THE WALK TOWARDS THE PROMISE:

A View of Mental Health
In
Global, Kenyan and Individual Perspectives

By

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Professor of Psychiatry
University of Nairobi

INAUGURAL LECTURE
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Prof. David Musyimi Ndetei

"God give me the courage to change things that I can change, the serenity to accept the things I cannot change and the wisdom to know the difference"

ABOUT PROFESSOR DAVID MUSYIMI NDETEI

Professor **David M. Ndetei** obtained his pre-university education at Makakoi Primary School, the then Kimutwa Intermediate School, and Machakos School, all in Machakos, Kenya. He still holds records in those schools. It was at Machakos where his medical career started. He was the dispensary prefect in charge of all medical matters. He joined the University of Nairobi Medical School on 5 June, 1970 graduating with a Bachelor of Medicine and Bachelor of Surgery (MB.Ch.B) degree in September 1975 after several months' delay caused by a university closure. He was immediately posted to the Coast General Hospital for internship, reporting on 27 September 1975. On 27 September 1976, he reported to Mathari Mental Hospital on post-graduate training programme. On 27 September 1977, he left for the Institute of Psychiatry, University of London on a British Council Scholarship to study Psychiatry. In 1979 he obtained a Diploma in Psychological Medicine from the University of London and in 1980 was elected to Membership of the Royal College of Psychiatrists of the United Kingdom. Simultaneously he undertook part-time studies at the Institute of Psychotherapy, London. In 1979 while still a student he published his first research paper in Psychiatry in the prestigious *British Journal of Psychiatry*. This paper has come to be the most quoted paper from Africa on African Phenomenology and prevalence in a clinic setting. In 1980, he submitted a hand-written manuscript to the *Acta Psychiatrica Scandinavica*, another prestigious Journal of Psychiatry based in Continental Europe.

The editor not only accepted it but also returned it typed for the usual proofreading before publication. That paper entitled, *"Psychiatry in Kenya: Yesterday, Today and Tomorrow"*, turned out to be very prophetic, almost to the letter, twenty years down the line. Thereafter doing research and publishing mainly in the world's top peer-reviewed journals became his preoccupation and pleasure.

While training in U.K., he was made to understand by his professors that in the United Kingdom, acquisition of Membership of the Royal College of Psychiatrists was no more than a starting point for higher professional training in psychiatry but totally inadequate if one wanted to pursue academics. A doctoral research-based degree, and in the case of clinical medicine in U.K. a Doctor of Medicine (M.D.), was indeed the minimum entry point into academics in Medicine, at least in the West. And since he aspired for competitive academics at the highest possible level by any world standards he began his doctoral work. Strictly in accordance with M.D. tradition of registering with the University of undergraduate qualification, he registered with the University of Nairobi while still studying in U.K. It was in U.K. where he collected his data in-between clinical duties and classes.

The data covered a wide cross-cultural population almost representative of the whole world,Africa included. To this end, he is entirely grateful to Professors at the Institute of Psychiatry, University of London and at the Guys' Hospital, University of London who inspired him and

guided him. He is eternally grateful to **Prof. Julian Leff, Prof. James Watson, Prof. Littlewood, Prof. M. Lipsedge, Dr. K. Shaw** and **Dr. Andrew Smith**, then editor of the *British Journal of Psychiatry*, amongst others who went out of their way to inspire him. The late **Prof. Muhangi** of the Department of Psychiatry, University of Nairobi, was particularly encouraging. Prof. Ndetei got the news of Prof. Muhangi's death in the hands of gunmen just outside Kampala on British TV on 1 April 1981 as he was sitting in his house in London sorting out the initial data.

On coming back to Kenya in 1981, he embarked on the lengthy analysis and write up which he completed in 1983 but with the usual administrative red-tape it was not until two years down the line that he was awarded the degree in 1985. He made history by becoming the first Bachelor of Medicine and Bachelor of Surgery (MB.Ch.B) graduate of the University of Nairobi Medical School since its inception in 1967 to be awarded this degree, which up to today only a handful in the history of the University of Nairobi have ever had. He was appointed Lecturer in absentia in 1980 and joined the Department of Psychiatry in June, 1981. He rose through all the ranks to become full Professor in 1995. He was Chairman of the Department of Psychiatry from 1988 to 2000. He thus served as Chairman of the Department for twelve years instead of the usual maximum of two terms of three years each. During this period he also had stints as Acting Dean, Faculty of Medicine and Acting Principal, College of Health Sciences. This was the most

contradictory period in his academic life, balancing out academics, walking a tight rope between partisan even, most regretfully, tribal politics within local academia and mundane administrative chores - on balance the most academically wasteful period of his career at the University of Nairobi.

Prof. Ndetei has published extensively in just about all the world topmost peer reviewed journals in psychiatry that specialize in original research. To many scholars, it is a life - time dream-come -true to have just one paper in some of these journals. These include the *British Journal of Psychiatry, British Medical Journal, British Journal of Medical Psychology, Acta Psychiatrica Scandinavica* and the *Archives of General Psychiatry.* In this respect he remains unmatched North of Limpopo and South of Sahara. This is not to ignore the *East African Medical Journal*, the *Central Africa Medical Journal* and a few other local ones where he has also published. He has published many other papers as proceedings of numerous national and international conferences. He was instrumental in the development of the first ever Psychiatric Research Diagnostic tool (the NOK–Ndetei, Othieno, Kathuku) developed in Africa and which is now being tried in Europe and U.S.A. He is a member of about 20 national and international professional and technical bodies and committees.

In the past Professor Ndetei has served on very many other organizations. He has been visiting Professor of Psychiatry in United Kingdom,

Germany and the Republic of South Africa. He has been external examiner in psychiatry in nearly all the medical schools in East, Central and South Africa. He has researched extensively individually and in collaboration with many national and international organizations. He has played pioneering roles in public education on Mental Health through print and electronic media, including a weekly column which ran every week for nearly fifteen years with well over 600 articles in the local press. For this he was recognized with an award for **"The Journalist of the Year"**.

Professor Ndetei was instrumental in developing innovative programmes for the Department of Psychiatry including the curriculum for postgraduate training in Psychiatry (M.Med) which was introduced in 1983. He also prepared curricula for Clinical Psychology, Psychotrauma, Substance Abuse, Clinical Psychiatry and Psychiatric Social Work. There is no other Department of Psychiatry in Africa the author is aware of with this wide range of options. He has been advocating for more recognition of psychiatry as an examinable subject at undergraduate level. He has trained more psychiatrists in Africa more than any other Professor of Psychiatry. Professor Ndetei has been involved in the development and implementation of psychotrauma training in response to major disasters, notably the **Rwandese Genocide** and the **August 7th 1998 Bomb Blast**. He has supervised and examined numerous Masters dissertations and several PhDs. He is the founder of the **African Mental Health Research Institute and Foundation**, a

co-founder of the **Centre for Education of Disaster Survivors** and a founder member of the **Kenya Psychiatric Association**. He was a co-founder of the first **National Aids Committee**. Currently he is involved in studying the psychotrauma aspects following the fire tragedy at Kyanguli Secondary School in which 67 students perished in March 2001. Currently, he is also undertaking a research project for **UNDCP (United Nations Drug Control Programme)** that will cover Kenya and other thirteen countries in Africa. He is also involved in several other education-based projects in the area of mental health. It is literally not possible to summarize his major academic achievements in this limited space.

Besides his teachers at pre-university education and university education, the day to today inspiration to face challenges came from his students and patients. These did not take anything for granted from him but instead asked incisive questions begging for simple yet correct and informed answers. But the foundation for his life came from his parents who have always reminded him to look beyond the sky for guidance and inspiration from God Himself.

Professor Ndetei strongly believes research is really meant for describing problems and prescribing solutions that affect the average man on the street. He also believes scholars should come down to the level where they can communicate complicated scientific and professional matters in a language that can be understood and followed by the most

ordinary lay person, even the beggar on the street. This is what he intends to attempt with this inaugural lecture, the first ever given by a Bachelor of Medicine and Bachelor of Surgery (MB.Ch.B) graduate of the University of Nairobi since its inception in 1967.

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Introduction

A popular phrase often heard from headmasters of high schools says "*mens sana in corpore sano*", I suspect many of them say so more to impress than educate, to sound erudite and learned though this has the double effect of inspiring the students to seek more knowledge. But at a deeper level, the pristine wisdom in this phrase, that ***sound minds should occupy sound bodies***, is one of the most enduring, often ignored, legacies of the Greco-Roman civilization whose influence has been so pervasive all over the world. It has continued to preoccupy scientists, educators, psychiatrists and psychologists in a long search for an understanding of the reciprocal relationships between the mind, the body, health, learning and human behaviour.

