Symposium

THE TREATMENT OF THE PSYCHONEUROSES AND MINOR MENTAL ILLNESS

1. *Present Facilities and World Trends*

DR. H. MOROSS, M.B., B.S. (DUNELM), D.P.H. (RAND), *Medical Superintendent, Tara Hospital, Johannesburg, writes:*

Since the establishment of Tara Hospital for Nervous Diseases in 1946 as a public hospital of the Transvaal, there has been an ever-increasing demand on it for the treatment of psychoneuroses and minor mental illness not only from persons resident in the Transvaal, but from all over the Union of South Africa as well as from territories beyond its borders. This clearly indicates the need for extending facilities for the treatment of the psychoneuroses and minor mental illness.

The Transvaal Provincial Administration caters for these illnesses, so far as it is the function of a provincial administration to do so. As I am familiar with the development of this service I shall describe its extent before suggesting what I believe should be done to develop services elsewhere in South Africa.

1. *A Department of Psychological Medicine at the Johannesburg Hospital*

(*a*) This department is in the charge of a full-time professor of psychiatry, who is head of the Department of Psychiatry and Mental Hygiene of the University of the Witwatersrand; he is a member of the staff of the Johannesburg Hospital and of Tara Hospital for Nervous Diseases; and is consultant at Sterkfontein Hospital. In addition, the resources for the teaching of psychiatry at Baragwanath and Coronation Hospitals, as well as of the Johannesburg central group of hospitals are at his disposal.

(*b*) One ward of about 30 beds at the Johannesburg General Hospital is available for the treatment of the sort of psychiatric cases that are manageable in a general hospital setting.

(*c*) Daily psychiatric out-patient clinics. In the last 12 months over 10,000 patients were seen at these clinics, which were held at the Johannesburg General Hospital. Patients are referred by the other departments of the hospital, by general practitioners, by social agencies, and by other Transvaal public hospitals. The clinics are in the main diagnostic; but special facilities are arranged for individual and for group psychotherapy at the out-patient level. In 1958, 909 attendances were registered at these groups. The staff is provided by Tara Hospital. Only 3-4% of the cases seen are certified and sent to mental hospitals. It is highly probable that, notwithstanding the number of cases seen, many more cases which could be classified as psychogenic are seen elsewhere in the hospital other than at the psychiatric clinics and that the total number passing through the General Hospital is therefore larger than the figures indicate.

(*d*) In-patient psychiatric consultative and therapeutic service. Two members of the Tara Hospital staff are attached to each of the medical firms and the corresponding surgical firms for consultation and psychotherapy in respect of patients accommodated in these firms (also for the teaching of undergraduate medical students). In addition, consultative services are available to the Transvaal Memorial Hospital for Children, the Non-European Hospital, the Queen Victoria Maternity Hospital and the City Fever Hospital. The foregoing services make the integration of psychiatry with general medicine possible; and not only with general medicine, but also with surgery, gynaecology, paediatrics and other branches of medicine. From the teaching point of view this is important.

2. *Tara Hospital for Nervous Diseases*

In essence, this is a unit for the treatment of the more serious and more urgent psychoneuroses and minor forms of mental illness, where physical and psychological treatment is carried out, and where more intensive social therapy can be provided than in the General Hospital. (Tara also caters for neurological cases.)

There is a close affiliation with the Johannesburg Hospital for treatment and teaching. Apart from the usual treatment facilities, 3 important services are provided, viz. a 'day section', a domiciliary service, and a children's out-patient service.

3. *Pretoria, Edenvale and the Reef Public Hospitals*

Each hospital has a part-time psychiatrist on its staff.

4. *Outlying Public Hospitals in the Transvaal*

Tara Hospital provides a consultative service to these hospitals as and when required.

In all the services enumerated above patient activity is sustained, as well as the demand for treatment.

WORLD TRENDS

If this is the situation in the Transvaal it is highly probable that a similar need exists in the other provinces of the Union. Before proceeding to suggest lines along which thought should be given for the development of services elsewhere, I want to list a few trends which I believe to be discernible.

During recent meetings of the Executive Board of the World Federation for Mental Health in the United Kingdom and Europe, I have had opportunities for obtaining information about facilities which exist in different parts of the world for the treatment of the psychoneuroses and minor mental illness, as well as on trends in planning for such services for the future.

