, if the LAR is again taken as an

example, it is found that, while the ratio of all psychiatric beds (1 380) to the total hospital beds (9 634) is 14 per cent, the ratio of medically qualified physicians (14) in charge of psychiatric institutions is found to be less than 1 per cent in comparison with the total number of medically qualified physicians (1 736) in other health services.

The point which needs no further emphasis here is that, while the face of medicine is generally changing and the magnitude of the mental health problems is seriously growing, the health strategy has to change reciprocally to face up to this new situation. As this is not the case, the present dilemma arises in the mental health field. For these reasons, ways and means have to be developed to make the top-level health administrators, who are the primary decision-makers and who are seldom mental health specialists, more sensitive to the mounting need for mental health services. The teaching staff of medical and nursing schools are also in a strategic position to influence the professional attitude towards mental disorders. The indifference towards mental health problems and the lack of concern for psychiatric patients, which have often been shown by general health workers in so many countries, can only be changed through better orientation and proper psychiatric training. This is discussed in some detail in section IV, 3(a).

3. Traditional treatment

Traditional healing practices in various forms and degrees are found in almost all the countries of EMR. Traditional healers are known by various titles in the different countries: doua newees (the supplication writer) in Iran[21], Zar Koudya or sheikh in Egypt and Sudan, rawany and marabout in Tunisia, mutawe'a in UAE, etc., which indicate the deep cultural heritage in which such practices have developed. Obviously space and time will not allow this topic to be examined in detail. However, a few pertinent questions may be raised. For instance, how often do psychiatrically ill patients consult traditional healers and do they get any benefit from such out-moded practices? Is there anything to be learned from them? Should they be banned, ignored, or integrated into the modern psychiatric system of care and so forth?

Several factors seem to determine the place of traditional treatment, mainly: the quality and availability of modern psychiatric services in the country, the geographical location of such services in relation to the community, and the socio-cultural background of the patient.

In the absence of systematic field surveys, it is rather difficult to state how popular the traditional healing practices are. The experience of the practising psychiatrists in EMR and their attitude towards traditional healing vary tremendously. The traditional healers also vary in their personal integrity, treatment methods and their role in the community's well-being, which makes the subject rather controversial. While in some countries psychiatrists do not show much interest and indeed ignore the issue of traditional healing, others befriend traditional practitioners and are knowledgeable about their

practices. In Tunisia, for example, the main state psychiatric hospital is located at Manouba, named after a famous traditional healer. Furthermore, in the estimate of Dr Bouricha, the consultant psychiatrist, El Hadi Shaker Hospital, Sfax, 90 per cent of the psychiatrically ill patients partake of traditional healing prior to reporting for modern psychiatric services. Incidentally, as Dr Bouricha was the only practising psychiatrist in the southern part of Tunisia, the catchment area for which he was responsible covered approximately one million population.

Traditional treatment which is usually carried out on an individual basis or as group therapy (e.g. the zar cult and hadra) is not regulated by any legislation, the patients attend voluntarily and no special order is required for those detained in special centres. Some of the latter centres such as those found in the Sudan (e.g. Shekeneba, Abu Haraz, Abu Deleig, Karkoaj, etc.) seem to have anticipated the modern concept of the village system for the rehabilitation of mentally ill persons for more than two centuries.

Evidently opinions seem to differ on the role of traditional healers as primary health workers in an organized system of mental health services. In this respect the recommendation made at the Addis Ababa, WHO Inter-Regional Seminar[22] 1973, for organized scientific studies of traditional healing, seems timely and worthy of follow-up.

4. Role of general health and welfare services

Four factors were found to be important in connexion with the role of general health and welfare services for the development of mental health care in EMR, namely:

- the underlying philosophy of approach to mental health problems;
- the relationship between the general health and welfare services and the mental health services;
- the leadership in both health and social services;
- the background of training in behavioural sciences and psychological medicine of the general health workers.

A few examples will be given to illustrate the implications of these general principles. The recent approach of incorporating psychiatric care into the general health services has resulted in several models which seem to be promising. Examples are found in the Psychiatric In-patient Unit, Hafiz Hospital, Shiraz, and the Psychiatric Clinic, Shahnaz Medical Centre, Meshad, both in Iran, the Psychiatric In-patient Unit, Mosul General Hospital, Iraq, the Psychiatric Ward Khartoum Teaching Hospital, Sudan[23] etc.

