GROUP MEETING ON MENTAL HEALTH
AND MENTAL HEALTH LEGISLATION

Cairo, 12 to 17 June 1976

DOCUMENT No.8

TRAINING OF AUXILIARIES IN MENTAL HEALTH

by

Dr T. W. Harding
Office of Mental Health
World Health Organization
Geneva, Switzerland

Contents

Introduction

Health planners in countries with widely differing socio-economic conditions are now seeking to rationalize the use of resources and manpower plans. In the industrialized countries, it has become clear that the demand for health services is not finite and that further investments often yield disappointingly meagre results; while in the developing countries a large proportion of the population lack even the most basic health needs. It has been claimed that both the cost effectiveness of health care and its coverage can be increased dramatically by delegating responsibility for health care to auxiliary health workers. This claim rests on the assertion that a large proportion of the work involved in health care can be carried out by workers who have not received the lengthy and expensive training prescribed for physicians and other professional staff. The increasing emphasis on the potential role of auxiliaries is therefore easily understandable.

On the other hand, some doubts have been expressed - auxiliaries are seen by some as a threat to "high standards" of medical care, and experience in the field has not always been wholly successful. There have been problems of rivalry between different categories of staff, of status and of lack of supervision. Some cadres of auxiliaries trained to perform a narrow range of tasks have lost their useful role when advances in health technology have overtaken their sphere of competence. These problems could be overcome through a comprehensive health manpower development approach closely linked to health service development (1).

Types of auxiliaries

Flahault (2) has distinguished two main types of auxiliaries. The "high level" auxiliary with several years training, of which the prototype is the feldsher of the Soviet Union, and the "low level", of which the prototype is the "auxiliar de enfermeria" of Venezuela. A recent comprehensive account of the training and utilization of feldshers (3) indicates that some mental health training is given (72 hours in the fourth year of training) and that feldshers are used to provide emergency psychiatric care. "High level" auxiliaries have also been introduced on a smaller scale in the USA and Micronesia in the MEDEX* programme (4). In the armed forces of a number of countries, similar experience has been gained with "medical orderlies" or "field medical assistants" and some mental health is nearly always included in their training. The medical assistants trained in Sudan, Kenya, Zambia, Algeria and several other countries also belong to the "high level" group. Their basic training usually includes little or no mental health (5), but Edgell (6) on the basis of experience in Uganda has described how, with limited additional training, medical assistants can become the backbone of a rural psychiatric service. A similar programme operates in Zambia. The "high level" auxiliary is therefore used either to further improve standards of care in a country in which there is no medical manpower shortage such as the Soviet Union or to provide a fairly high level of expertise in areas where very few doctors are available, thereby extending care. In both cases it may be that their mental health care potential has not been fully realized. At a WHO seminar on the training

* "MEDEX" - the word was selected as a simple, acceptable, non-pejorative, descriptive term for "physician's assistant".

and utilization of medical assistants in Khartoum, 1974 (7), it was concluded that "appropriately trained" medical assistants could deal with 90% of health problems - and one must assume that mental health problems would be included. At the same seminar some of the reasons for lack of success of medical assistant programmes were also considered, including overcentralization, lack of local autonomy, logistical support or coordination and dissatisfaction of workers with their workload. The need for linkages with sources of authority and money, and with the community and for detailed job descriptions was stressed. At another WHO seminar on mental health services in developing countries, Addis Ababa, 1974, Swift (8) described the psychiatric functions which medical assistants could undertake and has put forward a sample course outline of 30-40 hours in mental health (see Annex 1).

The "low level" type of auxiliary receives training of one year or less - for example, the Venezualan "auxiliares de enfermeria" and the "promotoras" of Colombia, who are young girls with two months of training following secondary school. Such "low level" auxiliaries are usually used primarily to extend health care to deprived populations, usually in rural areas.

One other distinction in the types of auxiliary can be made. Some auxiliary cadres have developed and remain in close association with one specialized professional group (for example, dental auxiliaries and auxiliary sanitarians), or their area of work is narrowly defined (for example, vaccinators, leprosy workers, malaria control workers). Indeed, where an overriding health priority exists, auxiliaries may need to concentrate on the most pressing problem (for example, in the Western part of Jamaica, "community health aides" concentrate their work almost entirely on problems of malnutrition in young children). In other cases, auxiliaries are trained and work in the general public health field. On the whole, the latter approach gives greater flexibility and there is a tendency in some countries to move from narrow to more broadly trained workers (for example, in India, cadres of family planning workers, vaccinators, leprosy workers and others are being retrained as "multipurpose" workers).