1. *Staffing*

In order to provide the staff necessary for existing needs, and for the development of future services, training facilities must be adequate so as to encourage aspirant psychiatrists, clinical psychologists, psychiatric nurses, social workers, occupational therapists, physical educationists, and community health workers to join them. Staff ratios continue to cause worry and in many places are barely sufficient to give adequate, let alone efficient, service. Various surveys are being conducted to determine the reasons for this shortage and to estimate rates of attrition in various full-time salaried services. Sometimes it is not clear whether conditions of service are all that they might be.

2. *Psychiatric Departments in General Hospitals*

In many of the teaching centres in different parts of the world the general pattern more or less corresponds to the service as it obtains in Johannesburg.

In England, the division of responsibility for bodily and mental ailments between different layers of Government have been overcome, in that regional hospital boards are vested with the responsibility for both.

In Canada, the movement is more and more in the direction of the development of psychiatric units in general hospitals. Here the administration of health services, and in particular mental health services, is in general the responsibility of provincial and local authorities. One of the causes for the entry of psychiatry into the general hospital is found in modern methods of early treatment of psychiatric conditions. Another is that it is now generally recognized that a knowledge of the psychological element in disease is important to general practitioners and to specialists in the various branches of medicine and surgery, as well as a knowledge of the psychological treatment of such disorders.

It is recognized, too, that specialists in psychiatry have an important part to play in the treatment of patients in general hospitals in consultation with the specialists in the other branches of medicine. Also, it is believed that there are aspects of psychiatry that can be better taught in the general hospital. This does not make the psychiatry of the mental hospital any less important to the medical student, and the answer to the problem is to make teaching and experience in both fields available to him. May I say, for the sake of completeness, that the Committee on Standards of the American Psychiatric Association suggests that something between 5-15% of all beds in teaching general hospitals should be allocated to psychiatry, and that

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there should not be less than 20 beds, because below this number there is not enough flexibility to be effective?

A small hospital should consider some sort of psychiatric consultation service.

3. *Ambulant Services and the Community Service*

The extension of ambulant services and the community service is a current international trend. The ambulant services include the day centre, the night centre, out-patient services, and the therapeutic social club. The ambulant services and the community service have been described in a contribution to this symposium by Dr. L. S. Gillis.

At the moment, although the final testimony regarding clinical results from the day centre and the night centre is somewhat guarded, it can be said that many patients who at one time would have received in-patient care have been successfully treated there.

THE GENERAL PLAN

A master plan is clearly essential in the development of the foregoing services. Changing facilities, however, demand that any plan for the future must be adaptable to the needs of the time and the place. Whenever extra-mural psychiatric services are being developed in relation to the psychiatric departments of general hospitals, the latter are seen as the strong central hub, the in-patient section being the area where the powers of the organization are aggregated in the form of the greatest concentration of staff. Here in this central hub is brought together the maximum strength of the department. Established outside it and supported by it are concentric rings of other diagnostic and therapeutic structures—the neurosis unit, the day centre, the night centre, the out-patient service, the therapeutic social club. Beyond this there would perhaps be an out-patient therapy unit (away from the hospital) to which individuals might come once or twice a week for special physical treatments and, lying still further out, the follow-up community service. Each of these concentric rings, as we pass outwards, requires less of the powers of the central hub of the department. The concept is that the patients are increasingly able to get along by themselves, to work and live at home, except for the limited support given by the particular therapeutic organization to which they have been assigned.

It is highly probable that the development of facilities for the treatment of the psychoneuroses and minor mental illness will be an evolutionary process, the starting point of the general plan being one of the components described above. The development will probably extend to the others over a period of time on a coordinated and integrated basis, each facility basing its function and standards of service upon its role in the whole pattern of the service of the area.

The foregoing is not an exhaustive analysis, but I offer these thoughts in support of the general point that we may need to think out anew our policies, our training and perhaps our techniques in relation to the present time and to the next 25 years rather than to the last 25 years.