So far the introduction of mental health activities in such important fields as school health services, maternity and child health, youth services, etc. has been rather limited. Where there are joint efforts by the school health services and the mental health institutions such as seen at the Psychiatric Clinic, School and University Health Centre, Tunis[24], rewarding results have been observed. On the whole, the relatively few general duty doctors,

who had been exposed to psychiatric work, proved very useful in the school health services. In contrast, those who were poorly trained were found to be seriously incompetent to deal with psychiatric disorders, especially with the psychotic group of patients. It is worthy of note that, in some countries, it was found that the potent psychotropic drugs were available even in the remote health centres. Yet the medical personnel failed to use them properly due to their defective psychiatric training and ignorance of the nature of the psychopharmacological drugs. The reverse of this was seen when a group of Sudanese medical assistants in charge of rural dispensaries was given a one-month training programme in psychiatric work.

On the other hand, the contribution of social welfare services to mental health work is a new development in a relatively few countries in EMR. It is, therefore, interesting to refer to the extensive work which has been achieved in Kuwait in a comparatively short time. Following a field study in 1960, social services were strengthened in the schools with the ultimate aim of providing one social worker for 500 students. The mental health component was generally obvious from the functions of the Directorate of Social Services which were geared towards:

- promoting the students' psycho-social welfare;
- detecting students with educational, social or behavioural problems and advising on the appropriate measures to be taken;
- fostering better co-operation between the home and the school;
- endeavouring to establish healthier conditions in the school and within the family;
- mobilizing community support for students in need.

As a specialized service of this Directorate, the Psychological Guidance Section, which was mainly run by educational psychologists, was attending to a group of children suffering from: educational backwardness, mental retardation, speech disorders, emotional problems, difficulty in social adjustment, etc. Clearly this type of model has many possibilities and potentialities to develop and its work can be further augmented through effective communication with the health and educational services.

From the Kuwait experience, as well as from other countries, the need for establishing an efficient framework for the proper organization, the close integration and the better pooling of resources between the educational, the social welfare services, and community agencies on the one hand and mental health services on the other, can be seen.

5. Availability of modern mental health services

A detailed analysis of the mental health services in EMR was given in another paper[25], and an outline of the salient data collected in 1974 will be provided here.

6. Physical resources

(a) Out-patient services

Psychiatric out-patient services have been established in all the countries of EMR, with the exception of two. Their number varied from one (Afghanistan and Qatar) to 115 (Iran). When these numbers are broken down in terms of population ratio the disparity becomes even greater. The ratio of clinics to the population in Afghanistan was 0.06 per million and in Qatar 8.3. The latter country came third after Cyprus and Bahrain with ratios of 21.5 and 13.6 respectively; while Iran, which showed the highest number of clinics came fourth. Again, the available data showed that the psychiatric out-patient services in the majority of countries were either proportionally equal to the number of in-patient facilities or even less in number.

More important, from the relatively low ratio of clinics per population it was clear that out-patient psychiatric services were not available to the great majority of the population, especially in those countries with extensive areas and inadequate means of communication.

(b) In-patient services

(i) Psychiatric Hospitals

With the exception of Oman and the Yemen Arab Republic (YAR), psychiatric in-patient facilities have been developed in various ways in all the countries of EMR. Although the number of psychiatric hospitals in countries varies from one to eighteen, the majority has one or two.

The number of psychiatrie beds in an institution also varies from six beds in Abu Dhabi Hospital (UAE) to 1 500 beds in Aminabad (Iran) and Taif (Saudi Arabia) and more than 2 000 in Abbaseya and Khanka (Egypt). When the number of beds per population is examined, the range of differences seems even wider. There are countries such as Afghanistan, where the ratio of psychiatric beds per 10 000 population is 0.03, which is extremely low when compared to Cyprus or Bahrain, where the ratio is 14 and 9.3 respectively. Here again one has to take into consideration the size of the country and the accessibility of the services to the general population. Compared with the total beds of health services, the percentage of psychiatric beds is found to be as high as 27 in Cyprus and as low as 1.5 in UAE. In the latter country, however, this percentage will soon change as a result of the implementation of the new five-year health plan, and the establishment of the proposed psychiatric facilities.