Auxiliary nurses and aides in the hospital services

The principle of auxiliary health workers (i.e., an auxiliary being a helper or one who gives support) has long been recognized in the field of nursing (9). Florence Nightingale herself advocated the training of "practical" nurses in addition to the more highly trained professional nurses. Few hospitals have been able to function without considerable numbers of "attendants", "auxiliaries" or "aides" - the names vary and the importance of their role often goes unrecognized but such workers have been underpinning the hospital services for many years. This is certainly true of most mental hospitals; indeed, a great number of large asylums relied on the availability of cheap labour to provide the basic working force. It was many years until the full therapeutic potential of such workers became recognized. Greenblatt and his colleagues (10) have described how weekly meetings of ward attendants with psychiatric staff to discuss problems played a large part in transforming a hospital from a custodial institution into a therapeutic community. Maxwell Jones (11) has also stressed the importance of auxiliary workers in the hospital environment. Several manuals for nursing auxiliaries have now been developed (12) and, increasingly,

the need for basic and in-service training for such workers is stressed. This would undoubtedly play an important part in improving mental hospital conditions. The greatest stress in such training has been placed on (a) maintaining as normal a relationship as possible with patients, rather than treating them as incorrigibly passive, dangerous or disturbed; (b) encouraging patients to be active, stimulating their interest and fostering their independence, and (c) understanding the nature of mental illness and its treatment. Auxiliary nurses can also be trained to carry out specific technical tasks such as assisting with electroconvulsive therapy, dispensing standard drugs, recognizing common side effects.

Several factors limit the usefulness of the auxiliary worker in the hospital setting. Low pay and status attached to the job frequently attract low quality recruits; many auxiliary workers may be illiterate and the rate of turnover is high. Furthermore, working only in the hospital environment gives a stereotyped and prejudiced view of mental disorder. Auxiliary workers themselves are prone to a form of "institutionalism" and may grow to prefer the regulated and orderly life of a purely custodial institution. If possible, therefore, all auxiliaries should have working experience outside the mental hospital setting - either in a general hospital or accompanying patients in the community. There are also problems of legal provisions and definitions of nursing staff (see the WHO survey on existing legislation on auxiliary personnel in nursing - 13).

In the "Guide for the training of nursing auxiliaries in Latin America" (14), the importance of motivation of behaviour, communication and understanding the physical and emotional needs of patients is stressed. Above all, the nursing auxiliary needs to be recognized as "an essential and permanent member of the health team".

Auxiliary workers in the community

The greatest growth in the use of auxiliary workers in recent years has been in the provision of basic health services at community level. The barefoot doctors of China are perhaps the best known example, but similar workers now exist in many countries and are being trained in still more. Such auxiliaries play the key role in primary health care programmes (15, 16). They represent an extension of the concept of auxiliary, since they are seen not so much as a peripheral extension of the regular health service but as a source of help generated and supported by the community itself. Their work is focused on preventive actions and on dealing with the most prevalent and dangerous illnesses in their communities. The WHO Expert Committee on organization of mental health services in developing countries (17) saw the possibility of including "simple, circumscribed tasks" of mental health care in the work of such primary health workers as a challenge and an opportunity to dramatically extend mental health care. It is known that the barefoot doctors' manual in China contains instructions on managing neuropsychiatric conditions (18), including the use of certain neuroleptic and anti-depressant drugs and that chlorpromazine is included as one of the basic drugs used by barefoot doctors. Nevertheless it remains an open question to what extent auxiliary workers at the village level can tackle mental health problems. In the recent WHO Working Document "The Primary Health Worker" (19) a section on "mental diseases" has been included (see Annex 2). This shows a possible approach to

sensitizing such workers to the problems of mental health (including alcohol and drugs) and to the possibility of working with traditional healers. It also seeks to impart skills in recognizing and dealing with acute psychiatric emergencies, epilepsy, chronic psychosis and mental retardation in children.