The late **Prof. Odera**, Professor of Philosophy, University of Nairobi and Founder - President of the African Philosophical Society researched extensively on African Philosophy. Reading through one of his collections, my attention was caught by his quotation of a Meru sage who defined a wise man as **"A person who knows where he has come from, where he is and where he is going".** While totally agreeing with the above definition of a wise man, I would hasten to add that **the wiser of the wise is also the one who, in addition, knows not only where he is going but also how to get**

there. The hero and the wisest of the wise is not only he who knows how to get there but leads the way.

But where there are heroes there are also detractors, to put it most mildly. While scientific critique is indeed necessary for science to progress, it can take ridiculous proportions as when it leads to a sub-profession with a syndrome of the chronic pessimist or the 'professional' critic who must, of necessity, see many wrong things in everything he looks at. The story is told of a man who for a long time was very fond of his wife and loved her cooking. He loved eating eggs every day, in one form or another. At some point he fell in love with another lady and, as is commonly the case, the wife did not know. One time the wife brought him a porched egg. He refused saying he wanted a fried one. When she fried another he was even madder saying she had fried the particular egg which was best porched, and the one she had porched was the one best for frying. The wife suggested they talk about the real issue, not the egg, which was an excuse. And since he had no basis for the real issue, he just threw up a tantrum and walked away. This illustration is pertinent. Sometimes we criticize, not on merit, but purely for the sake of it. The long journey of scientific evolution is fraught with equivalents of this story. At this point early in my discourse I rest the case of the chronic pessimists and the professional critics but their destructive work in matters of scientific endeavour in Kenya is so effective that I would not be surprised if they pop up again.

As I was pondering over mental health, I couldn't help but find equivalents of "the wise, the wiser and the wisest" in the long journey of mental health. The giants who have arisen over the centuries to explain **the functions of the mind and its control on normal and abnormal behaviour** and who fit into the above categories were amazing. They were amazing in the ways they first critiqued the available evidence and then stated their cases in the face of overwhelming criticism and cynicism even outright opposition from their contemporaries and peers, a phenomenon that persists to this present day. But unlike in political democracy where the majority is the deciding factor, in academic freedom even academic democracy, it is usually the minority, and quite often the pedant or even the single individual who focuses only on the scientific evidence who eventually carries the day. Put in a different way nearly all the scientific breakthroughs were made by people who stood their grounds on the basis of available scientific evidence, despite the prevailing majority thinking.

Let me illustrate this by only one example: **Hippocrates of Cos** (460 - 370 BC), popularly known as the Father of Medicine, writing on Epilepsy, then regarded as the sacred disease with supernatural causation said: **"The sacred disease appears to me to be no more divine nor more sacred than other diseases, but has a natural cause from which it originates like other affections. Men regard its nature and cause as divine from ignorance and wonder be-**

cause it is not like other diseases." What an amazing statement! More so because it was made in the then prevailing socio-cultural, religious and medical environment! It took at least 2,000 years to authenticate that statement. If it were today he would have been called all sorts of names by, amongst others, his colleagues with the kind of venom that would have made the language recently used on **Prof. Arthur Obel** sound like sweet music. I say this without prejudice of course. Critics who are less chronic in their desire for peer destruction do not drive an invention under. They seize the opportunity to build on it- improving on its merits and removing the demerits.

If it will console and give us courage in our current status today, and in the challenges of tomorrow, lest we forget our roots, let us go back to our history. Mental disorder in one form or another has been recognized from time immemorial going back before Babylonian time 2500 B.C. **However it is only in recent times that serious attempts have been made to study and understand mental illness.**

Progress has been slow. The difficulties have been in three areas: professional apathy, public prejudice and the inherent complexity of the subject. Professional apathy rightly occupies the first position. It is the medical profession, which has been the greatest enemy and hindrance to the study and development of mental health

as a major branch in medicine. This will become clear in the course of this discourse.

Inspite of the above difficulties, great advances have been made though such advances have not been sufficiently recognized. To appreciate these advances we need to go as far back as records allow us. Writers on the history of psychiatry have drawn from written records, Greek poetry and mythology and **episodes of mental illness affecting prominent people**. All of these sources of historical records have their own shortcomings, and in particular cannot help us relate those recordings to clear cut psychiatric states as we understand them today.

The following are examples: -

1. Early Egyptian papyri of about 1500 B.C allude to senility in these words **"The heart grows heavy and remembers not yesterday"**. This statement may have its basis on organic state of the mind.

2. **Elliot Smith** has demonstrated *arteriosclerosis* in his dissections of mummies.

3. Epilepsy was the type of mental illness with which the ancients were especially familiar and was known, as indicated earlier, as the "Sacred disease." We have already seen the position taken by Hippocrates. Besides epilepsy Hippocrates wrote extensively

about many other mental health problems, including hysteria and depression, their causes and management. Indeed Hippocrates, the Father of Medicine, wrote more on mental health than on physical illness and for all practical purposes was more of a psychiatrist than a physician.

Cambyses, the King of Persia (the biblical Kingdom of Persia) is a much quoted case of Epilepsy. **Since these early days psychiatry has held the promise - the promise of enabling people to become the best that they could, as individuals and as a society as they relate to their internal and external environments.**

Treatment of Mental Illness

Equally occupying the minds of the heroes of the past was also the management of mental health problems. Gleaning through all this, one finds astonishing traits and themes that we wish we could adequately deal with today not merely out of intuition, but out of currently available scientifically adduced evidence. Let us look at some selected cases.

Plato's Republic alludes to perhaps the first documented treatment of the insane. **"If anyone is insane let him not be seen openly in the city, but let the relatives of such a person watch over him at home in the best manner they know of and if they are negligent**

let them pay a fine." At around the time of Hippocrates it was the custom for the mentally afflicted to visit the temple of Aesculapius, where sacrifices and prayers were offered. Incantations and purifications seem to have been recommended for epilepsy, although Hippocrates himself believed that the brain was the organ of mind, and he denied that there was anything occult or mysterious about the occurrence of mental disorder.

Democritus in his correspondence with Hippocrates referred to a herb called *Helebore* and made the curious statement that **"when given to the sane Helebore pours darkness over the mind, but to the insane is very profitable".** Haemorroids and varicose veins were alleged to relieve a disturbed mind. This particular "allegation" may have been the basis for bleeding of patients as a form of treatment that was practised in later years, as will be shown in the course of this discourse.

Asclepiades (in the 1st Century B.C), later described in the Christian era by **Celsus,** advocated two widely divergent methods:-

1) Starving, chains and flogging for those who refused food. This way, he advocated, they started to eat, and in certain cases the memory was refreshed.

2) He deprecated venesection and the use of fomentations of *poppy* and *hyoscyamus*, which by today's standards are hard drugs. He

maintained that everything possible should be done to divert the melancholic and commented favourably on sports, music, reading aloud, rocking in a hammock and the sound of waterfall as methods of treatment.

Thermion, another disciple of Asclepiades, recommended a liberal diet, baths and fomentations. There were extremes on the other hand, just like the saying that in every market there is a mad man. Such one was **Titus** who had the invidious distinction of recommending stripes.

Caelius Aurelianus is worthy of much praise. He placed his patients under the best conditions of light, temperature and quiet. He recommended that everything of an exciting character should be excluded. He further recommended tactfulness in attendants for the avoidance of antagonism, limited and cautious use of physical restraint, theatrical entertainment, riding, walking and work, particularly during the period of convalescence. **The doctor should not see the patient too frequently, he suggested, lest his authority be undermined.** Topics of conversation were to be such as would suit the patients' condition. Later, excursions by waterways and various other distractions were to be used. Of note he denounced semi-starvation, bleeding, chains and excessive drug therapy.

Galen, basing his treatment on humoral pathology, recommended a balance between "moisture" and "dryness". **Aretaeus,** probably a contemporary of Galen, advised bleeding to relieve the liver in melancholia, purging by means of aloes, and baths, and in convalescence, natural hot baths for their sulphur and bitumen.

Mediaeval Europe

We know very little of what happened in the medieval times. Treatment of mental illness was left to priests. Superstitious beliefs in witchcraft and the like flourished. From anecdotal reports, treatment by herbs, binding in chains and fetters and washing in special wells scattered in Scotland, England and Ireland were widely practised.

Hospitals and Lunacy Legislation in England

However from the mid 1200's AD there were renewed and well-documented activities on mental health, with the State taking more interest, in England. For example in 1247 AD, **Bethlem Hospital** was founded in London as a priory of the order of the Star of Bethlem, and became the first hospital in the British Isles to care for the insane. In 1403, six lunatics were confined there.

St. Bartholomew's Hospital was founded in 1546 AD and became the second hospital to treat lunatics. Coupled with this were legislations on mental health related issues. For example in 1340 AD, during the reign of **King Edward II**, it was legislated that the property of lunatics should be vested in the crown.