(ii) Psychiatric in-patient services in general hospitals

Psychiatric in-patient services in general hospitals, though known in this Region six centuries ago, have rather slowly developed and in relatively few countries. In fact, countries like Ethiopia, Iraq, Lebanon and Syria, with comparatively longstanding and large mental hospitals, have been found to lag behind in incorporating psychiatric facilities

in general hospitals. Nonetheless, the small number of established psychiatric facilities in general hospitals as previously shown[4], signifies an important development in the delivery of mental health care and marks an effective step in its integration into the total health system.

(iii) Specialized psychiatric institutions

Psychiatric institutions for the differential care of special groups of patients, such as the mentally retarded, the drug-dependent and the mentally abnormal offender, have been developed rather recently and in a few countries. Over the last decade, for example, a good beginning has been made in the care of the mentally retarded in Egypt, Iran, Jordan, Kuwait, Lebanon and LAR. Very recently, magnificent institutions for the care of physically and mentally handicapped children have been established in Teheran under the auspices of the National Organization for the Protection of Children. Notwithstanding this excellent work, there are still two constraints to be resolved, namely the development of a central organizing body for more effective involvement of these services with the educational and health care system[26], and the provision of more flexible facilities to provide wider coverage, especially for those severely retarded.

The preliminary efforts made in other countries, such as in LAR, are promising; however, like most countries, the list of retarded children awaiting admission into special institutions greatly exceeds the available facilities.

More concern is increasingly being shown with regard to the management of drug-dependent persons in Egypt, Iran and Pakistan. In the last two countries, the available resources are far from being adequate to cope with the complex problems of opium dependence. The current therapeutic approach in Iran, which is basically centred on the methadone-withdrawal technique, showed a high relapse rate, which consequently raised serious doubts regarding its efficacy and other methods for more effective rehabilitation have been considered.

In Pakistan, WHO assistance through the United Nations Drug Control Fund has been provided this year in initiating a treatment programme for drug dependent persons in Karachi and for research studies in Lahore on the lasting effects of cannabis in chronic users.

The evaluation of the treatment programme of drug dependent persons at Ataba Clinic, Cairo, through WHO assistance, is one of the attempts to improve the therapeutic techniques and establish more effective approaches for dealing with the intriguing problems of drug abuse.

The care of mentally abnormal offenders should also deserve special mention. In the majority of countries this category of patient is looked after either in the general prisons or in special wards in mental hospitals, such as seen in Khanka Hospital (Egypt), the Lebanon Hospital for Nervous and Psychological Disorders, the Hayder Abad Mental Hospital (Pakistan) etc. Separate institutions are found in the Sudan (e.g. Kober and Maringan) and Detention Centres in Qatar[27] and Dubai (UAE).

Experience shows that the care of mentally abnormal offenders is one of the most complex issues in mental health services and much effort is needed in this often neglected area. A Regional WHO meeting in 1976 to discuss the problems of mentally abnormal offenders is now being planned and it is hoped that the recommendation emanating from this activity will help in the promotion of care for this special group of patients.

7. Legal and administrative provisions

The great majority of countries in EMR (85 per cent) have legal regulations in the form of mental acts, laws, special regulations and orders to deal with involuntary mental patients. Though quite a number of these laws have been reviewed, such as the Mental Patient Law, 1931 (Cyprus), the Lunacy Act, 1938 (Democratic Yemen), the Law No. 11, 1959 (LAR), there are others, such as the Lunacy Act, 1912 (Pakistan) and the Mental Act (Lebanon), which are outmoded and have to be reviewed. The Egyptian Mental Health Act, 1944, has been recently under review and it is hoped that it will soon be promulgated.

In countries where there are no mental laws patients who commit acts of aggression, or are dangerous to themselves or others, are detained, after medical certification, by a special judicial provision and on the basis of a Court order. Obviously all these legal regulations need revision and updating and WHO has been actively engaged towards this end.

It has to be remembered, however, that in the absence of proper care-providing institutions, lack of effective rehabilitation programmes, and due to the restrictive nature of forensic services, it is generally the rule that the detention of abnormal mental offenders becomes prolonged with all the commonly-known complications of social alienation, chronicity and difficulty of going back to normal social life. It is for all these reasons that this topic continues to be a challenging issue.