2. *Psychiatric Services in General Hospitals*

DR. H. WALTON, M.D. (CAPE TOWN), D.P.M. (LOND.), *Senior Lecturer, University of Cape Town, and Psychiatrist, Groote Schuur Hospital, writes:*

Present Status of Psychiatry

The great strides psychiatry has taken in other countries have yet to occur in South Africa. The narrowing of the gap between general medicine and the field of mental disorder has not taken place. An outcome of this divorce of psychiatric practice from the main body of general medicine is the survival permitted to an antiquated fallacy: that of equating psychiatry as a whole with the custodial needs of the insane. Only by insulating psychiatrists from the field of general medicine can the myth be maintained that the needs of patients in the psychiatric sphere are adequately met once the country has had 10 mental hospitals established.

This asylum-outlook derives from an uninformed and narrow view of what constitutes psychiatry. The stage of psychiatric development in our country, historically, is that of the mid-19th century, after Chiarugi and Pinel had unchained the mental patients, deprived keepers of their dogs, and urged humane treatment for people who were not inhuman although they had become cut off from others. Griesinger argued nearly 100 years ago that while psychiatry uses concepts of its own, medicine and psychiatry are related disciplines. An early gain from this *medical orientation* towards mental disorder was the discovery by Wagner-Jauregg that malarial therapy cured a fatally-progressive mental illness, general paresis. After this contribution from general medicine, the neurologists of the late-19th century made a great contribution to the *concept of psychoneurotic illness*. Charcot and Freud developed the awareness that minor mental illness is often due to a 'pathogenic idea' (which may be unconscious) in the mind of the patient who, physically, is perfectly healthy. The patient's 'illness' consists of faulty patterns of reaction to his environment. These patterns are learnt during childhood, and can be unlearnt by corrective emotional experiences provided by psychotherapy.

Another fresh development in contemporary psychiatry, yet to find representation in our country, is derived from the *child guidance movement* early in this century. Psychiatric treatment methods were influenced in the direction of teamwork. A doctor alone did not suffice to deal with many disorders, but a combination of many therapeutic influences was called for—from psychiatrists, physicians, social workers, occupational therapists and representatives of the community (e.g. employers, ministers of religion, and school-teachers). Such influences often find the most coordinated expression in a *therapeutic community*, which mental hospitals should carefully strive to be. In this way concerted efforts can be made to revive the patient's self-respect, so that by expressing his own abilities he can regain his social and working status in his community. Recently psychiatry has come closer to general medicine through the *concepts of psychosomatic disorder*: an illness expressing itself in physical symptoms may have aetiological components calling for psychiatric treatment.

These recent developments in psychiatry have had only rudimentary acknowledgment in South Africa. Doctors now in practice will recognize to what extent they were taught only the portion of psychiatric knowledge which (for historical emphasis) may be called asylum psychiatry. Medicine is being practised without the necessary facilities for proper handling of minor mental illness (the psychoneuroses and personality disorders) and psychosomatic illness. Moreover, the state of our mental hospitals gives grounds for grave disquiet even within the mental hospital service itself where doctors, often untrained, have to cope with too many patients.

This is a medical responsibility no doctor can lightly ignore. Can we be content to send our patients to the mental hospitals when we know that overcrowding and inadequate treatment makes for progression, deterioration and chronicity in mental illness? The 10 mental hospitals constituting our country's mental health service are a monument to the disregard of the principles that the best psychiatric treatment is that given while the patient can still function in the community; hospitalization is not necessarily therapeutic. Our mental health service, so-called, provides no follow-up care for the discharged patient, has no social workers, in fact no machinery for helping the patient to re-adjust himself in his community. By contemporary standards, our closed mental hospitals with their locked wards and isolation from the surrounding community, are anachronistic.

Such pilot establishments as Tara Hospital, and the fact that some of our university teaching hospitals already admit psychiatric patients, have not affected the prevailing medical torpor. On the contrary, the sods are already being turned in the Cape Peninsula for yet another vast mental hospital.

A realistic start to the provision of psychiatric services can be made by setting up psychiatric units in general hospitals. In the teaching hospitals such units should undertake the additional

responsibility of studying the measures required to lift us out of the stagnation affecting this field of medicine.

Facilities at Groote Schuur Hospital

A full-time psychiatrist has been on the hospital staff since 1957. Part-time psychiatrists work twice weekly at afternoon out-patient clinics. Both European and non-European in-patients are admitted for treatment and study of minor psychiatric disorders to a joint department of neurology and psychiatry. Post-graduate theoretical discussion meetings are held weekly, and clinical case conferences take place fortnightly. The patient material is also drawn on for undergraduate teaching, patients being allocated for student case-work. In addition each patient is allocated to a student nurse for her to obtain experience in establishing a personal therapeutic relationship as distinct from a technical nursing relationship. Each week the nurses meet as a group with a ward doctor. The house physicians and registrars obtain psychiatric and psychotherapeutic training under close supervision, usually continuing to see, after discharge, some of the patients cared for initially as in-patients.