Great psychiatrists also emerged. The treatment and management prescriptions they issued are worthy of note, not because they are ingenious but to illustrate the desperation of the time. The work of the great **Sydenham** in treatment of mania, a kind of mental illness, can be cited. For this condition he prescribed the *Venice treacle* - which contained the **flesh and blood of vipers** and sixty-one more ingredients and **canary wine** and **honey**. This concoction was given three times a day, with rest in bed, even in pregnancy. In addition he strongly recommended bleeding in the treatment of mania saying **"young subjects, if of a sanguine habit, are to be bled to the extent of nine ounces on two or three occasions, with three days between each bleeding"**. This bleeding was to be followed by a course of purgative pill. A caution was given not to exceed this amount of bleeding, **"otherwise idiocy and not recovery will result"**. It would appear this treatment worked by causing anaemia, which then caused the patient to lack energy, with the consequent slowing down in activity. It produced some results in the perceived disturbed behaviour, but at what cost?

Denis of Paris in 1667 introduced the transfusion of blood, which he employed in the case of a lovesick youth, with fatal results and an ensuing action for damages. Perhaps he believed "Love" flowed in the blood!

One of the most famous patients in the history of Mental Health was **King George III**. His doctor was **Dr. Willis**. As will become clear the sickness of this king of England brought to light the plight of the mentally ill, and in the process opened new avenues for the care of the mentally ill.

King George III of England suffered from recurrent attacks of maniacal excitement, which caused a lot of public interest. **Dr. Willis** who used to run a private psychiatric hospital for 20 patients was brought in. He allowed his maniacal patients a lot of freedom. If they escaped the wages of the delinquent attendant were withheld until the patient returned.

He treated his patient **King George III** like any other patient and if need be he was knocked down. One attendant was overheard boasting that he had knocked the king **"as flat as a flounder"**

He prescribed Peruvian bark, but other physicians did not agree with him, leading to an open rivalry, which became known by the **House of Lords** who subsequently appointed a committee to look into the

treatment of the King and also to the medical and nursing care of all mentally afflicted throughout the whole country. This way there was, as a result of mental illness in the King, an increased awareness on the plight and management of the mentally ill. In a nutshell, this one case catapulted us to the next phase, the immediate forerunner of what is happening today.

Modern Era of the Treatment of Mental Illness

This era dates from the end of the **18th Century** and may be divided into four periods, though with considerable overlap: -

1. The period of humane reform.
2. The introduction of non-restraint.
3. The hospital period.
4. The social and community period.

Humane Reform

One of the most outstanding players in the period of humane reform was **Dr. Philippe Pinel** who worked at the **Bicetre Hospital**, in Paris which accommodated about 200 male patients - who had been chained and tethered and confined to dungeons for many years. In 1794, instead of blows and chains, he introduced light and fresh air, cleanliness, workshops and promenades, but above all kindliness

and understanding. The results were outstanding. His prescriptions were later transferred to the female mental hospital, **Salpetriere.**

Pinel, a shy, timid, self-conscious man was not only an excellent hospital administrator and physician, but also set up very high standards of medical care and practice. He insisted on good case taking and made contributions to psychiatric literature. He taught by his writing and character more than by word of mouth. Thus one sees here the seeds of academic psychiatry. **Jean Etienne Dominique Esquirol,** Pinel's most distinguished pupil, was appointed to Salpetriere in 1812. He instituted lectures in psychiatry and attracted students from beyond France. He also set up many psychiatric hospitals - a total of over 10.

William Tuke and **Lindley Murray** opened the **York Retreat** in England in 1796. Four years earlier **Dr. Andrew Duncan** in 1792, then Professor of Medicine at Edinburgh University and President of the Royal College of Physicians, Edinburgh, had sponsored an appeal, leading to the establishment of the **Royal Edinburgh Mental Hospital** in 1813.

The reforms began in England by Tuke were followed by the introduction of a Bill in Parliament for the better treatment of the insane known as the **Wynn's Act** of 1808, for providing "better care and maintenance of lunatics being paupers or criminals of England".

Amending Acts came in series in - 1811, 1815, 1819, 1824, 1849, 1913, 1959 illustrating the sustained interest in Mental Health.

Inspite of all these advancements, the care of the mentally ill was still very far from perfect despite the best intentions. The following narratives illustrate this and one may be forgiven if they see traces of these in our hospitals today. In 1815 a Committee was appointed to investigate the condition in 'madhouses' in England. The Report stated that keepers of houses for the insane admitted a greater number of persons than they were calculated for, there was insufficient staff, too much restraint was used, and the certificates on which the patients were received were often faulty and the visitation and inspection of private madhouses was inefficient. The Report drew attention to the flagrant abuses, which existed, but no immediate action was taken. For instance, at the **York Lunatic Asylum** it was found that there had been great neglect and cruelty. Of 365 patients who had died, the deaths of only 221 had been reported; a patient had been killed and his body disposed of so as to avoid an inquest; and two sets of books had been kept.

When **Dr. Munro,** the Superintendent of Bethlem, was questioned about the treatment of his patients, he said: **'patients are ordered to be bled about the latter end of May, according to the weather. After they have been bled they take vomits once a week for a certain number of weeks. After that we purge the patients. That**

has been the practice of years, long before my time.' It is true there were no strait-jackets - irons were held in more esteem! Patients were chained in a state of nudity to tables. A female patient in a hospital at **Bethnal Green** was confined in a pigsty. Male attendants not infrequently had charge of female wards (the practice appears to be returning) and the immorality and depravity, which existed, beg description.

As a result of this report in 1828 an Act (9 Geo. IV, c. 40) was passed appointing fifteen Metropolitan Commissioners to visit Homes in which the insane were detained. Elsewhere, humane treatment of the mentally ill was gaining momentum. For instance, **Frickle** in Germany, in 1793 applied humane treatment and greatly reduced mechanical restraint. In the USA **Bond, Kirkbride** and **Rush** instituted changes that were much in line with what was happening in Europe.

Abolition of Restraint

The Lincoln Asylum is an important hospital in the history of mental heath. It was in that asylum that **Gardiner Hill** and **Charlesworth** initiated the phase of non-restraint. In 1827 there were 72 patients, 39 of whom were constantly in restraint for a total of 20, 424 hours in a year. In 1837, **Hill** and **Charlesworth** changed this - out of 130 patients only two were under restraint for a total of 28 hours per

annum. Subsequently mechanical restraint was entirely abolished with the following results: - **"Patients showed a great improvement in their physical and mental health, their conduct was more controlled"** and **"the number of accidents and suicides was greatly reduced".**

Hanwell Asylum in 1838 under Conolly

Conolly became an enthusiastic advocate of non-restraint, and in one of his reports he wrote, **"There is no asylum in the world in which all medicinal restraints may not be abolished, not only with perfect safety, but with incalculable advantage".** In 1856 he embodied his wide experience and his wisdom in a book entitled *The Treatment of the Insane without Mechanical Restraint. The Edinburgh Review,* in 1870, commenting on Conolly's remarkable achievement the editor wrote as follows: "**To Conolly belongs a still higher crown, not merely for his courage in carrying out a beneficent conception on a large scale and in a conspicuous theatre but for his genius in extending it. To him, hobbles and chains, handcuffs and muffs, were but material impediments that merely confined the limbs; to get rid of these he spent the best years of his life; but beyond these mechanical fetters he saw there were a hundred fetters to the spirit which human sympathy, courage and time only could remove."** This is indeed a remarkable commendation on a person. Lest I be accused of dwelling too much in

the past, let me hasten to add that there are many mental hospitals in Africa where this practice of restraint in the manner described above is practised.

The Work of Dorothe Lynde Dix

Anybody, despite their background, can make positive contribution inspite of opposition even from professionals. One of the most outstanding and courageous personalities among the early pioneers was the American schoolteacher Dorothe Lynde Dix. This remarkable woman, handicapped as she was by her upbringing and poor physical health, showed a spirit and an enterprise in relation to the welfare of the mentally disordered, which has reverberated throughout the world. In America she was not only responsible for effecting great improvements but also founded approximately thirty-two institutions. I cannot do better justice to her contribution than **Professor Ivor R.C. Bachelor's** glowing tribute to her: - **'Could all the prisons on new and better plans she carried Bills for, and all the alms houses she caused to be thoroughly reconstructed be added to these and then all brought vividly before the mind's eye, the impressions would be amazing indeed.'** Bachelor continues: "Here in Scotland we are under a particular debt of gratitude to her".

She had come to Great Britain to recuperate from a serious physical illness. She came to Edinburgh and visited a number of houses and

hospitals where mentally ill patients were being cared for. Some were reasonably well conducted but in others she discovered the most serious abuses. She tried to interest the local authorities, lawyers and doctors in what she felt was wrong but her protestations were received with coldness and contempt. She was dubbed 'the American invader', an interfering busybody. She was, however, a woman of great determination, and irrespective of all obstacles and local antagonism she journeyed to London, and was successful in obtaining an interview with the Home Secretary. The evidence which she presented so impressed him that in a few weeks a Royal Commission was appointed to inquire into the condition of lunatic asylums in Scotland, and the existing state of the law of that country in reference to lunatics and lunatic asylums. The Commission was appointed on April 3, 1885, and it was largely as a result of its findings that public mental hospitals were established throughout Scotland. She had accomplished in a few months "what others during many years had striven to do".