If auxiliary workers in the community are to take on a mental health role, several steps need to be taken: (20)

a) A limited range of priority conditions should be defined according to the criteria of prevalence, consequences (for the individual and community) and susceptibility to simple forms of management.

b) Problem outlines for each priority condition should be produced, so that the tasks involved in treatments and control can be defined.

c) Only those tasks which could be within the competence of the auxiliary worker should be assigned to him. Educational objectives corresponding to these tasks should be clearly defined and training methods and manuals designed; if possible simple "flow charts" should be designed, as developed for physical diseases by Essex (21). An attempt has already been made to do this for epilepsy and acute psychiatric emergencies (20).

d) A limited range of drugs should be made available. WHO recently organized a consultation on drug treatment for neuropsychiatric disorders in developing countries which concluded, among other things, that the drugs to be provided at the most peripheral level could be limited to chlorpromazine and phenobarbitone.

e) A system of supervision and referral must be established.

f) In the training, stress should be placed on seeking contact with and assistance from community resources such as the police, teachers and village chiefs in the care of the mentally ill.

If possible mental health should be included in the basic training of community auxiliary workers but in many cases brief refresher courses will be the only feasible approach. It has been suggested that special mental health auxiliaries be trained for mental health work (22), but it seems unlikely that such an approach would be supported by public health administrators. Rather, it may be possible to add mental health skills to those of auxiliaries at present concerned with only one or two diseases, such as leprosy or tuberculosis.

The effectiveness of auxiliary workers

Objective assessments of health care are not easy. Nevertheless, there is impressive evidence that auxiliaries can perform tasks efficiently and accurately and can provide high quality care. Specific tasks in dental care, fluid replacement, vaccination are carried out by auxiliaries at a high standard. Lowry et al (23) compaired the accuracy of assessment of gestational age by auxiliaries and by physicians and found no significant difference. In the mental health field, Climent and his colleagues (24) have shown that psychiatric patients seen routinely in outpatient follow up

clinics by auxiliary nurses did at least as well as those seen by physicians and Schmidt (17) has described how hospital assistants can provide effective mental health care in remote areas.

There is a need for further objective evidence relating to mental health work by auxiliaries. This is one of the main reasons for a major WHO collaborative study on strategies for extending mental health care which aims to establish whether it is feasible to include mental health care in the peripheral health services. A variety of auxiliary workers in several study areas (at present in Colombia, India, Senegal and Sudan) will be included, ranging from "promotoras" in Colombia, to "auxiliary nurses" in Senegal, to "medical assistants" and "dressers" in Sudan and to "multipurpose workers" and "Ayurvedic nurse aides" in India. Objective measures of the result of such training will be obtained. They will include an assessment of the attitudes of auxiliary workers towards mental illness together with their diagnostic and therapeutic skills, information on the number of mentally ill under treatment and an assessment of the functional level of those with mental disorders in the community.

Conclusions

The potential of auxiliaries in mental health care remains largely untapped. Several unique experiences indicate that auxiliaries can take on mental health tasks and thereby improve and extend mental health care. Further experience and evidence is needed. In the case of peripheral health workers a very limited number of priority conditions could be considered and a task oriented approach to training followed. More skilled auxiliaries such as medical assistants could handle several psychotropic drugs and deal with a significant proportion of cases. Some could receive special training and concentrate their work on mental health in the community.

In hospitals, the role of the auxiliary should be made explicit and steps taken to improve their training, extend the scope of their work and provide extra-mural experience

Psychiatrists and psychiatric nurses need additional skills to allow them to train, supervise and support auxiliary workers.

References

1. Pitcairn, D. M. and Flahault, D. (ed.) The Medical Assistant. Public Health Papers, No.60, Geneva, World Health Organization (1974)

2. Flahault, D. "Review of current use of medical auxiliaries in health delivery systems". In: Medical Auxiliaries, Scientific Publication No.278, Washington, Pan American Health Organization (1973)

3. World Health Organization, The training and utilization of feldshers in the USSR. Public Health Papers, No.56 (1975)

4. Smith, R. A. MEDEX. Lancet, 2, 85-87 (1973)

5. Harding, T., Moser, J. and Raman, A. C. Mental health training in Africa. African Journal of Psychiatry (awaiting publication) (1976)

6. Edgell, H. G. The medical assistant and psychiatric care. Psychopathologie Africaine, 6, 83 (1970)

7. World Health Organization Regional Office for the Eastern Mediterranean. Report of a seminar on the training and utilization of medical assistants, Khartoum, 16-20 December 1974

8. Swift, C. R. "Types and roles of auxiliaries". In: Mental health services in developing countries, ed: Baasher, T. A. et al. Offset Publication 22 Geneva, World Health Organization (1975)

