WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

GROUP MEETING ON MENTAL HEALTH AND MENTAL LEGISLATION
Cairo, 12 to 17 June 1976

EM/GR.MTG.MH.ML./10

ENGLISH ONLY

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This study covers 13 countries out of the 24 countries included in the Eastern Mediterranean Region (Bahrain, Cyprus, Democratic Yemen, Egypt, Ethiopia, Iran, Iraq, Jordan, Kuwait, Qatar, Saudi Arabia, Sudan and Syrian Arab Republic). Out of these 13 countries, 6 have a legislation on mental health and 3 more are considering the adoption of a law. We have had access to a copy of the draft law from both Iraq and Saudi Arabia, documents originally written in Arabic but translated by the WHO Translation Unit. We had only a description of the draft law presently under consideration in Ethiopia, in the questionnaire. This leaves 5 countries (Bahrain, Democratic Yemen, Jordan, Kuwait and Qatar), with no legislation in the field of mental health and which have been referred to as "informal systems". All of these countries have been listed in the different tables included in the general review.

The years of enactment of the different legislations are as follows:

Cyprus: Mental Patient Law of 1931
Democratic Yemen: Lunacy Act of 1938
Egypt: Mental Health Act of 1944
Iran: Legislation scattered in different codes (civil code of 1928 and others)
Sudan: Mental Health Legislation of 1975
Syrian Arab Republic: Mental Health Legislation of 1954-1965.

It should be noted immediately that both the Cyprus and the Democratic Yemen laws have been directly influenced by the British legislation and furthermore, that the law in application at the present time in the Democratic Yemen is the old Lunacy Ordinance of 1938, part of the "Laws of Aden" and is almost word for word the exact replica of the Indian Lunacy Act of 1912 still currently in application in India.

It was felt that besides the questionnaires and the text of the laws themselves, it was necessary to gather and consult more material on the mental health services and programmes in these different countries in order to get a broader picture of the background, the problems encountered, the accomplishments already measurable and the projects for further improvement of the condition of the mentally ill patients in this Region. A large amount of information has been taken from the Reports of the WHO Regional Office for the Eastern Mediterranean Region.

These countries vary a great deal in size (from 598 km^2 for Bahrain to 2,505,813 km^2 for the Sudan), population (from 80,000 in Qatar to 34,840,000 in Egypt) and density (from 4 in Saudi Arabia to 368 in Bahrain), which of course colours differently the nature of the problems to be solved. Culture, traditions and degree of urbanization and industrial development also have to be taken into account.

This study will be divided into two general sections. The first one will deal with the question of mental health services and their relation to the existing legislation in some countries or the draft laws to be adopted by others. We shall also include in this section the countries with currently no legislation and try to look into the reasons for this absence and the possible desire for change. The second section will deal with more practical problems such as the existence of a mental health programme, the availability of services to different categories of people like the mentally retarded, alcoholics, drug dependent persons, geriatric patients and finally the question of the training of personnel.

I. Mental Health Services

It can be said without risk of overgeneralization that the movement away from old traditional custodial care of mental patients towards more voluntary access to care and informal outpatient treatment is to be found in most of the countries included in this study (Table I).

A. Formal legislative systems (Table II and Table III)

Cyprus legislation dates back to 1931 and is modelled after the 1890 English law. It does not contain any provision for voluntary access to care. Hospitalization is only compulsory and the procedure is based on a court order. The one psychiatric hospital, in Nicosia, the Athalassa Hospital, opened in 1964, had in 1973 around 850 patients in residence, divided into 23 wards. There are occupational therapy departments at the hospital and 75% of the patients are free to use the hospital grounds. However, most, if not all of these patients are under detention. A psychiatric wing was opened in late 1963 at the Nicosia General Hospital. Besides a small inpatient department of 30 beds, it offers an outpatient and consultation service. Admissions are all voluntary: by self-referral or referral by physicians, private psychiatrists or social welfare department. The total number of outpatients in 1971 was over 2000 and there were over 15,000 recorded attendances. It should be added that only neurotic and mild psychotic cases are admitted in the psychiatric wing.

Large groups of professionals are asking for radical changes in the legislation, and the government has appointed a special Committee to review and revise the existing law.

Democratic Yemen. As was indicated before, the Lunacy Ordinance of 20 July 1938 was closely modelled on earlier British legislation. It provides both for voluntary access to care and involuntary hospitalization, based on a magistrate or court order. The mental health services in Democratic Yemen include: one new hospital under construction which will be functioning in 1978, with 206 beds, in Aden; one old hospital functioning since 1966 with 87 beds, in Aden, which needs modernization and expansion; one small psychiatric unit in Ankalla with 10 beds; 2 outpatient clinics at Sallam hospital and Jamhouria hospital, both in Aden. The respondent estimates that there are approximately 60% of voluntary patients. Only social workers and psychiatrists feel that some limited changes are needed, consisting of additional rules and regulations "on duties and responsibilities of the medical staff and of the social workers". There is an obvious concentration of services in Aden.

In Egypt, the tradition of medicine goes back to antiquity, and psychiatric cases have been treated in a separate ward in a hospital created as early as 873 AD. Mental patients were also treated in Qula'un hospital founded in 1248 and were the only residents left there, poorly nourished, sickly and chained to the wall, at the time of the invasion of Egypt by French forces in 1798. In 1856, the hospital was so deteriorated that the inmates were transferred to an old orphanage and in 1880 to an old palace in Cairo. This, on being repaired after a fire, became Abbassia Mental Hospital. In 1912 was established the second Cairo mental hospital - Khanka Hospital. These two institutions functioned on the basis of detention and custodial care and together "contained" until the fifties a total population of over 6,000 inmates with the well known consequences of lack of care, over-crowding and chronicity. Except for the introduction of shock therapy, the situation remained the same until 1952.

The Mental Health Legislation was introduced in 1944 and contains a provision, in Article 21, for voluntary access to treatment. The patient himself or his guardian can request hospitalization on written application and the patient can leave the hospital at will on written notice. However, it was only after 1952 that the social function of medicine was really recognized and consequently the hospital became more of a therapeutic community with the adoption of the open ward system and the intensification of occupational, cultural and other activities. Extramural and outpatient services were created along with a policy of decentralization and extension of mental health services outside Cairo. The psychiatric facilities consist now of psychiatric hospitals, psychiatric units in general hospitals, outpatient psychiatric clinics and school mental health clinics. The most striking achievement made in the two main mental hospitals of Abbassia and Khanka has been the considerable reduction in the number of inmates, along with the therapeutic progress and the larger proportion of short-stay hospitalization. The name of Abbassia hospital was changed to "Treatment House for Psychological Health". The rate of voluntary admissions has increased substantially from 8% in 1959 to 54% in 1969, and the respondent mentions a current rate of 99%.