Colonies, boarding out and other improvements were the next step with patients being given opportunity to be together during day time but live in their own homes or to live in boarding houses for sometime.

The Work of Thomas Laycock

Thomas Laycock held the parallel appointments of Professor of Medicine at Edinburgh University and Lecturer in Medical Psychology and Mental Diseases. In 1840 he published a book entitled, *"Nervous Diseases of Women"*. In 1860 he published another one entitled, *"Mind and Brain"*. As an example of his imaginative foresight he stressed the reciprocal action of body and mind and stated that... **"a practical knowledge of mental science is essential to parents, jurists and legislators, governors of jails, schoolmasters, and teachers, ministers of the gospel, naval and military officers and employers of labour."** In Laycock's estimation psychiatry was not a narrow speciality but a discipline for general application in studying the conduct of man.

As regards **research,** it was in 1866 that the **West Riding Mental Hospital Reports** were published on research in neurology. From 1866 onwards, various clinical research awards were established in various mental hospitals for the study and treatment of acute psychiatric disorders.

The Hospital Period

Since the beginning of last century the modernization and upgrading of mental hospitals has been a continuing process. The moderni-

zation has resulted in numerous beneficial changes in the following areas: - administration including infrastructure, medical staffing, nursing staffing, psychiatric social workers, occupational therapists, psychologists, chiropodists and hairdressers. These developments were made possible by various legislative acts that provided for and funded such activities.

The transition from non-restraint to modern hospital care of mental patients was bridged by a short-lived concept. This involved manual "seclusion", but not isolation, for dangerous impulsive patients who could not be trusted. This consisted of the use of single rooms - sometimes referred to as strong rooms, and of padded rooms which were locked, and in which the patients might be confined both during the day and at night. This arrangement had several advantages: - it prevented struggling with the patient, it obviated serious accidents, there was much less necessity to use powerful sedatives and it eased the burden and responsibility of a small, often sorely-tried medical and nursing staff.

As the medical and nursing staffs became increased, both in quantity and quality, it soon became evident that the vast majority - if not all of the so called single room cases responded more cooperatively when cared for and nursed in open wards where they could be adequately supervised.

The mental hospital today has established outside contacts and interests which previously did not exist. In addition to in-patient administrative and clinical duties they also involve themselves in such activities as:-Out-patient clinics, Child guidance clinics, Domicilliary, Consultations, Medico - legal work and University Departments of Psychiatry. Instead of closed high wall hospitals there has been a move towards open- door systems where the wards are unlocked, where patients are given the freedom of the grounds and adjoining city or country side and day and night hospital visits.

There are determined efforts to treat patients in their homes through home visits, family practice units, clinical psychologists, psychiatric social workers and health visitors. The aim is to diminish mental hospital admission rates and to maintain patients at work so long as it is compatible with their well -being.

The Evolution of Liaison Psychiatry

Liaison Psychiatry has also evolved. It involves the establishment of closer liaison with general practitioners, medical, surgical and other specialists. This relationship is of mutual benefit to all specialities, and also has the advantage of removing prejudice and stigma so traditionally associated with mental illness.

Teaching of Psychiatry at Undergraduate Level

On this issue, I cannot do better justice to this topic than **Prof. Bachelor** writing in 1920s. He wrote, **"A prerequisite for the extension of psychiatric work and service revolves around a comprehensive development of undergraduate Psychiatric education. We advocate the establishment of Chairs of Psychiatry in every medical school, and the incorporation of a *professional examination in psychiatry undergraduate training.* A medical student should be as adequately trained in psychological as in physiological (physical) principles, and we believe this can be effected by blending these disciplines throughout the undergraduate career."**

The University of Nairobi had better hear that loud and clear, and ask themselves why they still live in the past that belongs to history in this particular respect which is purely administrative. In actual fact this is an abnormality that sticks like a sore thumb because the University of Nairobi through the Department of Psychiatry has otherwise done exemplary work towards the development of psychiatry in Africa, particularly in research.

Post Graduate Training

In 1912 the University of Edinburgh started a Diploma in Psychiatry. Psychiatry was also made an optional sub-speciality in the membership of the Royal College of Physicians of Edinburgh. Since then there has been a proliferation of post-graduate training in nearly all medical schools. The emphasis and curriculum content, while maintaining some basic standards, have been on local needs first and foremost. This too, should be our approach. That is why I do not tire of mentioning Egypt as a classic success story.

Units in General Hospitals

In many hospitals through out the world, several wards in General Hospitals are reserved for mental patients. Indeed 5 - 10% of the beds could be usefully reserved for mental patients. Modern methods of treatment by means of drugs, ECT (Electro-Convulsive Therapy) and appropriate psychotherapy have made it possible to treat a wide variety of mental illnesses without disturbing the amenity of the general hospital. Psychiatry thus assumes an equal status with general medicine to the advantage of both. **This is part of the promise.**

Child Psychiatry

This is a very important area that should be incorporated with the pediatric services of any hospital. Seeds of many mental illnesses are sown in childhood. Childhood constitutes the golden period for the inculcation of mental hygiene; it is the plastic period of development, the time when prophylactic work should have its greatest reward. Appropriate modification of environment and social circumstances can work wonders. We need the concerted effort of psychiatrists, psychologists, educationists, social workers, parents, schoolteachers, the law courts, employers of labour and social organizations. **Emotional and social security is the greatest safeguard against all subsequent disorders of life and conduct.**

History in Perspective

While we note the recent changes and advances in psychiatry we, the psychiatrists of today, appreciate that even the changes of today are part of an evolutionary process rather than a revolutionary one. It is salutary to remember the enormous contributions of our predecessors, and to disabuse ourselves of a misguided notion. This notion suggests that the real study of psychiatry stemmed from **Emil Kraepelin** of 1890s, **Sigmund Freud** in the 1890s, the World Wars of 1914 - 1918, 1939-1945 or **Cerlatti** and **Binn** in 1937 or **Delay** and **Denker** in 1952, with all the explosion of psychopharmacology,

the neuroscience and related technology of the immediate yesterday. These people of the last 100 years or so made important contributions. But our memory for recent events may occlude the memory of the distant past, which was indeed the foundation on which we have built on in the recent 100 years or so.

Community Period

The evolution of social medicine illustrates the changed outlook on the prevention of illness in preference to cure. Social Medicine, and in particular Social Psychiatry, seeks to promote measures which will protect the individual and the community so that **man's mental and physical capacity can be maintained at its peak.** For this purpose investigations into the social, genetic, environmental and domestic factors are being undertaken in the hope that we may acquire greater knowledge in relation to the epidemiology of human disease, and of those more subtle influences which produce nervous and mental instability.

The whole personality of man has to be studied in relation to his social setting. Indeed the psychiatrists were already doing this in line with the psychobiological principles formulated by **Adolf Meyer** long before Social Medicine became fashionable. More recently **George Engel** has proposed the Bio- Psycho- Social model in the

causation and management of medical problems. This concept has been embraced widely.

The economics of mental health, and their impacts on individuals and societies cannot be ignored. **The fact that 8% of all children born will have a nervous breakdown and 3% will spend some part of their lives in a mental hospital is alarming enough, but it completely fails to express the anxiety, distress and unhappiness of sorrowing relatives.** The fact, too, that the combined number of mentally ill and defective is closely approximate to all those under treatment in general hospitals is indicative of the social and economic burdens for which the healthier members of the community have to assume responsibilities.

In a study, **Canby Robinson** (1942) found that of 174 patients admitted to the medical wards of **John Hopkins Hospital, Baltimore,** not less than 66% presented social problems that were related to their illness and in 36% social and emotional factors were the chief precipitating causes of illness.