9. Brown, E. L. The nursing profession and auxiliary personnel. In: Aspects of Public Health Nursing. Public Health Papers, No.4, Geneva, World Health Organization (1961)

10. Greenblatt, M., York, R. H. and Brown, E. L. From custodial to therapeutic patient care in mental hospitals. New York, Russell Sage Foundation (1955)

11. Jones, M. Social psychiatry in the community, in hospitals and in prisons. Springfield, Jackson (1962)

12. Hyde, R. W. Experiencing the patient's day. New York, Putnam (1955)

13. World Health Organization, Auxiliary personnel in nursing: a survey of existing legislation. International Digest of Health Legislation, 17, 197-232 (1966)

14. Pan American Health Organization, Guide for the training of nursing auxiliaries in Latin America. Scientific Publication No.98 (1968)

15. Newell K. ed., Health by the People. Geneva, World Health Organization (1975)

16. Djukanovic, V. and Mach, E. P. Alternative approaches to meeting basic health needs in developing countries. Geneva, World Health Organization (1975)

17. WHO Expert Committee on Mental Health, Sixteenth report. Organization of mental health services in developing countries. Wld Hlth Org. techn. Rep. Ser., No.564 (1975)

18. Medical Revolutionary Committee of Hunan, Peasant Village Physician's Handbook. Peking, People's Hygiene Press (1971)

19. World Health Organization, The Primary Health Worker - a Working Document. Geneva (1976)

20. Giel, R. and Harding, T. Psychiatric priorities in developing countries. British Journal of Psychiatry (in press) (1976)

21. Essex, B. J. Approach to rapid problem solving in clinical medicine. British Medical Journal, 3, 34-36 (1975)

22. Wintrob, R. M. Toward a model for effective mental health care in developing countries. Psychopathologie Africaine, 9, 285-294 (1973)

23. Lowry, M. F., Howell, V. and Bird, S. Paramedical assessment of gestational age in the newborn. West Indian Medical Journal, 25, 17-22 (1976)

24. Climent, C. E. (1975) Personal communication - results awaiting publication

25. Schmidt, K. E. Mental health services in a developing country in South-East Asia (Sarawak). In: Freeman, H. L. and Farndale, J. ed., New aspects of the mental health services, Oxford, Pergamon (1967)

Annex 1

COURSE OUTLINE FOR MEDICAL AUXILIARIES

This is a sample outline of a course for medical auxiliaries. It is intended that these discussion sessions would occupy between 30 to 40 hours, including interviews with representative patients. This of course would normally take place during the final year of two or three years of training for the general duty medical auxiliary. Student intake would be after 10 or 12 years of general education. The course outline is intentionally general; it should be adapted to fit the needs of the particular country. The purpose of the course is to prepare the auxiliary for general medical duties, especially in outpatient clinics, dispensaries and health centres. The emphasis of the course should properly be on prevention and health education.

With some modifications this outline could be used as a course for nonmedical, community based auxiliaries receiving certificate training in social work, welfare (probation) work and the like.

INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRY

A. Student attitudes toward psychiatric illnesses

An initial opportunity for free student expression:

Exploring belief in witchcraft, the stigma and fears.

Acceptance of various views by teacher.

Emphasis made that students do not need to choose between traditional beliefs and the content of this course.

B. Behaviour

Determinants of behaviour:

Genetic factors,
Environmental factors.

C. Anxiety

Normal versus abnormal anxiety

Origins of anxiety:

Fear of abandonment,
Fear of injury (death),
Fear of failure,
Fear of consequences of one's anger.

D. Stress

Examples of stress in everyday life.

Each stress experience results in

Mastery (adequate coping), or
Failure (inadequate coping).

How does a person cope with stress?

Healthy ways:

Continuing usual life routines as much as possible,

Obtaining encouragement from own past experiences, from friends and people important to the individual (including health personnel),
By the use of identification, with parents and others,
Talking about it with special friends,
Reducing the stress.

Less healthy ways:

Withdrawal, avoidance of stress,
Regression,
Blaming others.

E. How does an auxiliary strengthen mental health?

Some examples of patients an auxiliary can help in this regard (include specific techniques):

A child whose mother has died,
A child whose father has become seriously ill,
A child whose mother delivers a baby,
A child who becomes ill and must go to hospital,
A secondary school student with complaints of loneliness and worry about family,
An adult woman who cannot conceive,
An apprehensive woman approaching childbirth,
An adult with an acute serious illness,
Any person whose close relative has died.