It is felt by the respondent that the new trends in psychiatry which include a change inthe role of the mental hospital and the treatment of more and more patients in the community through the establishment of psychiatric units in general hospitals and of psychiatric clinics, is not at all reflected in the present legislation with its emphasis on involuntary hospitalization according to a complex, rigid procedure. A mental patient, if considered to be dangerous to himself or to others, or to the public security, can be hospitalized either after being arrested by the police (with one medical certificate) or at the request of relatives (with two medical certificates); in both cases the director of the hospital is bound to notify the admission to the Board of Control which within 30 days will either discharge the patient or confirm his detention. This confirmation will allow detention for one year. Further detention must be authorized by the Board of Control after a medical examination and for set limits of time (this provision can be considered to be equivalent to periodic review and is one of only two encountered in the Region). The appeal is to teh Director of the Hospital or to the Board of Control. The law contains, among other provisions, conditions of discharge and trial discharge.

It is felt by the respondent that this system does not encourage sufficiently treatment of patients within the community and is too much hospital-bound and should be revised.

Iran has at least 18 mental hospitals, but approximately 60% of all psychiatric beds are in Teheran and of these 90% in Rozi Mental Hospital, Aminabad. As in other countries, the major problem related to treatment in hospitals is the need to reduce chronicity. It seems that there is only one psychiatric unit, in a general hospital at Hafez Hospital in Shiraz, which was established in 1970 and has 35 beds. Out-patient care was first established in 1967 in Teheran and more Mental Health Clinics were subsequently opened in other parts of the country. There is also a "Mental Health Village" which has the double purpose of therapy and rehabilitation of chronically-ill psychiatric patients.

We have been faced with some difficulty concerning the legislation in Iran. Although we have found a reference to a "New Mental Health Act" which would consist broadly in the formalization of the existing practice with great emphasis on the informal voluntary access to care and the large number of appeal procedures opened to the patients, it seems that the current legislation does not constitute a simple Mental Health Act as such, but is made up of provisions dealing with mentally disordered persons in several different codes. We have indications that such groups as the medico-legal department and the Pezechki Ghanooni Review, the Iranian Psychiatric Association and the Iranian Medical Council are pressing for radical changes.

One of the respondents refers to a very old Islamic tradition considering a mentally disordered person as a "patient" rather than as someone possessed by demon and consequently persecuted. Islamic teaching combined with French law have been the roots of the Iranian legislation which has always been oriented towards the "protection" of the mentally ill. Some provisions dealing with these patients are to be found in the civil code enacted in 1928.

The existing practice, based on these different legal provisions (civil code and other codes), places a great emphasis on informal voluntary access to treatment. Respondents indicate that the percentage of voluntary patients has reached from 90% to 95%. It seems, however, that included in these are patients who, although they have not sought treatment themselves, have not objected legally to their admission. Involuntary admission is based on a Court order. In practice, the police are often asked to escort a person to the hospital, but such a case should be reported to the public prosecutor who, according to Article 1223 of the Civil Code, should submit the case to the Court. If mental illness is established, the same public prosecutor will refer the matter to the Guardianship Office of the Ministry of Justice which will appoint a guardian. There is also the very common practice of hospitalization of a patient on medical certification only. This hospitalization can last three weeks before the Magistrate is notified and the question of formal commitment is decided. It allows for a substantial number of patients to either respond fully to treatment and be discharged or to have sufficiently recovered to accept treatment on a voluntary basis. This measure is thought to be instrumental in reducing the number of committed chronic patients. Appeal procedures are numerous. A patient can appeal to a Magistrate during these three weeks of hospitalization on medical certification, he can appeal to a Judge of the Supreme Court against refusal of discharge, he has free access to the Ombudsman and direct appeal to the Minister.

In Sudan, mental disorders have been known to exist for a long time. They have been attributed to different causes, from possession by evil spirits to cursing through witchcraft and sorcery. Treatment was accordingly carried out by magical rites or religious therapy. Modern psychiatry has a short history in the Sudan. The first medical school was built in 1924 during the Anglo-Egyptian administration and the curriculum contained a few lectures on mental diseases.

For many years, there was no qualified psychiatrist. Only after an excited patient had been sent to the prison for lack of a vacant room in the civil hospital did the central government council authorize additional money for the building of a section in the general hospital to receive such cases. However, there was no general measure taken for the treatment of mentally ill patients. It is interesting to note that when it was decided to create a special centre for the care of psychiatric patients, in the late forties, it was based on the following policy: work on an extra-mural basis, use of the existing facilities in the general hospitals, location within easy reach of the community and due consideration for the social and cultural background of the Sudanese people. The new institution was called "Clinic for Nervous Disorders" to avoid stigma attached to the word "mental". Although it was a real challenge because of the competition with the traditional methods of treatment, it gained rapidly the confidence and the support of the people and more psychiatric institutions of this nature have gradually opened in various parts of the country. In Khartoum there are now, besides this hospital, psychiatric clinics and in-patient wards in other hospitals, and there is a psychiatric unit in each of the 18 Provinces.

The current mental health legislation consists of one chapter in the new general public health law of 1975. It is a very short law. It does not contain any provision on voluntary access to care which therefore operates on a completely informal basis. Both respondents indicate that most admissions to hospital are voluntary. Very few provisions deal with involuntary hospitalization. It is only specified that such hospitalization has to be ordered by a Provincial Mental Health Board after the recommendation from one psychiatrist if a mentally disturbed person is felt to be dangerous to himself or others. A psychiatrist must communicate a monthly report on the condition of the patients to the board. Finally, the patient so detained can appeal the decision of the board within one month, to a judge of the high court.

It is felt by the respondents that the present legislation is adequate. It was drafted by psychiatrists in conjunction with the legal department and no group feels that any change is needed. By-laws and regulations are to be enacted in the near future.

In Syria, in the absence of a formulated policy, for the last half century the care of the psychiatric patients has been limited to hospital-based services. They were mainly also limited to the capital cities of only two governorates out of 14. The first hospital is Ibn Sena Hospital in Damascus. In 1975, it was reported that this hospital, critically understaffed, housed 665 patients, generally housed together irrespective of diagnosis. 80% of the patients were chronically ill with five years or more of hospitalization. The hospital is functioning on a strictly custodial basis and is overcrowded. There is a shortage of medical staff and a lack of therapeutic and rehabilitative programmes. New buildings currently under construction will not lead to substantial improvements. The Doweirenea Hospital was established in 1953, 15 km from the city of Aleppo. It is functioning on the same policy of isolation and presently has a bed occupancy of 154%. It is governed by the same principle of custodial care and has the same shortage of medical staff and overcrowding. Only a few psychiatric clinics offer out-patient services and these are privately run.