Sir Aubrey Lewis, the celebrated Professor of **Psychiatry at the Institute of Psychiatry, University of London,** wrote in 1951 as follows: - **"Of all the studies in this field, I think those called "ecological" have been the most promising and informative...."** The chief of them was carried out by **E.L. Faris** and **Warren**

Dunham. They examined the origin of nearly 35,000 patients admitted to **Chicago Mental Hospital** between 1932 and 1934, and they found that those areas which had the highest rates of incidence of mental disorders had the highest incidence of social disorganization: *suicide, venereal disease (think of AIDS today!), family disruption, juvenile and adult crime.* High mobility in population, poverty, demoralization, cultural heterogeneity were also at a high level in these areas." At another point he commented: **"And in his daily work the psychiatrist, even more than any another physician, is incessantly forced to consider the social relations of his patients."**

The field of community involvement cannot be complete without the contribution of those who themselves have had an experience with mental ill health. The best example is that one of **Clifford W. Beers** who in 1907 wrote an autobiographical study entitled, "*A Mind That Found Itself.*" Therein he described his experience while he had been a patient in mental hospitals and made constructive suggestions as to the improvements that might be effected. In furtherance of his ideas in 1908 he founded the **Connecticut Society for Mental Hygiene.** This was followed by many such societies through out the USA. Today we have the **World Federation of Mental Health.** The consumers of mental health services have a say. Yes indeed!, the potential consumers, which is you and I, have a say. **This is part of the promise.**

I appreciate the fact that we have made tremendous progress in the last two decades on the biological understanding of mental illness so much that what we knew one decade ago is history now. **Nevertheless, it humbles me to acknowledge that we still know very little. It is like putting the tip of your toe into the ocean water at the beach. The vast knowledge is still beyond the coral reef.**

Current Global Situation

At least 500 million people (about 8% of the total world population) in the world today do suffer from some form of mental disorder and can benefit from appropriate care and support. **As many as 150 million people worldwide are estimated to be suffering at any given time from some kind of neuro-psychiatric disorder, including mental, behavioural and substance abuse disorders.** A third of them may be affected by more than one neuro-psychiatric ailment. **Three quarters of those affected live in developing countries.**

All over the world about 52 million people do suffer from severe mental disorders. Out of these, there is an estimated 45 million people with schizophrenia in the world and more than 33 million of them live in the developing countries. Anxiety disorders are estimated to affect 400 million people at any point of time. Mood (affective) disorders affect around 340 million people worldwide at any given time and depression is estimated to be present in 10% of

all those seeking care at **Primary Health Care** facilities worldwide. **40% of all disabilities are attributed to mental illnesses globally.**

Between 5 - 20% of children below the age of 15 years do suffer from mental disorders and the majority suffer from minor mental disorders such as anxiety, depression and emotional disorders. A World Bank study in 1993 reported mental health problems the world over to produce **8.1% of the Global Burden of Disease.**

The African, Kenyan and Individual Perspectives

The development of Psychiatry in Africa and Kenya in particular has passed through three stages with considerable overlap. These are primitive/non-scientific, humanistic and scientific. These stages are similar to those in the development of psychiatry in the Western societies. But as we now turn attention more inward, it is important to emphasize that the lessons learned from the very well documented history in the West have been crucial in our rapid movement in **this long walk towards the promise of better mental health.**

As an example, **Prince** in 1960 wrote, '.... **It is interesting that in 1925, long before tranquilizers or shock therapies were known to European psychiatry, Chief Adetona, with his Rauwolfia medicine, travelled to England to treat an eminent Nigerian who had become psychotic there....**' In 1980, **Ndetei** observed '**... Although**

the presumed psychopathology bears many similarities to that found in Western culture at various points in the equivalent stages of psychiatry, it is noteworthy that such extreme physical therapeutic approaches as flogging, binding, starving, etc were practiced least in Kenya. So it would appear that a more humane approach, regardless of presumed causation, was the norm throughout the non-scientific stage...'

From its inception in 1911 to the late 1950 **Mathari Mental Hospital** in Kenya was the only hospital in the country offering in-patient mental health services. These services were mainly custodial. However, in the early 60's an attempt was made at decentralization of mental health services by the establishment of psychiatric units in the Provincial General Hospitals. Thus provincial psychiatric units were established in **Nakuru, Kisumu, Nyeri, Kakamenga, Machakos, Mombasa** and **Murang'a**. Psychiatric nurses who had been trained abroad manned these units. Later in the 80's more psychiatric units were established in the districts as district psychiatric units in **Kisii, Eldoret, Meru, Siaya, Isiolo, Kerugoya** and **Embu.** It is envisaged that every district in the country will have established a district psychiatric unit to serve as a base for the provision of mental health services by the year 2020. At best this is the wish of the Government.

Twenty years ago, four psychiatrists working in Kenya made certain observations and recommendations, which have had profound influence on the practice of psychiatry in Kenya. These psychiatrists were **Dr. Gulam Mustafa**, the guru of psychiatry in Kenya, the late **Prof. Muhangi**, the Father of Academic Psychiatry in Kenya, then Professor of Psychiatry, University of Nairobi, the late **Dr. Willy Muya**, the Father of Policy Issues in Psychiatry, then Chief Psychiatrist, Ministry of Health and **Dr. D. M. Ndetei** - then a trainee psychiatrist. Ndetei while being specific on the various issues to be addressed, summarized them as administrative difficulties, failure to see psychiatric problems as totally medical problems, and lack of resources. He for example pointed out that in 1979 there were only nine (9) practising psychiatrists for about 15 million Kenyans. These commentators also borrowed extremely from other observers on the African scene in general. Those recommendations are summarized below, with a brief mention of what has come to pass.

1. **Post-graduate training of psychiatrists:** The emphasis must be on local post-graduate training rather than abroad training, for various advantages. If there was any case history to borrow from it was Egypt, which had embarked on a home-grown training programme which produced psychiatrists for Egypt and the rest of the Arab world. They looked for Egyptian standards and perfected them. Today Egypt still remains the show - piece success story.

2. **Increased input of psychiatry teaching hours in under-graduate medical training:** The Department of Psychiatry at the University of Nairobi succeeded in this only very recently, under very intense internal but not external opposition. **Need I remind you of the case of porched and fried eggs!**

3. **University examination in Psychiatry at undergraduate level:** I need not add to what I've already said. This is our shame.

4. **Increased training of paramedics in psychiatry:** Unfortunately this has hardly taken off, although the Department of Psychiatry, University of Nairobi has fully developed curricula in various aspects prepared in the last two or so years at the initiative of Prof. Ndetei. Again this took place against strong internal opposition.

5. **Establishment of Chairs (full Professorships) in the following areas:** Adult Psychiatry, Child Psychiatry, Forensic Psychiatry and Community Psychiatry. The special significance of Child Psy chiatry and Community Psychiatry have already been dealt with under **"Historical Developments and Global Perspectives"**. Let me re-emphasize that these two particular branches of psychiatry are vital if we are going to make an impact. They are more preventive than curative. Prevention is always better than cure. They will be very useful, particularly in the related research aspects,

for it is research in these particular areas that will sharpen the process of policy decisions. There is a huge gap in our understanding of the epidemiological patterns and characterizations of the various psychiatric disorders and so far we only depend on foreign epidemiological data. **How can we formulate policies using irrelevant foreign data?** We do not ask this rhetorical question out of misplaced chauvinism. We ask it for pragmatic reasons.

Currently there are only two positions of Chair in Psychiatry between Nairobi and Moi Universities. **The magnitude of psychiatric issues begging for attention dictates that we should have more. More could be filled if qualified candidates were available.** ***The emphasis is "qualified".***

6. **Decentralization of Psychiatry** from the then Mathari Mental Hospital (currently known as Mathari Hospital), then Gilgil Hospital and the provincial units to District General Hospitals, both public and private and to Health Center level. The new Mental Health Act provides for this. So far decentralization to some general hospitals has taken place.

7. **Emphasis on Community Based Psychiatry** rather than purely hospital based Psychiatry. This has hardly taken off.

8. Any future creation of **psychiatry hospital beds** to be based in general hospitals in order to enhance Liaison Psychiatry and reduce stigmatization. Unfortunately there have been moves here and there in the opposite direction.

9. Concerted **Public Health Education** through electronic and print media. This has been perhaps the most successful.

10. A modernized **Mental Health Act.** This was put in place in 1992.

11. On **Psychotherapy** and **Behavioural Therapy,** Ndetei observed 20 years ago thus **"If the argument is that, as one often hears amongst Western Psychiatrists, developing countries have already too many severely mentally ill patients and there fore, because of the nature of patients, non-physical methods of treatment have little role to play, then we had better laugh at the naivete of this argument lest we weep...!"** I cannot improve on this except to say my post-graduate students of today are indeed demanding for it.

12. **Research.** This is vital and therefore worthy of more attention. The Department of Psychiatry at the University of Nairobi has fulfilled this mandate quite well. We have the most extensive publications in the world's top most peer reviewed psychiatric

journals South of the Sahara and North of the Limpopo. Further, we have nearly 100 quantitative research based dissertations and documents not yet published. This is a colossal wealth of information. However it is not enough to sit in the glory of what the Department of Psychiatry University of Nairobi has singularly achieved, even if we were riding on the clouds. We should not merely measure ourselves in relation to others, but more on what more we could do and remains to be done. Research is the cornerstone of academics. Without research there is no University in the real sense. There is so much that we do not know about psychiatry in Kenya. You will understand therefore if I talk much more on research and academics, more so with some passion.

Let me take this opportunity to sound a word of caution to fellow local researchers. I believe we have first class minds in Kenya for research, by any standards in the world. Our only problem is resources. But we must never allow our lack of resources to be misunderstood by our western colleagues to mean that we are incapable of original thinking and therefore, the best we can do is merely to collect data, while they have the money to pay for the exercise and consequently own the data and all the intellectual property.

This academic colonialism and imperialism, which turns excellent African researchers to no more than research assistants is unacceptable. We must also be alert to people who come in the most diplo-

matic approaches when all they want, as the saying goes is to tap our brains, then go develop the ideas and own them. To our colleagues in the West I call upon you that we work as collaborative teams.