8. Economic factors

Economic factors in mental illness include various components, some of which, e.g. cost of treatment, are measurable; others such as the reduction in productivity, and the effects on family life, the ensuing psycho-social stresses and the losses incurred to society, etc. are rather difficult to quantify and analyse accurately. In general, there is a common dearth of information regarding the cost/benefit and cost/effectiveness of mental health services in EMR. For example, no systematic studies have been conducted to compare the cost of ambulatory with residential psychiatric care services. This may be partly due to technical difficulties involved, but mainly to the lack of orientation of health personnel and mental health planners on matters pertaining to economic factors and their relationship to mental illness. Certainly the subject is generally unfamiliar to the overwhelming majority of those working in the mental health field in developing countries. However, with the present range of mental health facilities, the influence of new methods of treament and the continuing advances in the field of psychotropic drugs, with their varying costs, economic factors are naturally assuming increasing importance.

It is worthy of mention here that, while in the poorer countries the shortage of psychotropic drugs, due to their high cost, constitutes a serious constraint, especially in the management of psychotic patients, the overuse of drugs in some of the richer countries is becoming one of the problems of affluent societies.

As a general rule, it can be stated that the development of mental health services in EMR has been closely associated with economic growth. In a Region such as EMR, where the per capita national income varied in 1972 from US $ 101 (Yemen) to US $ 4 375 (Kuwait), the role of economic factors in determining the state of mental health services is obvious. Nonetheless, whatever the economic situation of a country, good knowledge of the economy of mental health will certainly help to plan better for psychiatric services and assist in establishing relevant programmes within the available means and in harmony with local conditions.

The only data which seem to be available in several countries are the cost of hospitalizing patients and it is found that the range of cost per hospital day varies from less than US $ 1 to US $ 9. Certainly this is not enough, as has been pointed out by May and others[28]; for valid therapeutic comparison, other parameters have to be taken into consideration. The need for systmatic research in this important field is obvious and comparative studies based on valid methodological criteria should be encouraged.

IV MANPOWER: RESOURCES, NEW TRENDS AND TRAINING

The study of psychiatric care in the countries of EMR shows the increasing demand for appropriate mental health services. The disparity between the demand and the supply is clearly demonstrated by the sensitive index of manpower resources. As the available data indicate that the serious shortage of mental health workers is the most over-riding issue in the mental health field, it is imortant to discuss this topic in some detail.

1. Manpower resources

It is instructive to point out that from data collected the number of psychiatrists in one single country varied from none (Yemen) to more than 100 in Egypt and Iran. Two countries, Democratic Yemen and Somalia, had one psychiatrist each, both of whom were expatriate. Clearly the scarcity of psychiatrists in relation to the increasing demand dominated the mental health scene. In this regard some of the rich countries made attempts to recruit qualified mental health specialists from within EMR and naturally such efforts were frustrated due to the general shortage in all the countries.

It has to be remembered that the scarcity of mental health workers such as the medical psychologist and the social worker was even greater than of the psychiatrists. Indeed in more than one-third of the countries there were no medical psychologists and in the majority the number was less than six. Similarly, in several countries there were no social workers fully engaged in the delivery of mental health care and in half their number was less than six.

More important, the number of auxiliary psychiatric nurses, who are supposed to form the broad base of the manpower resources, generally showed a low ratio compared with the total population or the number of patients.

Furthermore, about half the countries had no therapists for vocational and rehabilitation programmes, much less teachers for educating and training mentally retarded children.

Ideally, the personnel requirements should be worked out on a population ratio, and the services mapped out on a set of catchment areas. The difficulties, however, in applying this to mental health services in developing countries are:

(a) the shortage of manpower;

(b) the prohibitive costs of establishing and running such services;

(c) psychiatric services are coming rather late and have, therefore, to compete with other more established medical institutions. Even in oil-rich countries where the second factor (b) can be overcome, the serious shortage of available qualified personnel, for years to come, will continue to be a major block in the progress of mental health care according to acceptable criteria.