The work of this department is seriously curtailed by inadequacy of staff. Adequate treatment can only be carried out for a few patients. The proportion of staff in a psychiatric department needs to be greater than in other branches of medicine, owing to the method in which psychiatric data is obtained and treatment conducted. Information is obtained from a psychiatric interview for which adequate time is required—usually an hour for each interview—and a particular patient may require a number of interviews before a relationship is established which enables the patient to impart his secret preoccupations. A single patient may have to receive psychotherapy for many months.

Group psychotherapy permits the psychiatrist to treat about 8 patients simultaneously. Two closed groups are in process at this hospital, the senior group having already met over a period of 15 months. The purpose of group therapy is to create a major change in personality for severely disturbed patients.

A recent extension of the department is the newly-established Cape Provincial Hospital for the treatment of alcoholism, the Park Road Hospital.* Provision is made for 30 in-patients, for day-patients and for extensive follow-up care.

In addition to direct responsibility for patients treated for minor mental illness, considerable additional tasks are imposed on the psychiatric department in a general hospital:

The Psychiatric Department in a General Hospital

1. *Teaching of medical students.* In a university teaching hospital the opportunity is provided to impart to future doctors an adequate understanding of psychiatric methods. Family doctors have to be given suitable training, because the problem of psychoneurotic illness is too vast to ever be dealt with through individual psychotherapy conducted by trained psychiatrists. (Few psychiatrists, in fact, receive specialist training in psychotherapy.) Through suitable teaching, some students may be encouraged to seek a psychiatric career for themselves. Unsatisfactory teaching of students may be an explanation of why so few first-rate students in this country have taken up psychiatry.

By its nature, the teaching of psychiatry imposes difficulties. A large staff is necessary. Twenty students can inspect one inguinal hernia or auscultate one stenosed mitral valve, but only one student at a time can interview a patient intensively enough to gain an understanding of the intimate and painful preoccupations at the basis of a psychoneurotic disorder. Moreover, each patient will permit only one student to undertake such a psychological investigation. To be taught psychiatry, the student has to be brought close to emotionally-disturbed people, to practise his own skills in the field of the patient's social disorganization. He can be taught the necessary techniques only if there are sufficient trained instructors with sufficient time at their disposal.

The great need for training personnel is a major reason for establishing psychiatric departments in general hospitals. In any hospital which trains nurses, social workers or occupational therapists there should be a realistic representation of psychiatric patients. As matters stand, every general hospital has its proportion of psychiatric patients, whether they are recognized as such, or merely have the tag, 'nothing abnormal detected' initialled on their case notes. When at length the time comes to discharge these patients, the respective laparotomy, X-rays or laboratory investigations have merely deepened, and not resolved, the clinical perplexity.

* See report on p. 280 of this issue.

2. *Consultative services to other hospital departments.* The psychiatrist is called in consultation to wards other than his own under a variety of conditions. The physical investigation may have been negative, and the physician, surgeon or gynaecologist then looks to the psychiatrist for an explanation of the patient's symptoms, e.g. a suspected ulcer patient who continues to have severe pain after a negative laparatomy. On the other hand, the patient may well have appropriate somatic impairment, but displays some behaviour disorder which disrupts the ward routine, e.g. an old man before a cataract operation may suddenly become wildly agitated, his intellectual impairment having been unrecognized before his confusion manifested itself; or a girl with vaginal bleeding admitted to the gynaecological ward after attempted abortion may make efforts to throw herself out of the window in a suicide bid. However, the psychiatrist is often asked to treat patients with psychosomatic disorders, the referring doctor recognizing that the patient has a disorder of personality, quite apart from his physical illness, and that treatment of the emotional disorder holds promise of alleviating the somatic symptoms.

This last demand imposes a great, and steadily increasing, burden on the hospital psychiatrist. Potentially, each patient represents a treatment problem that cannot be met because the psychiatrist's time is so limited. The time factor is, perhaps, the hospital psychiatrist's main difficulty. Any patient might suddenly make imperative demands, and if the psychiatrist is not able to respond with his full attention, the outcome might be tragic. Furthermore, a desperate person needs not only an interview, but also an emotional response from the psychiatrist. A harassed psychiatrist is not an effective one.