But while we strive to set the pace for local research as described above, we must be careful that we too do not become our own enemies through petty professional jealousy. I am reminded of **Kemron** and **Pearl Omega**, and the works of **Dr. Davy Koech** and **Prof. Arthur Obel**. They made two courageous local scientific attempts to address the **HIV/AIDS** menace. Without prejudice on the merits and demerits of their work, I wish to observe that it was Kenyan professional colleagues who became the most vitriolic critics of the much desired local efforts. In many ways the local colleagues confused the lay public, for in their criticism they could not distinguish between professional jealousies, personalities, partisan politics and scientific issues. Even if there was no scientific basis on the parts of Dr. Koech and Prof. Obel, could we not find a way that protected their potential discoveries from plagiarism or being claimed by others, or at least encourage them? The story of collaboration with Kenyan scientists in the search for an AIDS vaccine is illustrative. The beef, in the form of copyright was long gone before the media raised an uproar.

Let me go on and make a further assumption that it was our local researchers who were wrong in every aspect we can think of. Even so couldn't we, the large scientific community, find a way to approach our own without public vilification? With these kinds of developments we may feel justified in asking what then is the difference between the politicians and us, supposedly dispassionate academicians.

And while we were internally fighting amongst ourselves, other scientists were busy evaluating the scientific demerits even if not merits of the claims made by our scientists. And if I may be allowed to say **so some of the people who were most vocal have nothing to show of their own even on elementary research beyond the basics expected as part of training at post-graduate level.** Kenyan scientists are some of their own worst enemies. They want to kill first and then look for the evidence why they had to kill. Lest I be misunderstood, let me say that there are Kenyan researchers and academics of the highest integrity who know the difference between endemic criticism as a syndrome and scientific critique.

The Universities have a role to play in promoting academics. In the best universities I have been to, the highest recognition is directly related to seniority in academics and efforts are made to recognize this. I leave it to the university administrators to ponder over this. An academician's calling is original thinking to generate

hypotheses and test them, that is to say describe problems and find solutions that are realistic and applicable. An academician is not merely the teacher we call lecturer just because he happens to be based at the **University** and does no more than pass on established information to others. The real **University** originates and generates new ideas but not just conveys ideas, for that just about anybody can do. If it can only convey established information, it is just no better than a tertiary kind of high school. A **University** is not just the building but the people who are associated with it and their creative ideas. A **University** is a **University** more because of what it causes to happen outside of its walls than what happens within its walls.

There is a common joke at the Institute of Psychiatry of the University of London, a world premier centre of academic psychiatry. They say that if you want to see one of its top most professors, then you camp at Heathrow Airport. That is where you see them as they go in and out of the country on academic pursuits. Well, it is only a joke as they say, but it makes the point clearly about the generation of novel ideas and making those ideas count for something in the society. In a different manner of speech, I am saying to Universities and lecturers - **publish** or **perish.** And they must never use the excuse that the University and/or the Government do not provide research grants. **Local researchers must learn to compete for grants in the open world market.**

Involvement of the Patient and Support System

An important empirical experiment took place at **Mathari Hospital** in 1981 - 1984 with considerable impact and long-term effects. **Ndetei** carried it out. Immediately on joining the Department of Psychiatry he was made in charge of Ward 7 Male, in Máthari. He introduced the **holistic approach** to the total management of the patient. What this means is that you take into account the total context of the patient. The **diagnosis** and **drugs** available are just part of the management of a patient. The **family**, the **support system** and the **socio-economic aspects** are all important. At that time the Ward 7 Male average population was well over 120, often reaching 150, and patients not only shared beds, but some slept on the floor. It so happened in that year and the following years that there was an acute shortage of drugs in the hospitals, and Mathari was particularly affected. The few drugs available had indeed been donated "before they expired." Then, as now, the economy of the country was going through the doldrums.

He started regular patients ward meetings besides regular weekly ward rounds in which the patients would meet. They were encouraged to talk freely about their problems, within and without the hospital. They had their ideas on how their lot in the hospital could be improved. Above all they had constructive suggestions about how their lot from without the hospital could be improved. One of the

most consistent theme was how they found it so difficult to fit in the society once they were discharged from the hospital. "We are simply labelled Mathari cases. If we laugh, we laugh like Mathari cases. If we weep we weep like Mathari cases. If we have wonderful ideas they are from Mathari cases. There is nothing we can do good or bad without it being dismissed as coming from a Mathari case". This is what stigmatization of a disease, any disease brings - alienation and further morbidity.

From these cues, efforts were made to educate their relatives on the nature of their respective psychiatric conditions, and what they, the relatives, could do to assist their sick ones. Apparently nobody had done this before. The relatives were quick to understand, and appreciate and accept to play their roles. Within a period of two years, we reduced the ward population from about 150 to 30 patients. The patients simply got better faster and on discharge did not seem to relapse. On appointment days on follow-up they all seemed much better. To my surprise this caused alarm, and I got messages that there were people in need of jobs and therefore the reduced population of patients was a threat to their jobs.

In retrospect that experiment was the turning point in the ward population at Mathari. It was not drugs - almost none was available; it was not changed type of patients - they had always up to now been the same. There was no increase in available psychiatrists.

Indeed there was at the time a relative decline. The local postgraduate programme had not produced a graduate as yet. **Indeed our greatest asset in the management of mental health problems is our traditional family and social support system. No technology, no drugs, can substitute this.**

Public Education

Once again a landmark development took place from April 1982, and lasted for over ten years. **Prof. D. M. Ndetei** carried a weekly series of articles on various aspects of mental Health. The results were remarkable. This was supplemented by Radio and Television programs. Others came on board. **Dr. Sam Gatere** deserves a special mention. Public Education has been the most successful exercise. It is possible to educate the lay public on nearly all types and aspects of mental health. This reduces stigmatization and enables people to go for early intervention. It also enables them to effectively participate in their care, especially at home, thus reducing the cost of hospitalization. It enhances the family and social support system.

Human Resources

Let us now touch on the thorny question of human resources. There is acute shortage of trained mental health personnel. To date, Kenya

has managed to train a total of 70 psychiatrists, 5 of whom are deceased. Out of the remaining 65, 13 psychiatrists have fallen victim to brain drain and are practising outside the country. Only 15 of the 52 working in the country are in public service. It is estimated that there are about 500 Kenya Enrolled Psychiatric Nurses (KEPNs) and about 300 Kenya Registered Psychiatric Nurses (KRPNs). There are 40 Medical Social Workers in the Ministry of Health and 30 Medical Social Workers employed by Kenyatta National Hospital. Please note these are medical, not psychiatric social workers. The above statistics call for serious human resource development efforts in terms of training of mental workers in different cadres.

At the level of undergraduates, starting at the global perspective, university examination in Psychiatry was introduced into Medical Schools at the turn of the last century and continues to attract increasingly more time. It is an examinable subject all over the world, including all medical schools in Africa, and including the new Medical School in Moi. Indeed in the Foreign Medical Graduate Examination, which foreign medical graduates intending to practice in North America must sit and pass, 30% of the questions are on Psychiatry.

TheUniversity of Nairobi Medical School, a premier medical school in Africa, has the distinction of not having psychiatry as an examinable subject. What a shame! And it was not because they lacked

professional guidance. Indeed they had the same guidance that other medical schools sourced from. But somebody somewhere listened to the professional critics. It was more like the husband and the egg story given at the start of this discourse. The victims are the Kenyans themselves who in the long run are denied an expertise they greatly and desperately need. And so, like the stone that did not respond to the hyena, it nevertheless heard the hyena, and the hyena went on its journey and took on other begging assignments and challenges on its way to the destiny of his vision. I have recently heard an interesting twist to this story of the hyena. It says that the hyena was surprised to discover that there were indeed stones that would respond, and so was grateful to the non-talking stone for hastening the onward walk to its visionary destination.

At the level of postgraduate training there is no doubt Kenya has done a commendable job. Table I, summarizes the Psychiatrist - Population ratio in some countries. We came tops South of the Sahara and North of Limpopo. In the rest of Africa outside South Africa we are surpassed only by Egypt with 600 psychiatrists practising in Egypt for a population of about 60 million. They have well over 10 medical schools training at postgraduate level while we have only one. Looked at this way, then Kenya tops in Africa, thanks to the Department of Psychiatry. In a recent international conference, **Prof. David Ndetei** received a special mention for having trained more psychiatrists than any other individual in the whole of Africa.

But more importantly than the number psychiatrists is the fact that in Egypt psychiatry is an examinable subject at undergraduate level. By the time of Independence South Africa had about 200 psychiatrists for a population of about 35 million and with 8 medical schools in which psychiatry is an examinable subject at undergraduate level. However Egypt remains a classical success story not only in the number of psychiatrists, but also in the relatively even distribution of those psychiatrists.