Throughout, the preventive potential of an auxiliary is emphasized.

F. Personality development

The goal here is to give the auxiliary some knowledge of the phases of normal personality growth.

Points of special emphasis:

Development from dependence (at birth) to independence (at maturity)
Negative behaviour, fears, aggressive behaviour.
Growth of sexual feelings in childhood and adolescence.
Social growth, especially during adolesence.
The process of identification.
Young adulthood, middle age, old age.

G. Abnormal psychology (psychopathology)

An introduction to the decription and meaning of various symptoms of psychological disturbance.

These will be discussed under disorders of:

Motor activity	Thinking
Mood (affect)	Memory
Speech	Awareness
Perception	Intelligence

H. The causes of the psychiatric illnesses

Brief presentation of genetic, physical and psychosocial factors.

I. The prevalence of psychiatric illness

Reference here to prevalence studies carried out in Africa and Asia.

Purpose: to give the student an idea of the frequency.

J. Introduction to interview techniques

Can often be done best in connexion with actual interviews with patients.

Few points to be emphasized:

Importance of rapport with patient,
Careful observation and listening (eyes and ears the best tools),
Importance of discovering the meaning of the patients' symptoms,
Value of "open-ended" questions,
Avoid judgements of behaviour,
Listen carefully to delusional content,
Avoid reinforcement by agreeing,
Simple explanation of patient's problems to the patient.

K. Clinical psychiatry

A brief introduction to the common disorders found in one's country; where possible to be illustrated by patient presentation.

The following disorders will be discussed:

Acute and chronic brain syndromes, especially acute confusional state,
Nutritional deficiency states,
Alcoholism and psychiatric conditions resulting,
Epilepsy,
Schizophrenia,
Affective disorders, especially depression,
Neurosis, including impotence and frigidity, and including vague functional complaints,
Psychophysiologic diseases,
Malingering.

L. Management of patients

Introduction to treatment.

Importance of liaison with family.

If patient is hospitalized, planning for his discharge begins when he is first admitted.

Education of family regarding the patient's illness.

Importance of continuity of care.

Emphasize again and again the preventive role of the auxiliary.

M. Traditional beliefs and psychiatric illnesses

A return to the subject of student beliefs and attitudes.

Traditional beliefs able to be integrated with main features of this course.

N. Mental health and psychiatric programme in the country

An outline of present programme and future plans.

Emphasize the important place the auxiliary has in this programme.

O. Closing session(s)

Unsigned questions from students to be discussed by teacher.

Student evaluation of the course by completing evaluation questionnaire.

Problem 6.10
MENTAL DISEASES

MENTAL DISEASES

TO BE IN GOOD HEALTH IS TO BE HEALTHY IN YOUR BODY AND IN YOUR MIND.

YOU ARE HEALTHY IN YOUR MIND, WHEN YOU LEARN EASILY, YOU ARE HAPPY TO BE ALIVE, YOU LIKE LIVING WITH OTHER PEOPLE, YOU SOLVE YOUR PROBLEMS AND YOU HELP OTHER PEOPLE TO SOLVE THEIR PROBLEMS.

MENTAL DISEASES ARE THE DISEASES WHICH AFFECT PEOPLE IN THEIR MINDS.

SOME PATIENTS FEEL SAD, UNHAPPY, ALWAYS TIRED AND COMPLAIN OF HAVING PAINS IN THEIR BODIES.

OTHERS STOP THINKING, NEVER DO ANYTHING, DO NOT FEEL LIKE OTHER PEOPLE ANY MORE.

OTHERS OFTEN HAVE CONVULSIONS.

SOME CHILDREN WALK AND TALK MUCH LATER THAN OTHER CHILDREN OR HAVE DIFFICULTY IN LEARNING AT SCHOOL.

MENTAL DISEASES

LEARNING OBJECTIVES

At the end of his training, the PHW should be able to:

1. identify patients with nervous troubles, convulsions and other mental disorders
2. inform people of the dangers of alcohol, wine, beer, coca,hashish, and on abuses of medicines and other drugs
3. assist patients in solving their own problems with the help of their relatives, friends, local authorities, etc.
4. care for and treat patients with convulsions or abnormal behaviour as mentioned in the guide
5. care for children who have difficulties in learning
6. send to the hospital or health centre cases above his competence.