The present legislation is the Instruction No. 1 of 17 January 1965 based on a 1954 Decree. It does not contain any provision for voluntary access to care and, contrary to other countries where, even in such an absence, there is a general policy of informal voluntary and out-patient treatment of a growing

number of patients, this does not seem to be the case in Syria. The involuntary hospitalization procedure seems to leave a great deal of discretion to the Director of the hospital who makes the final decisions on admittance and discharge of patients and to the security authorities which have the right to send directly to the hospital any person who is considered dangerous to himself or to others. There is no specified length of time of detention nor any appeal procedure.

B. Countries considering the adoption of a law (Table II and Table IV)

In Ethiopia, there is no Mental Health Law at present. There are some provisions in the Civil Code concerning the civil capacity of insane persons (including "feeble minded, drunkards, intoxicated persons and senile people"), and in the Penal Code concerning criminal responsibility and measures applicable to mentally ill offenders. There is, however, pending before the legislative authorities a law "for the protection, treatment and care of mentally disordered persons" drafted in 1973 by the Ministry of Public Health, mental health professionals, in collaboration with lawyers but not yet enacted. The respondent gives a detailed description of this draft law. There is a provision for voluntary access to care: any person above 18 may voluntarily admit himself, and a minor can be admitted at the request of his parents, guardian or nearest relative. In both cases, the director of the institution or a qualified practitioner of the institution has to approve admission. Voluntary patients can leave the hospital at will with 72 hours notice. At the moment, there are about 25% to 35% voluntary admissions. Involuntary admission is ordered by a Court. The police can detain any person believed to be suffering from mental disorder and deemed to be dangerous to himself or others, but such a person has to be produced before the Court within 24 hours. The police can also report to the Court neglect or cruel treatment of a mental patient. Individuals having a mental patient under their custody can also request a Court order.

The draft law provides for appeal procedure against wrongful detention or refusal of discharge.

It seems that at present there is no satisfactory protection against wrongful detention or of the patient's personal possessions and property during his illness.

The respondent indicates that this legislation should be beneficial in offering a more adequate protection of the rights of the individual who is mentally ill. However, he also remarks that it does not commit the concerned Ministry to provide the necessary facilities for treatment. "The available mental health manpower is so meagre and the problem is so great that whatever law there is or envisaged it is too difficult to implement it" and his final comment reads: "the danger of mental health legislation when manpower and services are lacking is very great. The existing institutions which are already crowded will be even more crowded if the letter of the law is to be followed without creating the manpower and services. It will also create an attitude in the community to abandon relatives once placed in an institution."

The respondent from Iraq describes the situation in his country as follows: voluntary access is obtainable by every adult and the proportion of voluntary patients is almost 100%. The main mental hospital (Shammayiah) provides for 1600 patients, mostly chronic schizophrenics, with a large closed complex for 300 patients who committed crimes. For the other patients, all wards are open

and they stay for treatment voluntarily. There is also a Psychiatric Clinic at the University of Baghdad and at least six Psychiatric Units in general hospitals in different parts of the country. Involuntary commitment, said to be very rare, is done by the family of the patient requesting in writing the local magistrate or police authorities to take the unwilling or aggressive patient to the Mental Hospital. A psychiatrist report is required with the approval of a Religious Judge for the Muslims or the Court for the non-Muslims.

The draft law of Iraq contains a provision for voluntary access to treatment. The patient himself if above 18, his parents or guardian if under 18, has to submit a written application for admission, accompanied by a medical report. He can leave the hospital at will. The involuntary hospitalization is done by Court Order or Magistrate Order and hospitalization cannot exceed four months on Court Order or three months on Magistrate Order. Discharge can be obtained through many different means with possible appeal against refusal of discharge by the Council for the Protection of the Mentally Afflicted. The law contains provisions for the protection and administration of patients' assets and property.

Saudi Arabia is the third country with a Mental Health Act in preparation which should be in effect in the near future. Functioning now is an informal system in which voluntary access to treatment is available through a request by the patient or his relatives to the specialist responsible for admission. Involuntary hospitalization is provided by admission of the patients handled by the police or administrative authorities. There is still in Saudi Arabia only one major Psychiatric Hospital. It was built in 1963 and was originally designed for 250 beds. The in-patient population has increased to 1200 to 1300, with once again the same characteristics of quasi-monopoly for the treatment of in-patients, restrictive structure of one basic massive building, overcrowding and chronicity. However, the new policy of incorporating psychiatric care into the general health services is being followed in Saudi Arabia. There already exists, although not totally adequate for lack of trained personnel, a small in-patient unit in the King Hospital in Medina which provides facilities for temporary detention of patients prior to their admission to the main Mental Hospital in Taif. And besides the out-patient department in that hospital, other out-patient units have been recently established within general hospital services in each of the six provinces of the Kingdom, at which large numbers of patients receive treatment. However, at the moment, there are no statistics on the percentage of voluntary admissions.

The new legislation will include a provision for voluntary access to treatment. Involuntary hospitalization will occur at the patient's family request, accompanied by two medical certificates, or when the nature of the disease could be prejudicial to the patient himself or others, with a medical certification, by an order of the representative of the Ministry of Health. No time limit is specified. A supervisory Council will have the power to look into patients' complaints or refusal of discharge, but no particular decision power seems to be recognized to this Council. According to the respondent, everybody seems to be satisfied with both the current situation and the pending adoption of the new legislation.

C. The informal systems (Table IV)

We can define these "informal systems" as countries without formal legislative structures governing mental hospitals or other forms of psychiatric care and treatment. Only the respondent from Jordan expresses a need for mental health legislation. There is in Jordan an apparently very simple procedure:

patients or their family can request treatment on a voluntary basis, and 40% to 50% of patients would fall into this category; the relatives of a patient or the police can in other cases bring him for involuntary hospitalization. It seems that discharge is possible for both categories of patients on the condition that they are not dangerous to themselves or to the community. There is no procedure for appeal. The respondent points out the still very strong socio-cultural tradition in Jordan which gives to the family the primary responsibility for all its members including the mentally sick. However, he recognizes that most groups are pressing for the adoption of a mental health legislation.