The psychiatrist has the privilege of changing the general atmosphere in the hospital in the direction of greater sensitivity towards the personal aspects of the patient, e.g. after only meagre reassurance a sister in a medical ward may prove herself exceptionally perceptive to the emotional needs of a suicidal patient, whom she had previously declined to nurse in her ward. The psychiatrist may in his consultations enable his colleagues in other branches of medicine to perceive the importance of unconscious motivation, of the irrational aspects of the patient's dependency on the doctor, and even how a doctor can have irrational responses to patients.

3. *Community needs.* The psychiatric department in a general hospital should be the centre for meeting the psychiatric needs of the surrounding community. At present, general practitioners have to cope with the problem and, because of the lack of adequate facilities for treatment psychoneurotic patients drift from doctor to doctor and hospital to hospital. Their doctors request treatment for them or send them to out-patient departments, but until adequate psychiatric units are established the attention given will be little more than diagnostic and in the nature of general advice.

Psychiatry today is as much concerned with patients in the community as it is with in-patient care. If a patient cannot cope socially, he may need only short admission until he has recovered from his emotional decompensation, or until he feels sufficiently adequate once more to take his place in a difficult home situation. These patients should never be admitted to a mental hospital, if the illness is of a minor and transient nature. The illness should be treated in the local hospital, in accordance with contemporary standards. Only in this way will the isolation of psychiatry from the main body of general medicine be overcome.

3. Basic Principles

DR. L. S. GILLIS, M.D., D.P.M., *Psychiatrist, Johannesburg,* writes:

Several basic principles must be considered in planning a service for the treatment of psychoneuroses and minor mental illness.

1. *Flexibility*

A fully effective service should be highly diversified in its facilities and must be capable of a considerable degree of flexibility so that the treatment of the individual case may be more or less adapted to his needs. Thinking in psychiatry has reached a stage of sophistication where we need no longer plan in terms of one large in-patient hospital catering for all needs, but rather of separate, yet coordinated and co-functioning smaller units with special

functions although perhaps accommodated under one roof. Ideally, there should be one of these composite organizations for each region, and it should consist of arrangements for in-patients, day patients, night patients, out-patients, a therapeutic social club, and most important, a community service. None of the separate units need be large or costly since in functioning together they make for a rapid turnover of cases.

2. *Continuity of Management*

To get the fullest advantage from this interlocking physical structure it is essential to organize it in a way that will facilitate a continuity of management of all cases dealt with. Psychiatric treatment must be viewed as a continuous process and planned as a comprehensive whole for each case from the patient's first contact with the psychiatric service to the end of the last of its acts, that of rehabilitation and after-care. In this way it will be possible for the patient to move progressively nearer to his normal life and community under the aegis of the same organization. For instance, he may move from the in-patient section to the day hospital and the community service as his treatment progresses. Rehabilitation and after-care are part of the process of recovery and must not be thought of as separate from treatment, as has sometimes been done.

3. *Suitable Personnel*

It is necessary to place emphasis on the fact that it is more important to train suitable personnel than to provide expensive buildings. We must invest in brains, not bricks, and the schemes outlined in this symposium will be futile if we are unable to find adequate personnel. Successful treatment of the psychoneuroses depends to a very large extent on the therapists, and the personal interrelationship between therapist and patient is more important than medication. Success also depends on the cooperation of a team of suitably trained personnel, e.g., psychiatrists, psychiatric nurses, psychologists, psychiatric social workers, and occupational therapists. Facilities for training exists for most of these groups in South Africa. Sufficient numbers of trainees, however, are not always forthcoming. Psychiatric social workers, play therapists and psychiatric community nurses are badly needed, but they cannot be trained in this country.