There are several other landmarks in the development of mental health in Kenya. These are summarized in the appendix. Even though Kenya has done quite well in comparison to other Africa countries, but there is no reason for sitting on her laurels. Out of those 60 or so psychiatrists available in Kenya none is, for all practical reasons, available outside the major towns. Those in Nairobi, for example, are either in the highly lucrative private sector or in administration or in academics, leaving relatively few for the day to day routine clinical work in the public sector.

It is unlikely therefore that in the foreseeable future - in the next twenty years or so that we will have enough psychiatrists for the public sector. Those present now and tomorrow will, out of necessity and expediency, be for providing leadership in research, teaching, policy issues and administration.

The strategy must therefore change. We must start focusing also on training paramedics in mental health. We have no Clinical Psychologists in the public sector. We have no Clinical Officers trained in Psychiatry. We have almost no Psychiatric Social Workers in public sector except one in the Department of Psychiatry. We have new and peculiar challenges that need special attention, particularly in the areas of substance abuse, psychotrauma. HIV/AIDS, in addition to the traditional areas of calling. **We will never have enough psychiatrists to effectively provide these services. No country in the world has enough.** Therefore in addition to training paramedical staff in the above areas, we must also give adequate and working psychiatric skills to both generic medical graduates and nurses. **The overall strategy should be such that any Kenyan, who makes a first contact with a health care professional of whatever kind, that professional should be able to provide mental health services and only refer the complicated cases. This is part of the promise.**

Clinical and Policy Issues

Policy issues have generally followed research findings and concerted efforts. **Research has shown that between 20-30% of all persons seeking medical assistance in both private and public health institutions in the country do so primarily due to psychological problems.** The prevalence of psychiatric illness amongst

those seeking medical help is not less than 20%. There is a need for a full range of the various psychiatric services, but the problems involved are immense and constitute major differences between the practice of psychiatry in Africa, in Kenya and in Western countries. There is however a clearly evident move to solve those problems.

The prevalence of psychiatric morbidity in Africa is similar to, if not higher than that found in the western culture. Unfortunately, there has been a tendency amongst commentators of psychiatry in developing countries to lump them all together. This inevitably results in overlooking the needs of the individual countries. The prognosis of a psychiatric illness may vary from culture to culture.

Descriptive and interpretive phenomenology and management by both traditional and western observers of psychiatry in Kenya have been documented by various workers who have all noted significant differences between developing and developed countries.

It has also been established that most of these patients are misdiagnosed as suffering from "chronic" malaria, amoebiasis, rheumatism and kidney disease. **Lack of proper diagnosis by clinicians leaves the patients at the mercy of wasteful prescriptions and costly laboratory and other investigations.** These lead to chronicity with resultant socio-economic disability aggravating

rising demand for mental health services. Ndetei and others have written extensively on these observations.

For a long time, mental health has not been regarded as an important component of total health. This state of affairs has led to mental health being given a low priority in the provision of mental health services in Kenya. Mental Health was not represented at the National level until 1987 when the Division of Mental Health was created and a Director of Mental Health appointed as stipulated in the Mental Health Act (1989) Cap. 248 of the Laws of Kenya, which commenced in May 1991. The Kenya Board of Mental Health and District Mental Health Councils were constituted under the Mental Health Act whose responsibilities among other functions include advising the Government on the Mental Health issues affecting the people in Kenya.

A very important policy issue decision was to incorporate Mental Health as the ninth essential element of Primary Health Care and in the process make Mental Health issues at par with other pressing medical issues. In 1996 the first Kenya National Mental Health Programme was launched. This gives a blue print of the National Mental Health Plan of Action for the next millennium. The Plan of Action gives the immediate, medium and long-term action plan. In a nutshell the mental health policy emphasis is on decentralization of mental health services to the community level, integration of

mental health services into the existing general health services, incorporation of mental health services within provision of Primary Health Care services and multi-disciplinary and inter-sectoral collaboration with community participation and involvement in the overall socio-economic development which forms part of the promotion of good mental health of not only the individual but also the family and the communities at large.

Ethnopsychopharmacology

This discourse would be incomplete without a mention of drugs as relates to our geographical, economic, cultural and social situation and the increasingly related topical question of ethnopsychopharmacology. In recent years, there have been astronomical improvements in drugs used in psychiatry. In 1937 **Cerlatti and Binn introduced Electro-Convulsive Therapy.** In 1949, **Dr. Cade** of Australia introduced Lithium Carbonate. In 1952 **Delay** and **Deniker** introduced Chlorpromazine. Imipramine was introduced in 1956. Thereafter there has been an explosion of highly innovative drugs introduced into the market. The biological basis of many types of psychiatric conditions have been understood, leading to a rational use of the available drugs. Whereas these drugs are available on the world market, it is important to know they are relatively unavailable to the overwhelming majority of Kenyans. I am reminded of a patient who was given a very expensive drug for free

by his physician. However there were conditions that had to be obeyed by the patient. He had to take it three times a day but on a full stomach. He said to the doctor - **"Doctor, I really want to obey you and take your drug for which I am most grateful for giving it for free. But Doctor, I haven't had a proper meal for the last two days, and I don't know when and where I will get the next one. So I am very sorry I cannot take your medicine".** The doctor's reply was not only arrogant but also insensitive. **"No problem, I will give them to somebody else who can fulfil all the conditions for indeed there are many who can do so",** the doctor said, as he called for the next patient.

Not so long ago, an oily, tarred poorly dressed tramp who happened to be suffering from a certain psychiatric illness walked into a doctor's office and straight away demanded for a cup of tea as he was very hungry. In his hand he was carrying a prescription given by a **"highly qualified and the best psychiatrist"** to borrow his own frequent descriptions and self-portrayal as per the patient's verbatim report. He had prescribed for the tramp to buy a medicine which costs 18,000/= per month. Yes, it was one of the new, allegedly "revolutionary" drugs. But really was it appropriate to prescribe it? It therefore needs no belaboring that the socio-economic aspects and indeed the total context and the unique individuality of every patient can only be ignored to the ridicule of professionals regardless of how qualified or good they may consider themselves. **If indeed**

we cannot humble ourselves enough to the level of, and relate on a two way basis with our patients, if we cannot communicate effectively with and enlist informed and realistic participation of our patient and/or where appropriate a relative or caring person, (the opposite of which is professional ivory tower arrogance) then our clinical qualifications are all but vanity. This said and done, trans-cultural psychopharmacology seems to suggest that nearly 30% of drug response may be accounted for by factors that have a cultural and geographical variation.

Pharmacogenetic and pharmacokinetic studies (that is studies on genetics and how drugs are metabolized) confirm this. There is therefore a caution that we must not take in - line, hook and sinker, the marketing forces of multinationals whose primary goal is profits. It is still possible that available and affordable drugs could be as effective as the newer generation but unaffordable drugs, provided they are used and prescribed judiciously and in much lower doses. This is supported by independent clinical studies which some multinational drug companies do not want to hear about and would go out of their way to "buy silence" on these studies. Lest you misunderstand me, all new drugs have their characteristics, but also equally important are the new insights that come in with the understanding of the biology of mental health problems. **Yes "innovative" drugs have a place, but not all the place all the time!**

Tomorrow - The Next Twenty Years and Beyond

We need to strive hard to fulfil all the dreams of yester years, for they still remain our dreams today. **Training and producing adequate and appropriate human resources** at both paramedical and undergraduate medical levels with adequate working and functional exposure to Psychiatry and Clinical Psychology is our only hope. This will be our salvation into the foreseeable future. The next 20 years will be critical in turning the tide.

The Department of Psychiatry has worked on measures to achieve this. Some are in place and others await implementation. In specialized training we are part and parcel of the worldwide trend in the decline in postgraduate training in General Psychiatry. USA has raised the alarm, Britain has raised the alarm. All African countries I know of, particularly the medical schools where I have been external examiner in, have been harder hit than Kenya. Kenya has indeed become a poaching ground for the rest of the world, confirming a decline in numbers of Psychiatrists even in the West. Besides generic training there is need for specialized training to address specialized areas even for non Psychiatrists in such areas as: Clinical Psychology, Psychiatric Social Work, Substance Abuse, Psychotrauma, Psychogeriatrics and others that will emerge according to demand and circumstances.

The University of Nairobi has put in place various syllabi to address these issues. Significantly, during the first week of May this year, the Department of Psychiatry inaugurated, a Master of Science degree in Clinical Psychology course. This is a demand driven course. It is driven by the expressed needs of many people in society who are suffering under the weight of psychological disorders and who are crying out loudly for help - if we have the ears to hear them.