Nevertheless, a beginning has to be made, and the proper deployment of the scarce resources forms a vital element in the organization and administration of the delivery of mental health care. As a general guideline, it may be more practical in developing countries, to think in terms of a balanced psychiatric team for every province or governorate and go down the administrative echelon to districts etc., rather than look upon the personnel requirements on the basis of the present criteria applicable in technically advanced countries.

2. New trends and the changing role of mental health workers

Over the years various attempts have been made to blend the medical sciences with the psychological, the social, the anthropological and the community resources into a more effective approach to cope with the growing needs in the mental health field. This has led to the new popular approaches, namely social psychiatry, community psychiatry and community mental health. All aim at expanding the boundaries of psychiatric work beyond the traditional medical model from its main focus on a therapeutic relationship inside a medical institution to that of the community. More precisely the community mental health movement aims at enhancing the community resources and more actively involving its members, especially those in key positions, such as the politician, the teacher, the administrator and the family. The new trend has found much support from the now universally accepted philosophy based on the importance of reducing the period of residential care in mental hospitals and keeping the patient near his home and place of work.

Essentially the wide use of psychoactive drugs in the last quarter century and its proven efficacy in controlling anti-social psychiatric manifestations have made it possible to treat

for more people, medical and non-medical, particularly the family, to participate in the general management and in the administration of new medication to their mentally-ill relatives.

For the sake of brevity the central themes in these new trends place the main emphasis on:

(i) Coverage: the mental health services should provide a wider coverage with the ultimate aim of bringing them within the reach of the total population.

(ii) Integration: the mental health services should be generally integrated into the total health system.

(iii) Range of facilities: the mental health services should be planned in such a manner as to have a wide range of facilities to meet the needs of patients at the different stages of illness.

This implies that other alternatives to the traditional hospital system, where the psychiatric services are mainly concentrated today, have to be developed.

Theoretically, this sounds attractive and full of possibilities. However, from the practical point of view, there are several hospitals in EMR, such as Abbasseya and Khanka in Egypt, the Gargarish in LAR, the Aminabad in Iran, the Shamaiya in Iraq, the Avicenna in Syria and the Razi in Tunis, which look like strange islands separated by a deep sea from the mainland of social changes and community life. How to forge a new mental health policy out of this historically imposed situation and how to develop these institutions into more effective therapeutic communities, are more than academic exercises which have to be resolved in order to clear the road for more efficient mental health services. Some of these hospitals are actively engaged in the training of undergraduate and post-graduate students. However, because of their geographical isolation and the general lack of close co-ordination between them and the educational institutions, their role has not been so effective in manpower development. A serious issue is that the bad conditions of certain hospitals have unfortunately been instrumental in the perpetuation of alienation in psychiatry, both in the public mind as well as among students.

Let us now see how relevant is the manpower situation and training in practice to the new trends in mental health.

For the sake of clarification it seems important to point out that in many countries of EMR, the four-member psychiatric team, which was originally developed in the Western culture, has been adopted as a model in mental health work and that the focus of manpower development has been mainly centred on the psychiatrists and nurses and less so on the medical psychologist and social worker. As no organized evaluation has been carried out on the effectiveness of the work output of the full team or on partial combination of its various members or with other non-medical workers, our knowledge seems to be incomplete to draw accurate conclusions on this issue.

In general, however, one would like to see an adequate number of qualified personnel well deployed to provide the necessary coverage for the total population. But this is obviously a distant dream, the realization of which is far from being possible in the foreseeable future. It has to be remembered that in the majority of the countries of EMR the number of psychiatrists is not more than one per one million population. And even in countries where this ratio is somewhat higher, the services of psychiatrists are confined to the major cities. Though the past is not an indication of the future, it is quite clear that the number of psychiatrists in any country of EMR for several decades to come will not be enough to meet the psychiatric needs of a total population. It is, therefore, here that a searching examination should be made to find alternative answers.

Outside the four-member psychiatric team, there seem to be two courses open for the enhancement of mental health work, namely, through the general health workers and the mobilization of the community manpower resources.

3. Training in mental health

(a) The general health worker

It is now generally accepted that the proper integration of psychiatric services into the general health system and the provision of a reasonable level of mental health care, especially at the district and peripheral levels, are achieved through the training of the general health worker. For the last quarter of a century, the members of the WHO Expert Committee on Mental Health have been advocating such views.