4. *Domiciliary Treatment*

As far as possible neurosis should be treated on an out-patient or domiciliary basis with the patient maintained in his normal community and in his usual life activities. We are fortunate that most patients suffering from psychiatric illness are ambulatory and also that most psychiatric treatments do not necessitate in-patient hospitalization. There are, of course, many cases that must be removed from too-stressful circumstances for a while, but they form a minority and there is little justification for basing an entire psychiatric service on their needs. If hospitalization becomes necessary it should be minimal in time and extent for each case, and its aim should be to provide active short-term treatment. An investigation at Tara Hospital has shown that over 95% of cases who benefited from in-patient treatment did so within a period of 100 days and that there is usually little reason for keeping patients with psychoneurosis and minor mental illness in hospital longer than this. A certain number of in-patient beds will, of course, always be required to deal with the acute phases of illness, but once these are over it will be better for the patients to move to the day hospital or the out-patient department as part of their rehabilitation.

5. *Other Facilities*

If minimum in-patient hospitalization is provided, it is important to make other facilities available in, or close to, the community. These facilities must all be easily accessible and situated in the centre of the population to be served. Great mutual benefit is to be derived from close physical and organizational contact with a general hospital—in fact, this is probably the situation of choice from many points of view. It is clear, however, that psychiatric patients have very different therapeutic needs from the general run of hospital cases. Other facilities should be established, as follows:

The day hospital affords an effective and highly economical way of providing close-to-maximum hospital care while retaining the patient in his normal community. It is possible to handle many cases of neurosis in this way which would previously have been considered only fit for full in-patient hospitalization. No residential accommodation is required, no special buildings need be erected, the equipment needed is modest and inexpensive, running costs are markedly less than for comparable in-patient facilities, and staffing needs are not excessive. Day hospitals may function quite separately, but are preferably incorporated with other psychiatric facilities in a coordinated scheme.

The night hospital. This is an arrangement that combines well with the day hospital because it is possible to use the same premises for a different batch of patients at night. Patients arrive after work, have their various treatments (E.C.T., psychotherapy, etc.), and return to their homes or their work in the morning. This has advantages for a certain selected group of patients, but staffing problems arise and in practice it is considered that the day hospital is a more useful organization.

The out-patient service. Most psychiatric treatments can be carried out satisfactorily on an out-patient basis, and for many cases, especially those needing long-term psychotherapy, it is the method of choice. For full effectiveness, however, something more than a routine diagnostic and consultative service is necessary, and specially designed arrangements for giving physical treatments like electro-convulsive therapy, and a psychotherapy unit, are needed. An immediate problem that arises in regard to a psychotherapy unit is to supply a sufficient number of skilled psychotherapists. This problem may be solved by using part-time therapists, after-hours sessions, and perhaps clinical psychologists. Group psychotherapy is another effective way of dealing with neurosis both thoroughly and economically.

The therapeutic social club is an organization that serves as a stepping stone in the rehabilitation of the patient to fuller participation in his environment. Most of its members will have been treated in some other section before and now meet weekly on a social level under the supervision of members of the psychiatric team. A club such as this is largely run by the patients themselves and is planned to provide continuity of observation, treatment and graded rehabilitation in conjunction with the other facilities already mentioned.

The community psychiatric service. By this is meant the treatment of patients with psychiatric illness in their homes, places of work and schools rather than in hospitals. Emphasis is placed on prevention, early detection of illness, rehabilitation, after-care and maintenance of the chronic patient in his community. This is a most important development in psychiatry and no planning for the future can neglect to incorporate such arrangements into the scheme of things. The essence of community care is domiciliary treatment by a team of professional workers and, in order that all the medical, social and occupational needs of the patients can be met, psychiatrists, psychiatric nurses, social workers, psychologists and occupational therapists are needed. This team should function in conjunction with the in- and out-patient services, and for full efficiency, should tie up with other agents already in the field, such as general practitioners, industrial and school medical officers, district and public health nurses, mental health societies, child guidance clinics, etc.

These facilities constitute the elements for an ideal, though not unattainable, scheme and, when for financial reasons or because the numbers of patients do not warrant it, a more limited service is required, they can be pruned down to suit the particular circumstances. For instance, a small scheme might consist of a psychiatric ward in a general hospital as the base, connected with an out-patient service and a small day hospital situated centrally (a large converted house serves the purpose adequately). Provision should also be made for a small community service.