The three remaining countries, Bahrain, Kuwait and Qatar, present a common attitude on the part of the respondents, which is very much against any mental health legislation. The arguments put forward are of two kinds. First, they all claim that, regardless of the existence or non-existence of a law, their respective country has introduced "modern" psychiatry, that is to say a system which encourages voluntary access to treatment, the integration of psychiatric care in general health services, a system which is informal enough to be acceptable by the community. Which brings us to the second aspect of the argumentation: The population of these small countries have "deep-rooted traditions and values and they do not welcome laws which restrict their freedom". The responsibilities which in other countries have been given to a state welfare service are still very much in the hands of the family or the close group of relations, friends, neighbours. Which means that, in a general way, the family will take care of a mentally disordered member itself or persuade him to be treated, and only in difficult cases, when the family is not able to handle such a person, will it call upon the Police to ensure that such a patient will get treatment in a hospital even against his will. However, it seems also that the respondents have a view of a mental health legislation very much influenced by the more traditional conceptions: a mental health legislation is only meant to provide for compulsory means of hospitalization. The respondent from Kuwait reflects his fear of an old traditional system in this way "legislation for psychiatric cases is rather synonymous to penal legislation and implies the notion of punishment".

In Qatar until 1971 the mentally-ill patients were taken care of in the psychiatric unit of Doha Hospital which served only as a detention centre. It was only then that a psychiatrist took charge of this unit and made a great effort to improve the situation of the patients. This hospital was supposed to be demolished in 1974 and the psychiatric patients transferred temporarily into a school until the new general hospital is built which will allow various transfers of services and the transfer of the psychiatric patients into the Women's Hospital. In addition to the psychiatric unit at Doha Hospital, there was still in 1973 a Mental Centre for excited mentally-ill patients, established as an annex to Doha Hospital, where a few patients were still under police guard, with no nursing staff. This situation may have changed since. However, in 1971 was opened a psychiatric out-patient clinic with an impressive attendance through self-referral.

The situation seems to be radically different in Kuwait. Before 1955, the then existing mental hospital was functioning as a purely custodial "mad house" with locked cells and physical restraints. But in 1955 the condition of the patients was improved a great deal and this hospital was abandoned around 1963 when the new hospital was enlarged. This new hospital, the Kuwait Hospital for Nervous and Psychological Disorders, was opened in 1958 and has a capacity of approximately 300 beds with a rapid turnover of patients. Already in 1962 the common problem of lack of skilled nursing care had been largely overcome in Kuwait.

The Kuwait Hospital for Nervous and Psychological Disorders has an out-patient clinic attached to it and encourages voluntary admissions. The respondent estimates that there are 95% voluntary admissions. If the psychiatrist decides to admit a patient (who either requested admission himself or was referred by another doctor), this patient or his family must give his written consent to treatment and any measure found suitable by the hospital authorities. The Police will intervene in the cases when a patient can be a public nuisance or present a danger to himself, but even then, the medical board of the hospital can judge him sound enough to discharge him immediately. If found mentally disturbed, he will be treated either as an out-patient or admitted to the hospital. The respondent claims that over the last 20 years there has not been any complaint for unnecessary detention. Appeal is possible to the head of a psychiatric unit, to the Director of the hospital, to the Minister of Public Health. Discharge is granted when the patient has improved with instruction to consult the out-patient clinic for follow-up. There can even be a discharge against medical advice when it is requested by the patient or his family.

To conclude this section, it can be said that in the majority of these countries a considerable effort has been made in the last 15-20 years to, on the one hand, improve the condition of the psychiatric patients in the mental hospital by a whole series of measures, from changing the name of the hospital to opening the wards, introduction of new therapies and reduction of overcrowding, and on the other hand to consider the mental hospital as only one part of a new distribution of mental health services, including in-patients psychiatric units in general hospitals and out-patient clinics more equally distributed in the country to facilitate access of everyone to treatment (see Table V). The countries with existing legislation fall accordingly in different categories: Cyprus and Egypt consider their legislation as out-dated and may be as a reflection of a too traditional conception of psychiatric treatment bound to one or few mental hospitals, the legislation in Syria reflects a situation in which there is little emphasis on voluntary access to care and hospitals retain a largely custodial function. Iran seems to have amended its legislation and both encourage the current practice of voluntary treatment and minimize the formal commitment of patients. The Sudan has enacted a very simple law which will later on be completed by regulations. There, the striking fact is that, although there is a rather long tradition of voluntary access to treatment, the law does not have any provision specifying its availability and it is left as a totally informal procedure.

II. Mental Health Programmes, Specialized Services, Availability of Trained Personnel (Table V and Table VI)

In this section we are concerned with the existence of national policies on mental health and the extent to which legal provisions are or become part of those policies, the existence of specialized services and the availability of trained personnel. A recent report from the Regional Office of WHO (1974) for the Eastern Mediterranean Region reveals that only one third of the countries of that Region could present a formulated statement on such a national policy.

In a general way, it can be said that special institutions or services for the care of mentally retarded, epileptics, alcoholics and drug addicts have been developed in a few countries rather recently and there is a general shortage of mental health personnel and training facilities.

We will try to go into a little more detailed description of the situation in the different countries of this study.

Analyzing the answers of the respondents from the countries with an "informal system", we came out with the following elements: Bahrain has a Department of Psychiatry at the Ministry of Health and plans have been put forward to integrate psychiatric services, including both in-patient and out-patient facilities, within the general hospitals. There is no legal provision dealing with any of the groups above mentioned and we do not have any data on the availability of services, official or voluntary, for these groups. Kuwait, relatively small in area and population, has benefited from greater financial resources per capita and has been able to establish comprehensive medical and educational systems that reach practically the whole population. Provision and administration of mental health services are still the direct responsibility of the Ministry of Public Health and there is no separate Department. Psychiatric facilities are treated like other medical facilities. Alcoholics, drug dependant persons and patients with sexual deviations are all treated at the moment in the mental hospital. Their admission can be voluntary or they can be brought by the Police for treatment. There are special institutions for mentally retarded patients. If they are considered educable, they are referred to a special school under the Ministry of Education. The severely mentally subnormal patients are referred to a special Institute under the Ministry of Social Affairs. It seems that most of the physicians practising in Kuwait, and in particular the majority of psychiatrists, are Egyptian. There was also a large recruitment of nurses and nursing aides trained in other Arab-speaking countries. However, a School of Medicine was opened at the end of 1971 and a nursing school was also started which should both soon provide more trained nationals.

Qatar is undergoing a very rapid socio-economic development and social change. The tremendous increase in financial resources has had a very strong impact on the growing of the capital city of Doha where 80% of the population of Qatar is concentrated and has allowed the development of a free education for the majority of school-age children and free health services. The general health policy seems only to aim at a wider coverage of services. But at the moment all medical facilities are under the direct control of the Ministry with no intermediary level. As in other countries, there are very few physicians of Qatari nationality (in 1973 only two out of 75). The first psychiatrist to practise in Qatar was recruited from Egypt in 1971. In 1973, this psychiatrist was joined by an assistant. There was at that time a very serious shortage of any other type of professional personnel. However, a Health Training Institute was established in 1969 which showed a definite interest in teaching psychiatric nursing. It seems that at the moment there is still a great need for either direct recruitment from or training in outside countries. The care for other categories of patients is still within the psychiatric unit of the hospital, with approximately 6% of mentally subnormal children.