Unfortunately, the scenario for the future is one in which the levels of trauma and stress in our society are set to increase-even exponentially. These will come principally from many socioeconomic factors as poverty becomes more pervasive, as a litany of school fires continues unmitigated such as we have seen in Nyeri, Bombolulu, Kyanguli and elsewhere, and as motorists, cruising feverishly helter skelter on our pot-holed roads consign some of our beloved relatives to death by the roadside. Others cannot even have the dignity of a burial as they are dispatched to a watery grave in avoidable accidents at the Mtongwe ferry and Sabaki bridge. By the time we mention HIV/AIDS, you realize that there is a formidable mountain of 'oppression' disordering the 'psyche' in Kenya. The production of Clinical Psychologists with expertise to address the 'hurts' created by this mountain of problems puts the Department of Psychiatry in the forefront of the fight against mental disorders not only in Kenya but in other Third World Countries with similar sociocultural conditions.

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Research

This is our tool in finding home made solutions to our problems. In an attempt to find answers to our mental health problems, it is only research and I am talking about 'scientifically valid and reliable' research that will save us. We must move away from mere case reports. Research will help us to do the following:

a) Understand the epidemiological patterns of the various psychiatric problems.

b) Understand the socio-cultural and economic aspects of the various psychiatric problems. Vital to this, but very rarely talked about is a Trans-cultural aspect of Psychopharmacology. Unfortunately we have been left to the mercy of the powerful marketing gimmicks of drug companies and we forget to raise very basic issues even when efficacy is not the issue.

c) Prioritize the kind of training that is most appropriate and decide what kind of service provision structure is best.

d) Identify the most cost-effective strategies to our problems. Egypt, an African country is the perfect success story of how research can be used to fulfil the above objectives.

e) Strategize on educating every lay Kenyan on mental health.

The Promise

The Promise of Psychiatry in the future is therefore one that foresees the following:

1. Psychiatry will continue to play an increasingly front-line role in understanding the human brain and mind. **The promise is that Psychiatry will one day take its legitimate seat at par with all other disciplines.**

2. **All citizens of this region will have access to appropriately trained personnel and access to an appropriate management that is affordable and effective and without discrimination or stigmatization.** This promise will only come true for Africa if it truly is African based, it will come true for Kenya if it is Kenyan and Kenyan nurtured. Research, appropriate training and public education are the vehicles on which we **shall ride to the promise**. Training and research are useless unless they can be translated to cost-effective service to consumers of our services.

"Eureka!" on its own only excites the inventor. We must move from the inventor to the consumer! The consumer is an individual who is a unique entity out of the slightly over 6 billion individuals who live on this planet earth. **Any management must therefore be tailor-made, taking into account his full context - social, genetic,**

economic, and cultural. This is the challenge. It is part of the promise. The promise is therefore affordable mental health for all that is at par with any other medical discipline. Research, and in particular operational research is our tool. This tool will be used together with advocacy, from the global level to the individual level.

Like Dr. Martin Luther King Junior speaking on Third April, 1961 in Tennessee (USA), I want to be honest with you and tell you we still have quite some way to go to **get to the promise.** Yes, we have a much shorter way to go than the tortuous one we have come. **But I am happy to report to you that I have been to the mountaintop, and I have looked over, and have seen the promise yonder.** There are still challenges and obstacles to overcome. I may not be there with you by the time the profession gets there but that does not matter to me. There are many I have raised and many more will be raised to take the profession there.

The other day, I was discussing a project with my post-graduate students. On one particular aspect I told them as much as I would love to delegate a particular function to them, I did not think the sponsor would wish anybody other than me to perform that particular assignment. Then one of them, as if I had provoked her retorted... **"But Professor, we can do it, go and tell them so, professionally we are your clones!"** So be it! If only they knew how much I long that they would mature to be better than I am. And then I

remembered some of my students who have excelled. One is the Acting Chairman of the Department of Psychiatry University of Nairobi, another heads the Department at Moi University, another teaches at the Harvard University U.S.A (perhaps the most prestigious medical school in the world), another one is Associate Professor in Zimbabwe and the highest flying Psychiatrist in that country, another is Director of Mental Health, Ministry of Health, another one co-ordinates Mental Health arising out of the Bomb Blast and many more. These and others both in Public and Private Sectors, in and out of Kenya, seem to be the flag bearers in that **cloning system.** That is my blessing that I pronounce upon them. Let them be courageous.

And so I stand here today purposely to pronounce encouragement and hope, and declare that we as a profession will get our people, the consumers of our profession, **to the promise.**

Each one of us walks their own different individual path **towards the promise**, but as fellow human beings there are common denominators in our approaches. I have found one of the most effective approaches to be an increasingly common but extremely profound statement that says ***"God give me the courage to change the things I can change, the serenity to accept the things I cannot change and the wisdom to know the difference."***

In my concluding words, my greatest gratitude is to the Almighty God, to whom all the glory belongs, for using me as a vessel to make my own modest contribution **towards the promise** and for pointing the way forward for many, particularly my students and patients. **To all my teachers from primary school to university, my students and patients, my parents and children, I dedicate this Inaugural Lecture.**

The End

PSYCHIATRISTS' RATIO TO POPULATION IN SELECTED COUNTRIES IN SUB-SAHARAN AFRICA:(MID 1997)* Table 1

Country	Population (Million)	Number of Psychiatrists	Psychiatrist/ Population ratio
Uganda	20.6	11	1:1,1,872,700
Tanzania	29.5	11	1:2, 681,800
Kenya **	**28.8**	**56**	**1:514,200**
Rwanda	7.7	1	1:7:700,000
Nigeria ***	102.1	100	1:1,021,000
Ethiopia	58.7	11	1:5,336,300
Zambia	9.4	2	1:4,700,000
Zimbabwe	11.4	10	1:4,140,000
Malawi	9.6	1	1:9,600,000
Mauritius	1.1	9 (all Government)	1:122,200
Cameroon	13.9	4	1:3,475,000
Ghana	18	11	1:1,636,300

*** Source:** *1997 World Population Data sheet publication of Population Reference Bureau Washington DC. 1998 WHO Africa Mental Action Newsletter.*

** Only one medical school training psychiatrists.

*** More than 10 medical schools training psychiatrists.

SOME LANDMARKS

1911 Mathari Hospital is started as the African Lunatic Asylum.

1947 Dr. Collins Carothers is appointed Psychiatrist at Mathari Mental Hospital. He was later to write extensively on African Psychiatry and Psychology.

1967 Department of Psychiatry within the new Medical School in Nairobi is inaugurated.

1975 Prof. Joseph Muhangi joins the Department of Psychiatry. He inspired and initiated academic psychiatry.

1976 Dr. Willy Muya initiates Overseas Post-graduate training of psychiatrists for Kenya.

1979 The first paper on **Phenomenology** and prevalence of mild Psychiatric Disorders in Kenya is published in the British Journal of Psychiatry. This is perhaps the most extensively quoted paper in Africa in this area.

1980 First Ever Inaugural Lecture in Psychiatry is delivered by Prof. J. M. Muhangi, (Title: ***Psychiatry in Kenya: New horizons in Medical Care***).

1980 The unprecedented and "prophetic" publication entitled, ***"Psychiatry in Kenya; Yesterday, Today and Tomorrow"*** published, in the Acta *Psychiatrica Scandivavica.* It set the agenda for the next twenty years.

1981/84 The Great but quiet revolution at Mathari Hospital initiated by D. M. Ndetei through the process of holistic approach. The population of patients decreased remarkably inspite of diminished resources.

1982 A weekly serialization of psychiatric articles by Prof. D. M. Ndetei in the *Daily Nation* starts and runs for nearly 15 years.

1983 Local Post-graduate training starts in the University of Nairobi with tremendous success.

1983 D. M. Ndetei (later on joined by Prof. Stanley Acuda) started regular University Health Services Psychiatric Clinics as part of their voluntary services to the University. This has since then been turned to a purely consultative clinic on pay basis.

1985 The University of Nairobi awards first Doctor of Medicine in Psychiatry, the recipient: D. M. Ndetei.

1991 Mental Health Act comes into effect.

1995 Changes in the curriculum for medical students increasing the hours in Psychiatry to an examinable level. However examination in Psychiatry as a University examination has not yet started.

1996 Mental Health Trophy for the ***Mental Health Worker of the Year*** in the country is donated by Prof. Ndetei to encourage and recognize excellence in mental health work. It is awarded by the Ministry of Health.

1997 The Development of the first internationally used psychiatry research instrument from Africa - The 'NOK'- (Ndetei, Otieno, Kathuku) Scale for Depression and Anxiety by Prof. Ndetei.

1999 Prof. D. M. Ndetei spearheads development of curricula for innovative programmes in the areas of Clinical Psychology, Psychotrauma, Substance Abuse, Clinical Psychiatry and Psychiatry Social Work under the parallel programmes of the University of Nairobi.

2000 University of Nairobi Senate approves curriculum for **Master of Science in Clinical Psychology.**

2001 First class of Clinical Psychology starts in the Department of Psychiatry.

2001 The University of Nairobi Senate approves curricula for post-graduate Diploma courses in Clinical Psychiatry, Psychiatric Social work, Substance Abuse and Psychotrauma.

2001 Second Inaugural Lecture in Psychiatry and first ever Inaugural Lecture by a University of Nairobi MB.Ch.B graduate is delivered.

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