In conclusion I should like to stress the importance of coordinated planning so that, even if the facilities needed can only be established singly, planning should still be done in accordance with a comprehensive scheme which takes into account the other sections to come. It is also not enough to meet only present needs. This is a time of change in psychiatry and we must recognize the fact that new advances have been changing its emphasis and will continue to do so. For this reason planning must provide for more than the conventional handling of established mental illness and must take into consideration avenues and venues not previously fully exploited, e.g. community services, day hospitals, and rehabilitation centres. Planning must also take into account those aspects of psychiatry that have been neglected, such as mental health education, prevention, after-care and rehabilitation, and it must allow for flexibility of arrangements and for the easy adaptation of buildings to meet changed needs.

We must not seek to erect structures to last a hundred years when it is quite possible that they will outlive their usefulness within a generation.

4. General Considerations

DR. B. CROWHURST ARCHER, M.D., *Psychiatrist, Durban, writes:*

The provision of a satisfactory mental health service for South Africa presents certain difficulties because of the size of the country and the uneven distribution of its multiracial community.

With the introduction of successful methods of physical treatment and the recently-proved economic and therapeutic advantages of early treatment centres situated in the 'catchment areas' of mental hospitals, the problem is not, however, as great as it would at first appear.

Early Treatment Centres

The present overcrowding in mental hospitals could be relieved by the gradual establishment throughout the Union of early treatment centres in the 'catchment areas' of the mental hospitals. They should be run on similar lines to the Antwerp[1] and Worthing[2] experiments which provide a small number of beds on a day-patient system which is a compromise between an in-patient and out-patient service, and full facilities for domicillary treatment. It has been shown that this district mental hospital system has so reduced the number of admissions to the neighbouring mental hospitals that it is contended that no further mental hospital need be built until these experiments have been fully worked out. As I have pointed out elsewhere[3] a pilot scheme of this kind should be started immediately in Durban. This city which is over 50 miles away from the amenities of the nearest mental hospital, will have to rely on its own resources, and is large enough to do so.

I have also recommended[4] a pilot scheme, on similar lines to the psychopathic hospital which has been established in Denmark, for the control and socialization, if possible, of persons suffering from psychopathic personality.

General Hospitals

The importance of the specialized mental hospital and its district mental hospital system should in no way excuse the general hospitals from providing facilities for treating mental illness.

The psychiatric department of every university medical school should be under the direction of a full-time professor of psychiatry who should have at his disposal for teaching purposes an adequate number of beds and out-patient clinic and auxiliary services—psychiatric social workers, non-medical psychologists and occupational therapists.

The range of activities of the psychiatric teaching unit should provide adequate training in psychiatry—in the out-patient department and the wards of the unit, for general practitioners and intending specialists, and psychiatric auxiliaries, including probation officers, health visitors, and similar workers. This unit should also establish, for teaching purposes, a close working liaison with institutions and services outside the unit so as to provide supplementary instruction and teaching material.

A children's psychiatric clinic should be an integral part of the psychiatric teaching unit and act in a consultative capacity to the child guidance centres in the region. Such a unit should also be a psychiatric teaching centre and coordinating focus of psychiatric research.

The Nursing Problem

The enrolment of auxiliary nurses, both in the early treatment centres and the psychiatric units of general hospitals, might contribute towards a solution of the problem of the acute shortage of nurses, provided the necessary teaching and training facilities are made available.

During the last war I commissioned and had charge of two Royal Naval Hospitals which I staffed in part with specially selected Red Cross V.A.D. nurses. They not only made a definite contribution to the morale and discipline of these establishments, so essential to any form of rehabilitation, but after training for a period of 3 — 6 months they became useful members of the psychiatric team. It is also interesting to record that some of these nurses, as a result of the teaching and training they received, qualified after the war as psychiatric social workers. Such auxiliary nurses would again become necessary in the events of war, national emergencies or other disasters.

Promotion of Mental Health

The preventive and rehabilitation aspects of mental illness should be the responsibility of the Public Health Services and Regional Officers of Mental Health should be appointed by the Commissioner for Mental Hygiene. The function of these full-time psychiatrists would be to work outside the mental hospitals and to coordinate and cooperate in all matters of mental health, especially with the Departments of Education, Social Welfare, Labour, the local authorities and the various voluntary social organizations.

Conclusion

The need to investigate the whole question of a mental health service for this country in a scientific and constitutional manner at the highest level is now urgent because there is a danger that the outmoded recommendations of the last Commission of Enquiry, which were published as long ago as 1937, may be implemented. This would mean that the old uneconomic and therapeutically sterile policy of custodial care and 'bigger and better hospitals' would be further entrenched.

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