In Iraq there is a Directorate of Psychiatric Health at the Ministry of Health and, as was said earlier, a Mental Health Act is under consideration. A mental health policy is expressed in the recommendations of the Society of Neurologists and Psychiatrists who also drafted the proposed Mental Health Act. It is proposed to include: an emphasis on the study of mental health in all medical teaching institutions, such as the Faculty of Medicine, the School of Nursing, the Higher Institute of Health and other training courses for health workers; the development of mental health training for newly-qualified physicians; the establishment of psychiatric wards in teaching hospitals and later on in other general hospitals; the establishment of out-patient clinics in general hospitals and the development of the out-patient services already existing at the Shammayiah Hospital by

introducing specialists in other disciplines, a measure which would both help the patients and promote the understanding of the nature of mental illness among the general public and change the suspicious attitude towards mental hospitals; ensure an adequate supply of drugs for the treatment of mental disease and provide financial incentive to encourage the recruitment of health workers in mental hospitals. The proposed law is meant to regulate the relationship between the patient, the community and the responsible authorities with due regard for the rights of each of the parties.

The law will ensure the care and the protection of patients, preventing their exploitation or the unrestricted disposal of their property and will provide for the supervision of the institutions providing treatment. The patients considered by the laws are persons suffering from the following disorders: mental illness, mental retardation, alcoholism or drug addiction.

Although the law will provide for the same hospitalization procedures for all these categories, there exist at the present time different institutions under the Ministry of Social Affairs, such as rehabilitation centres and schools for the mentally retarded.

Saudi Arabia is considering the adoption of a Mental Health Act. The impetus stems from the creation at the Ministry of Health of a Supervisory Council on mental diseases with supervision and investigation responsibilities. The practised policy at the moment consists of the opening of more in-patient and out-patient units in general hospitals and halfway houses for the reception of discharged patients as a step towards final discharge back to the community. It seems that at present there is practically no differential treatment offered to the special categories of patients such as children, elderly patients, alcoholics or drug dependents. To meet the actual shortage of trained personnel, which is in great contrast with the amount of available material facilities (highly sophisticated and ultra-modern equipment), there is a great emphasis on both local training and training abroad for mental health workers and doctors seeking psychiatric specialization.

Mental health services in Cyprus are administered by a Medical Superintendent who is directly responsible to the Director of Medical Services. There is no Mental Health Department in the Ministry. The respondent feels the great need for such a Department which should be under the direction of a psychiatrist qualified to conceptualize the actual requirements for a programme of mental health promotion.

It has not yet been possible to develop separate services for special categories of patients. Social welfare services commitments include the official after-care of a certain number of patients. It includes visits and reports to the hospital.

There is a lack of facilities for people suffering from mental retardation or psychiatric patients. These tend to constitute a large part of the mental hospital population. However, through the initiative of voluntary associations, a number of schools have been established, with the support of the Government. There is a sheltered workshop and a Government Training Centre for the Disabled. Through the same initiative, a Centre for the Care of Untrainable Children has also been created. No special facilities exist for the psychiatric treatment of children or the treatment of alcoholics and drug addicts.

A recent report from WHO indicates that in Cyprus the nursing staff is adequate as opposed to other professionals. Training is still depending mostly on study abroad.

The respondent from the Democratic Yemen indicates that all mental health facilities are under the supervising authority of the Ministry of Health. And, although a six-month training in psychiatry for qualified nurses is available at the Sallam Hospital in Aden, the present number of specialized staff is inadequate for the needs.

Although there may be a lack of coordination at the two levels of mental health facilities and existing legislation in Egypt, this country has an impressive list of both legal provisions in many different areas related to mental health and mental health services depending on different Ministries or voluntary associations.

Among the legal provisions and besides the Mental Health Act of 1944 itself, there are specific legislative provisions for mentally ill prisoners, juvenile delinquents, drug dependence, rehabilitation of handicapped and special education.

The different type of services under the administration of the Mental Health Department at the Ministry of Health have been partially listed earlier. To this list should be added child psychiatric clinics, special wards for the treatment of drug dependence, special wards for the care and rehabilitation of severely retarded and psychotic mentally retarded, units for epileptic patients. There are also Universities psychiatric clinics and psychiatric services provided by health insurance and other administrative bodies, such as prisons, railways, military. The Ministry of Education provides special classes in ordinary schools and special schools for education of mentally subnormal children. The Ministry of Social Affairs supervises a special institute and a model centre for the rehabilitation of the mentally retarded and special institutes for the care of delinquents. Voluntary associations are providing services for alcohol and drug dependants and there is a committee for the care of the handicapped. Other associations work in the field of prevention and research in mental health.

The number of trained mental health professionals in Egypt is considerable compared with other countries. As was pointed out earlier, several countries have recruited many doctors and other staff from Egypt. Psychiatry, psychology, psychiatric social work, psychiatric nursing and other mental health training are available in different teaching institutions.

In Iran the health policy is part of a series of five-year development plans. In the Third Development Plan (1962-1967), it was recommended that the Ministry of Health should gradually limit its activities to the preventive and public health fields, with special focus on health problems of national importance, assistance to the public and private sectors to maintain and develop curative services, integration and coordination of health services at the planning level. As a consequence of this policy, the responsibility for curative medicine has been gradually shifted to various organizations in the private or semi-private sectors and to the Health Councils and the Universities for the teaching hospitals.

There are a few exceptions, and among them psychiatric hospitals which have been until recently still administered by the Mental Health Department of the Ministry of Health. One of the respondents from Iran indicates that the mental hospitals have been transferred recently to the Ministry of Social Welfare. He also indicates that there is now a plan to join the Ministry of Health and the Ministry of Social Welfare. But the Mental Health Department still has the responsibility for guidance and supervision, setting standards and collection of statistical data for all mental hospitals. It seems that in some provinces there

is a close administrative relationship between the chief psychiatrist, the public health office, the University and the institutions of the private sector. But in other cases there is a lack of coordination between these different levels. Other elements of the health policy include the extension of community health services in the country, together with the opening of more in-patient units in general hospitals.