MENTAL DISEASES

YOU CAN AND YOU MUST IMPROVE MENTAL HEALTH IN YOUR VILLAGE/DISTRICT:

- *by looking for and helping people who complain of nervous troubles, people who have convulsions, children who have difficulty in learning and all the people who have been mentally ill for a long time*
- *by taking care of old people, especially those who forget things easily*
- *by making sure that young children are properly fed and looked after, especially those who have lost their parents or whose mother has gone away*
- *by advising people not to drink too much alcohol, wine or beer*
  not to take medicines, especially pregnant women
  not to take dangerous drugs (opium, cocaine, Indian hemp, ...)

MANY PEOPLE WHO HAVE MENTAL DISEASES ARE TREATED AND ADVISED BY HEALERS OR BY PRIESTS IN THE VILLAGE OR THE DISTRICT. YOU SHOULD GO TO SEE THESE HEALERS OR THESE PRIESTS AND TALK TO THEM. TRY NOT TO OPPOSE THEM, BUT ON THE CONTRARY, OFFER YOUR HELP. THE TREATMENT WHICH YOU MAY SUGGEST CAN SUPPLEMENT THE SKILLS OF THE HEALERS. TRY TO WORK TOGETHER. TELL THEM ALSO TO CALL YOU IF THEY NEED HELP.[1]

---

[1] *This paragraph is typical of those which do not necessarily apply to all countries and to all situations. It should be adapted to the conditions characteristic of each country.*

MENTAL DISEASES

1. IF THE PATIENT COMPLAINS OF NERVOUS TROUBLE

The patient tells you that he feels weak and that he gets tired easily
that he has pains in his head, his belly, his arms, his legs
that he has no appetite, that he has difficulty in getting to sleep, in having sex

but above all he comes back to see you often because there is something new wrong with him, or because he has pains in many parts of his body
Let the patient talk and listen carefully to what he says.
Ask him if he is worried because
- of family quarrels (with his wife, his children, his parents)
- he does not have any children or because he has too many
- he does not have any money
- he is having difficulties at school or at work
- he is having quarrels in the village (with his neighbours)
- he is the victim of evil spirits ...

1.1 Either you think he has nervous trouble: arrange to speak to the patient and his closest relative.
If you do not have the time, tell him to come back another day.
Do not give him any medicines and tell the patient and his family that he will get better, but try to find someone in the village who can help him solve his problems (a friend, the village chief, his boss, a clergyman, the teacher ...)
If he does not get better, or if the patient cannot sleep, feels sad, cries a lot, stops eating or working, send him to the hospital or the health centre.

1.2 Or you think that the patient probably does not have nervous trouble: find out
- if the patient has a temperature of more than 38°
- or he has a cough
- or he is pale,

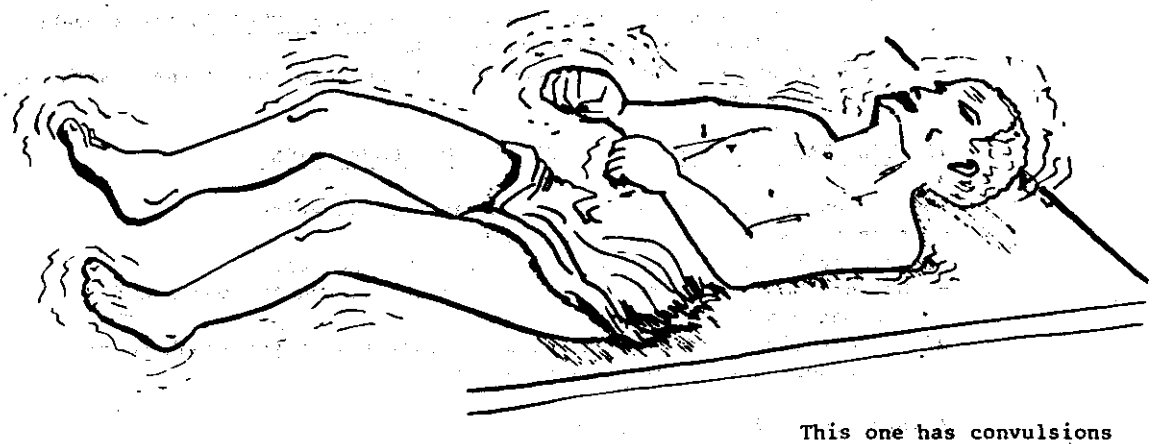
In these cases, see "Feverishness"
" "Respiratory diseases"
" "Weakness and tiredness".