In reviewing the trends in mental health, 1949 - 1960, for example, the Expert Committee on Mental Health (1961)[29] noted with approval the recommendations made by previous committees in 1950 and 1961 for the training of general health workers. Due emphasis was placed on the importance of training in mental health for the general practitioner, the specialist physician, public health personnel, public health administrators, nurses, midwives, social workers and other personnel in the health services. It is also worthwhile to note that the Directors of Schools of Public Health (1967)[30] stated that "it is difficult to conceive of a curriculum of basic studies that does not include such an important public health area as mental health"; they further added that: "the more mental health programmes become integrated with public health practice, the more they must be regarded as integral parts of the public health curriculum".

Another important statement in connexion with psychosomatic training was also made by an Expert Committee (1967)[31], which called upon "schools of medicine, public health and nursing to re-examine their curricula and develop the psychosomatic approach".

Training in mental health for general health workers has been dealt with in some detail elsewhere[32]. It is felt important to examine the situation regarding psychiatric teaching in undergraduate medical education for four reasons:

(i) Undergraduate medical education constitutes a fundamental basis for the future medical graduate.

(ii) It is far easier at this stage to inculcate the principles of the mental health approach and to overcome the resistance to psychiatry.

(iii) Medical graduates are commonly leaders and key personnel in health services and their approaches to medicine including training are bound to affect all health institutions and other personnel.

(iv) The subject was studied[33] before and the resulting data may be helpful for our discussions. The findings of this study, which embraced thirty-one medical schools in EMR, showed quite a range of variation in the years of the curriculum, the teaching time, the methodology and the content of training. It is significant to note that the teaching time, for example, was found to vary from sixteen to 232 hours. Again, eight of the medical schools did not include behavioural sciences in their curricula. Based on these findings and others, the WHO Seminar (1970)[34] "noted with regret that the minimum requirements recommended by the WHO Expert Committee (1961) have not yet been implemented in most of the Medical Schools of the Region and recommended strongly that the following minimum requirements be implemented......as a first step :

- behavioural sciences - sixty hours of instruction,
- clinical psychiatry - twenty-five hours,
- full-time clerkship under supervision - one month."

Again this recommendation and many others unfortunately have not yet been implemented in many of the medical schools in EMR. However, the report of the above mentioned Seminar still provides practical guidelines for improving the place of psychiatry in medical education and forms a good basis for future work.

(b) Training of psychiatric nurse tutors

The available facilities in terms of qualified teaching personnel and recognized centres for training in psychiatric nursing are unfortunately even more defective than in the case of undergraduate or post-graduate training in psychological medicine. Notwithstanding the efforts exerted in the existing psychiatric nursing schools such as that of Asfouriyeh (Beirut), Cairo and Omdurman, it is a curious fact that there is not more than a handful of qualified psychiatric nurse tutors in EMR, who can competently run a training programme for psychiatric nurses or who can help in introducing an acceptable curriculum into the basic health teaching for general nurses. For this reason, it has been considered that the priority in psychiatric nursing in all the countries is the development of psychiatric nurse teachers who should be equipped enough to establish realistic training courses for nursing personnel in mental health institutions as well as in the general health services.

(c) Post-graduate training

With the exception of Egypt and Iran, where there are organized training programmes for a higher qualification in psychological medicine, the majority of psychiatrists obtain their specialization from outside the Region, mostly from the United Kingdom. However, the current changes in the post-graduate training programmes in the United Kingdom, the scarcity of opportunities for proper placement, and more important, the type of training to suit local needs, make Regional training an urgent issue. Despite the shortage of organized training facilities, the exchange of visits between the various workers and fellowships inside the Region were found to be rewarding and should be encouraged.

(d) Mental health education and the community

The great majority of patients' relatives simply do not know the nature of mental illnesses or how to deal with them, hence the need for sensible advice and practical education. The need for mental health education of relatives and other members of the community is not only felt in developing countries such as those of EMR but in the technically advanced countries as well. A recent survey of relatives of schizophrenic patients by Creer and Wing[35], for example, revealed the general lack of advice to relatives regarding psychiatric abnormalities, incomplete knowledge of the supervision of medication and defective information on what to do in the case of exacerbation of symptoms, etc. Years ago, when the mental health approach was mainly based on keeping patients as long as possible in hospitals, this was not encountered as a serious problem. Today, when the emphasis has shifted to the community, the general orientation of the family has become a central issue in the management of patients. As a matter of fact, the writer considers the family role as the most determinant prognostic factor, especially in psychotic conditions.