The specialized mental health services include two hospitals for "addicts" which offer a three-weeks treatment to opium dependent patients. Together with the expressed need to use more efficient therapeutic methods and further psychological and social after-care and follow-up programme, two recent developments have taken place: the Narcotic Research Project initiated in 1971 by the Ministry of Public Health of Iran and the National Institute of Mental Health of the United States; and the opening in 1973 of a Rehabilitation Centre for opium-dependent patients, with two more similar centres under construction. The care of mentally retarded children is divided between special classes supervised by the Ministry of Education, private institutions, special wards in mental hospitals and the NOPC (National Organization for the Protection of Children) founded in 1950 which provides care, education and training in different clinics, schools and houses.

Here again, there is a striking gap between the available material resources and the number of trained personnel, with a particular shortage of qualified psychiatric nurses , social workers and auxiliary personnel. There were about 100 psychiatrists in Iran in 1973, with 60% practising in Teheran. This concentration in one city is again to be found in training institutions, with a large percentage of students taught and trained in Teheran.

To complete this picture, we should mention the existence of a Health Corps, created in 1969, for the purpose of extending medical services in the rural areas. All categories of personnel are given a six-month training course, including a two-week general orientation in mental health.

As was mentioned earlier, the mental health legislation in the Sudan is the chapter 13 of a more general Public Health Law. At the level of the Provincial Mental Health Board, there seems to be an integration of all interested Ministerial personnel, from Mental Health to Department of Prisons, from the Ministry of Justice to the Ministry of Social Affairs and the Board of Public Health. The responsibility of this Provincial Board includes a broad policy expressed as follows: to study and carry out the research related to psychological, mental and neurological disturbance, to make available the necessary facilities for their prevention and treatment as well as to provide rehabilitation and after-care for the patients. This was already the policy prior to the enactment of this law with an early emphasis on the opening of out-patient and in-patient units in general hospitals and of rehabilitation centres in the various provinces or the treatment and socialization of chronic patients.

A series of studies have been directed at gathering more data on the utilization of general psychiatric services for the care of the mentally ill children and collecting more information on childhood psychiatric disorders in the Sudan in the late 1960's. The conclusion was the need for more incorporation of psychiatric care in general health services and collaborative programmes between the Departments of Mental Health and Paediatrics together with close work with all the persons concerned with the care, welfare and education of children.

It seems that all special categories of patients are included in the mental health legislation. And we do not have any data on the existence of specialized institutions. The respondent indicates that the legislation is realistic in terms of available manpower.

Syria is undergoing the same socio-economic changes as other countries of the region, with urbanization, rural migration and the stress that accompanies them. Also it will have to face the specific problem of mass movement and re-settlement of tens of thousands of people affected by the construction of the Euphrates Dam.

As was pointed out earlier, there has not been any formulated policy dealing with mental health problems. Services have been limited to hospital care under the Ministry of Health. This is probably related to the lack of psychiatrists and the very limited impact they have been able to have in the country. In 1975, it was reported that there were only seven psychiatrists in Syria (one per million population), the same number as 15 years ago, all of them being located in Damascus and Aleppo - four men in the private sector and two in the Government services, leaving one full-time teacher in the Medical Faculty of Damascus. This is also probably the reason why folk healing practices are still popular, although traditional healers are not officially recognized.

An important percentage of patients in the two mental hospitals are mentally retarded. The reported cases to out-patient clinics and the cases detected in the school health services indicate a definite need for specialized services, but they have not been developed as yet. There are no other specialized services for any of the other groups either, except a number of institutes for the training and rehabilitation of juvenile delinquents.

There is an acute shortage of qualified personnel in Syria in the field of mental health. The one chair of psychiatry created in 1972 allows for a very limited amount of teaching to the 350 students involved, and this is rendered even more difficult due to the absence of an in-patient unit in the teaching hospital. There is no mental health programme in the nursing schools and few general nurses have been sent abroad for psychiatric training.

To conclude this section, it can be said that, although the situation is different from one country to another, there is growing need for an effective control body which could collect data on the specific mental health problems of a country and the available resources and services, formulate a general policy, provide planning and coordination, evaluation and training. There is also a growing need for the creation of more specialized mental health services and a remedy against the general shortage of mental health personnel.

TABLE I

PROVISIONS ON VOLUNTARY AND INVOLUNTARY HOSPITALIZATION

Rough estimate by respondents				Involuntary Hospitalization	
	Mental Health Legislation	Provision of Voluntary Admission	% of Voluntary Admission*	Provision for Involuntary Hospitalization	Appeal against involuntar Hospitalization or refusal or discharge
BRAIN	No legislation.	Informal voluntary access to treatment.	20%	- Police escort. - Court order.	No procedure.
PRUS	Mental Patient Law of 1931.	No legal provision. Some informal voluntary access to treatment.	None to psychiatric hospital. 100% to psychiatric wing of general hospital.	Court order.	Appeal to Supreme Court.
OCRATIC EN	Lunacy Act of 1938.	Legal provision: request by patient himself or his family.	60%	-Magistrate order. -Court order.	Appeal to the Court.
YPT	Mental Health Act of 1944.	Legal provision: written application by patient himself or guardian.	99%	Medical certification.	Appeal against detention or refusal of discharge t Director and Board of Control.
IIOPIA	Draft Law.	Legal provision: above 18, request by patient himself; under 18, by his parents or guardian.	25% to 35%	Court order.	Appeal against detetentic or refusal of discharge t Director and Court.
N	Scattered legal provisions.	No legal provision but informal voluntary access to treatment.	90% to 95%	-Medical certification for 3 weeks. -Magistrate order for formal commitment.	Appeal against detention or refusal of discharge t Magistrate, to Judge of Supreme Court, to Minister Free access to Ombudsman.
AQ	Draft Law	Legal provision: above 18, request by patient himself; under 18, by parent or guardian.	Almost 100%.	- Court order. - Magistrate order.	Appeal to the Council for the protection of the mentally afflicted.
RDAN	No legislation.	Informal voluntary access to treatment.	40% to 50%	- Family or police escort. - Court order.	No procedure.
AIT	No legislation.	Informal voluntary access to treatment.	95%	- Family or community escort. - Police escort.	Appeal - to the head of psychiatric unit; - to the head of hospital - to Minister of Public Health.
AR	No legislation.	Informal voluntary access to treatment.		Family or police escort.	No procedure.
DI ARABIA	Draft Law.	Legal provision: request by patient himself or person responsible for him.		- Order of the Ministry of Health or deputy. - Medical certification.	No provision.
AN	Mental Health legislation of 1971.	No legal provision but informal voluntary access to treatment.	100% (involuntary only to special security institutions).	Provincial Mental Health Board order.	Appeal to the Board.
IA	Decree of 1954. Instruction of 1966.	No legal provision. No informal voluntary access to treatment.	None.	- Order from the Ministry of Health. - Discretion of hospital director.	No provision.

TABLE II

VOLUNTARY ACCESS TO TREATMENT

?T ntary)	Mental Health Act of 1944. Art. 21.	Written application by patient himself or guardian.	Not required	Report within 2 days by hospital director to board of control on the condition of the patient.	At will on written notice.	Possible when the mental condition o a voluntary patie so requires, pro- vided procedure fo involuntary hospit ization is follow
US olun- t Hos- n).	The Mental Patient Law of 1931.	No legal provision No formality (only neurotic and mild psy- chotic cases are ad- mitted to wing of General Hospital in Nicosia).	Not required			
AN -100% untary)	Informal	No formality, free access to treatment.				
st 100% ntary).	Informal Draft Law	Voluntary access avail- able for all Written application - above 18 by patient; under 18 by a parent or guardian.	1 medical report.		At will. For minor, at request of parent or guardian.	
AIT 5% luntary)	Informal. (Agreement between health authorities and police author- ities).	By patient or his family.		Signature of a special form for consent to treatment.	When condition has improved. Trial discharge. Discharge granted against medical advice.	
EN	Informal					
RATIC EN	Aden Laws, Chapter 87. Lunacy Ordinance of 20 July 1938.	Request by patient or family in writing.	Not required.	Consent of patient or family required. Consent of 2 visitors.	At will on 24 hrs written notice.	
AR	Informal.	Request by patient or relative.				
AN	Informal.	Patient and family have complete access to treat- ment.			At will.	
DAN	Informal.	Patient himself or family.				
AN	Public Health Law of 1975.	No legal provision. Informal admissions.				
RIA	1954 Decree 1965 Regulations	No legal provision.				
DI RABIA	Informal	Request of patient or relative.			On request after permission of specialist or after recovery.	
	Draft Law.	By patient or person responsible for him.		Agreement of the Director of Hospital.	By order of the Director of hos- pital when suf- ficient improve- ment or on re-	Possible provid that procedures involuntary hos- pitalization ar followed.

TABLE III

INVOLUNTARY HOSPITALIZATION
(Formal legislative systems)

	Grounds	Application by	Decision making Authority	Medical Certificate	Other Formalities	Length of stay	Appeal	Periodic Review	Discharge	Trial Discharge	Change of status
EGYPT Mental Health Act of 1944	Dangerous to himself, to others or to public safety.	Written application by relative or guardian. Notification by a medical officer or public prosecutor.	Arrest by police	2 medical certificates. 1 medical certificate.	Notification of detention by director of hospital to Board of Control. Within 30 days the Board must either discharge the patient or confirm his detention.	Confirmation by Board of Control valid for 1 yr Possible prolongation following medical report for: - another year then - 2 years - 3 years - 5 years	Appeal against detention to director of hospital to Board of Control(also against refusal of discharge)	See "length of stay" Necessity of a medical report supporting decision of prolongation	By Board of Control Automatic discharge if Board does not issue within legal delays a decision to confirm or prolong detention By hospital director on own accord or upon application by patient's relative	Trial discharge for periods limited to part of a day or a day.	Involuntary patients when improved may be accepted on a voluntary basis.

TABLE III

	Grounds	Application by	Decision making Authority	Medical Certificate	Other Formalities	Length of stay	Appeal	Periodic Review	Discharge	Trial Discharge	Change of status
CYPRUS Mental Patients Law of 29 May 1931	Person mentally afflicted and a proper subject of confinement Person wandering at large believed to be unsound of mind and dangerous.	Information on oath by any informant. Apprehension by a police officer.	Court order. Court order.	1 medical certificate.	District court has custody, control & management of property of mental patient and may appoint administrator of such property. Notification of admission by superintendent to director of medical services.	Not specified.	By or on behalf of patient to the Supreme Court.		By director of medical services, whether patient recovered or not.	Absence on parole for such period as Director of Medical Services thinks fit provided some person will take charge of patient.	
SUDAN Public Health Law of 1975 Chapter 13	Mentally disturbed person felt to be dangerous to himself or others.		Mental Health Board (Psychiatric Provincial Council)	Recommendation of a psychiatrist	Consent of a specialized court to any legal action taken to safeguard patient's money until he is cured.	Not specified.	Patient can appeal against Board's decision to province court within 1 month of decision.	Monthly report to Board by a psychiatrist			
SYRIAN ARAB REPUBLIC Decree No. 687 of 12 May 1954 Regulations of 17 Jan. 1965.	Danger to patient himself or to others Persons considered dangerous to general public or who have disturbed the peace	Written application by guardian of patient Written application from judicial or executive authorities Referred to hospital by public security authorities	Director of hospital	1 medical report	Medical examination in hospital within 1 week of admission to determine whether condition requires confinement or release	Not specified.			Upon request by guardian if he takes responsibility of patient Director of hospital can release patients upon recovery or cessation of justification for confinement	Trial discharge to patient's family (temporary or permanent) at request of treating physician	

DEMOCRATIC	Grounds	Application by	Decision making Authority	Medical Certificate	Other Formalities	Length of stay	Appeal	Periodic Review	Discharge	Trial Discharge	Change of status
YEMEN Lunacy Ordinance of 20 July 1938	Allegation of lunacy	Husband, wife or nearest relative or other person	Magistrate's reception order	2 medical certificates	Personal examination by magistrate		Possible to Court in cases of Court order after inquisition when unsoundness of mind claimed to have ceased		By order of 3 visitors Upon application by person who made petition for reception order unless dangerous or unfit to be at large Delivery into care and custody of relative or friend When found not to be unsound of mind on inquisition		
	Person believed to be lunatic & found wandering at large, dangerous or not under proper care & control or cruelly treated or neglected	Arrest by police or report by police or informant	Magistrate's reception order	1 medical certificate	Personal examination by magistrate						
	Person alleged to be lunatic, of unsound mind & incapable of managing himself or his affairs	Relative, administrator or government pleader	Court order after inquisition	Not required							
IRAN Provisions in different codes	When patient presents danger to himself or others		Magistrate's reception order	1 medical certificate	Patient can be admitted on medical certificate & remain 3 wks. before magistrate notified & question of formal committal decided	Not specified.	By patient or relative during 3 wks. to magistrate; Magisterial inquiry to be ordered by Minister of Health; Against refusal of discharge to judge of supreme court; Free access to ombudsman; Direct to Minister	Yes			