Besides the family there are other social systems, mainly the school and industry, where mental health problems are receiving increasing attention. Here again, the need for innovative approaches in training, as well as in services, has increasingly been felt.

In this respect there are two interesting examples in EMR. One is that of Kuwait, where the Social Department of the Ministry of Social Affairs had endeavoured to promote mental health work in the schools and which has already been discussed (see p.7). The other example is Iran[36], where mental health work was extended to the rural areas through the Health Corps. As a routine, all categories of personnel are given a six-month training course including two weeks of general orientation in mental health before they are engaged in rural services. Though a two-week training course seems to be a rather short period for a wide and complex subject like mental health, the sensitization and concern it generates are certainly worth the effort. Furthermore, it opens up new possibilities for future programming and gives a practical example of how mental health could be injected into other social and health programmes.

V CONCLUSION AND GENERAL RECOMMENDATIONS

An attempt has been made in this paper to outline the magnitude of the mental health problem and show the disparity between the available resources and the increasing needs.

To conclude, it is essential to point out that in the proper development of mental health services, the specification of practical objectives and the setting of realistic priorities should be clearly stated. In principle, the objectives should aim at (a) reducing the incidence of mental illness (b) improving the organization and administration (c) strengthening the services and (d) integrating them more effectively with the total health system.

As the shortage of qualified mental health workers is the most serious impediment facing the development of mental health services in practically all the countries of EMR, the first priority in mental health work should be given to the development of health manpower.

The next priority should be directed towards the establishment of an effective central organizational system which is competent to collect information, assess the needs, draw up an all-round countrywide programme, pool resources, incorporate psychiatric care into the total health system and mobilize the resources of other related services (social, educational, law enforcement and community agencies).

The incorporation of psychiatric care into the general health services should be regarded as an eminent priority in many countries; where the services are still based on detached and isolated mental hospitals. In this connexion, the mental services should be planned on a countrywide basis, and the construction of large mental hospitals (500-bed and more) in capital cities, into which all the resources are drained, should be discouraged. As a general approach, the services must be community-oriented with a range of facilities. This entails the provision of emergency services, out-patient care, early treatment facilities, long-stay rehabilitation programmes and active family and community participation.

In countries where there are no psychiatric services or where such services are newly introduced, it is far better to develop, in the initial phase, out-patient services rather than mental hospitals. The UAE provides a good example in this respect.

The criteria for establishing out-patient community mental health centres should be generally flexible and in harmony with the local needs. The previous WHO recommendations[37], though they are useful and serve well as general guidelines, have to be modified and applied in the light of the realities in developing countries.

For in-patient care, there is a priority in all the countries for the excited and aggressive patient and the deteriorated psychotic with no family support. While the tendency in many countries is to think in terms of hospitalization, which should be conceived as only one phase of treatment, rehabilitative programmes are very defective and not at all helpful for effective readjustment and gainful reproduction. There are no good models on

which to draw, and systematic evaluative studies are therefore indicated in this important area. Moreover, rehabilitation programmes for mentally handicapped children, drug-dependent persons and mentally abnormal offenders deserve special consideration.

When a modicum of competent staff is available, there should be no difficulty in incorporating psychiatric care into the general health services. A significant development is that it has been accepted in some countries to establish psychiatric in-patient care units in general hospitals on the basis of 5 to 10 per cent of the total bed capacity.

The focal point for the provision of wider coverage and for the extension of the delivery of mental health care into the periphery seems to revolve round the primary health worker. For this new role, he has to be well-equipped and actively involved within the organizational and administrative framework of the integrated health services. Regional training activities as indicated in the text of this paper should be given all possible support.

With reasonable assistance, several countries in EMR, such as Cyprus, Egypt, Iran, Iraq, Kuwait, Pakistan and Sudan, are now ready to launch mental health training programmes and to develop psychiatric care services. WHO Medium Term Programming, which has been in operation since last year, is one of the new activities for providing such assistance. However, it is clear that more effort, national as well as international, should be exerted to meet the growing needs in the mental health field.

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