TABLE IV

INVOLUNTARY HOSPITALIZATION

Informal systems

AHRAIN	Call for police. Court order.			Police. Court.	Not specified.	Discharge after recovery.
AQ contd.)	Application in writing by the patient's family to - magistrate or police authority.	Unwilling or agressive patient.	One psychiatrist's report required.	By Magistrate or Police with approval of - religious judge or court for non-Muslims.	Not specified.	By the treating physician. By a relative who will take over responsibility for his treatment. By patient himself.
IQ aft Law s: 5-11.	Information received from police, or civil authorities or patient's family		Recommentation from the medical committee.	Court order.	Not exceeding 4 months.	By responsible officer on the basis of a medical recommendation. Notification to Magistrate or Court. On application by supervisory committee. In case of refusal by responsible officer, final decision by the Council for the Protection of the Mentally Afflicted. On request by Director General of Medical Services in the Ministry of Health for non-violent patients. Upon application by family, discharge into care of family who will supervise treatment by examining Magistrate.
	Report by police officer or other person responsible for public order.	Suspicious or immoral behaviour, danger to health or life, neglect or exposure to personal or material injury.	Examination by a physician or the Medical Committee.	Magistrate issuing an order for non-voluntary treatment.	Not exceeding 6 weeks. Possible extension by examining Magistrate on medical recommendations for period not exceeding 3 months.	
RDAN	Relatives. Police.			Police. Court.	Not specified.	By family or by patient himself if not dangerous for himself or the community.
WAIT	Family or community or the police.	Disturbance to community or public nuisance.	One medical certificate (by a psychiatrist).	Admission by hospital - right to appeal to the Court in case of detention of a dangerous patient against his will.	Not specified.	Discharge when condition has improved, back to the police with a medical report. Discharge upon application by family or patient himself even against medical advice. Trial discharge.
TAR	Family of patient when request for help to the police, does not have to be in writing.	The family of the patient feels it has difficulty in coping with the patient.	Decision of a psychiatrist.	No admission without patient's or family's agreement.	Not specified.	
UDI ABIA	Police. Psychiatric clinic in Provinces. Administrative-source.				Not specified.	Upon a request of his sponsor after permission by the specialist. By family or through mass discharge of recovering patients. Upon appeal by the patient himself to the specialist.
aft Law	Patients family.	Nature of disease is such as to be prejudicial to security or order or to arouse concern for the safety of patient or others.	One medical certificate =	Order of the representative of the Ministry of Health or his deputy.	Not specified.	By order of Director of Hospital - when cure completed or sufficient improvement; upon application by patient's family or guardian. Trial discharge for non-violent patients.

TABLE V

*PSYCHIATRIC FACILITIES AND SERVICES

	Population Area Density	Number of Psychiatrists	Number of Psychiatric Hospitals	Number of in-patient units in General Hospitals	Number of out-patient Clinics	Speciali Servide
AHRAIN	220,000 598 Km^2 368/Km^2	3	2 (186 beds).	Some.	3	
YPRUS	650,000 9.251 Km^2 70 /Km^2	15	1 (910 beds).	1 (30 beds).	1	Some for mentally retarded patients
EMOCRATIC EMEN	1,510,000 287.683 Km^2 5 /Km^2	1	1 (87 beds) + 1 new hospital to function in 1978 with 206 beds.	1 (10 beds).	2	
GYPT	34,840,000 1.001.449 Km^2 35 /Km^2	120 qualified + 50 students.	5 (around 5600 beds) plus 2 under construction (700 beds).	26 (approximately 490 beds).	Many.	Large nu ber of special schools, habilita centres, wards fo treatmen drug dep dents, et
THIOPIA	25,250,000 1.221.900 Km^2 21 /Km^2		2 (650 beds).		2	Some re- habilitat centres.
IAN	29,780,000 1.648.000 Km^2 18 /Km^2		18 (3758 beds).	1 (33 beds)	115 + Mental health village	Services for the treatment drug addi and insti tutions f the care mentally tarded children.
AQ	10,070,000 437.924 Km^2 23 /Km^2	25	9 (2090 beds).	At least 6.	7	Some scho for menta subnormal children rehabili- tation centres.
RDAN	2,470,000 97.740 Km^2 25 /Km^2	5	1 (110 beds).			
AIT	910,000 16.000 Km^2 57 /Km^2	9	3 (698 beds).	Some.	Several.	Institute of special educatcn for menta handicappe children.
AR	80,000 22.014 Km^2 4 /Km^2	2		1 (22 beds).	1	
DI ARABIA	7,970,000	10	1 (1500 beds).	6 short-stay units	6 (1 in each	

	Population Area Density	Number of Psychiatrists	Number of Psychiatric Hospitals	Number of in-patient units in General Hospitals	Number of out-patient Clinics	Specialis Service
JDAN	16,470,000 2.505.813 Km^2 7 $/Km^2$	17	8 (788 beds).	Number of Psychiatric units (at least one in each of the 18 provinces).	At least 7.	
YRIA	6,660,000 185.180 Km^2 36 $/Km^2$		2 (1050 beds).	None.	No officially organized out-patient service.	Institut for the training rehabili tation o Juvenile delinquer

TABLE VI

MENTAL HEALTH POLICY

	Authority responsible for admission of Mental Health Services	Mental Health Policy
BAHRAIN	Department of Psychiatry at Ministry of Health.	Integration of Psychiatric Services (in-patient and out-patient) in general hospitals.
CYPRUS	Director of Medical Services.	
DEMOCRATIC YEMEN	Ministry of Health.	
EGYPT	Mental Health Department in Ministry of Health.	Large number of services depending from Universities, Health Insurance, Administrations, Private sector, Ministry of Education, Ministry of Social Affairs, Voluntary Association. Need for coordination.
ETHIOPIA	Ministry of Public Health.	
IRAN	-Mental Health Department in Ministry of Health. -Ministry of Sicial Welfare.	-Standardization of Mental Health Services. -Extension of Community Health Services. -Opening of in-patient units in general hospitals.
IRAQ	Directory of Psychiatric Health in Ministry of Health.	-Establishment of wards in teaching hospitals and other general hospitals. -Establishment of out-patient clinics. -Ensuring adequate supply of drugs. -Training of Mental Health personnel.
JORDAN	Ministry of Health.	
KUWAIT	Ministry of Public Health.	Encouragement of voluntary admission.
QATAR	Ministry of Public Health.	Wider coverage of services.
SAUDI ARABIA	Director General of Curative Medicine in the Ministry of Health. (The draft law creates a Supervisory Council on Mental Diseases.)	Opening of more in-patient and out-patient units in general hospitals.
SUDAN	Ministry of Health and in the provinces, Province Commission and Mental Health Board.	Studies and research pertinent to neuro-psychiatric disorders and creation of required facilities for their prevention and treatment, the rehabilitation and after-care of patients.
SYRIA	Ministry of Health.	

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