2. IF, DURING THE PREVIOUS FEW DAYS, THE PATIENT HAS BEEN FEELING STRANGE, IF HE NO LONGER THINKS OR NO LONGER ACTS LIKE OTHER PEOPLE

- Either, the patient no longer talks normally or says strange things
- Or he sees or hears things which other people do not see or do not hear
- Or he no longer knows where he is or what he should do
- Or he is angry, or shouts or fights for no reason
- Or he no longer washes, no longer dresses or no longer works
- Or, he runs away from home, refuses to speak or eat

This patient is always sad

This patient behaves in a strange way



This one has convulsions

In all these cases, you should get in touch with the police, the religious authorities and the people in the village/district and tell everyone that this patient needs to be treated, that they must not hit him, or shut him up somewhere or make him leave the village, but that they must be kind to him, and put him in a quiet place. Talk to him in a kind way and make sure that there are not too many people around him.

Examine the patient: take his temperature.
If he has a temperature of 38° or more: send him to the hospital or the health centre
But if the patient has had convulsions, give him PHENOBARBITAL (see page 238) before sending him to the hospital or the health centre.
If he has a temperature of less than 38°:

1. the patient has perhaps drunk too much alcohol, in which case you should let him sleep for a few hours and if he is no better after he has slept, send him to the hospital or the health centre.

2. the patient has perhaps received a blow on the head, send him to the hospital or the health centre.

3. if the patient has not drunk too much alcohol and has not received a blow on the head, give him CHLORPROMAZINE (see page 237) : 2 tablets morning, noon and night for 2 days. Comfort the family and tell them to give the patient something to eat and drink, not to tie him up and to be kind to him.
   See the patient again after the 2 days treatment:
   If he is better continue with the CHLORPROMAZINE for 2 weeks and see the patient every 2 days
   If he is no better, send him to the hospital or the health centre.

3. IF THE PATIENT HAS A CONVULSION OR CONVULSIONS

The patient falls down and no longer answers questions
- then his whole body becomes stiff
- then he has violent movements in his arms and legs
- he has foam (sometimes with blood in it) around the mouth and sometimes he may urinate

After some time, the patient begins to answer when you speak to him, but he does not remember what happened

Always try to find someone who saw the convulsion to make sure that the patient really had a convulsion, because he himself does not remember it.

If it really was a convulsion, put the patient in a quiet place and take his temperature:

MENTAL DISEASES

3.1 Either the patient has a temperature of more than 38°

If the patient is a child of less than 2 years old, give him some ASPIRIN

If the patient is a child of more than 2 years old, give him some ASPIRIN and some CHLOROQUINE and send him to the hospital or or the health centre

If the patient is an adult, send him to the hospital or the health centre.

3.2 Or the patient has a temperature of less than 38°

If the patient is a child under 2 years old, do nothing, but see him again on the following day. If the convulsions continue, send him to the hospital or the health centre. If he no longer has any convulsions, ask his family to bring him back if the convulsions start again

If the patient is a child over 2 years old,

- Either, the child had only one convulsion. In this case, do nothing and see the child again a week later
  If he has had no more convulsions, ask the family to bring the child back if the convulsions start again
  If the child continues to have convulsions, send him to the hospital or the health centre
- Or, the child has had several convulsions. In that case give him PHENOBARBITAL for 6 months, but see him again every month.
  If the convulsions continue in spite of the treatment, send him to the hospital or the health centre

If the patient is an adult: for how long has he been having convulsions?

- for less than a year: then send him to the hospital or the health centre -
- for more than a year: then give him some PHENOBARBITAL

4. SOME CHILDREN HAVE DIFFICULTY IN LEARNING (or learn more slowly than the other children)

They are children who walk or talk later than the others. At school, they do not learn like the others

You should find these children: by talking with the mothers who bring you their children when they are ill and by talking with the village teachers, especially the ones who teach 1st or 2nd year schoolchildren.

Ask to see these children:

1. who, at 2 years old, cannot walk on their own
2. who, at 3 years old, cannot talk properly
3. who cannot learn anything at school.

Then examine these children:

1. Is the child well-fed? Weigh him and measure him, and see "The badly-fed child"

2. Can the child hear properly? Talk to him very softly behind his head. If he cannot hear you, send him to the hospital or the health centre

3. Can the child see properly? Show him a drawing or a book and ask him to tell you what he can see or read. If he is unable to, send him to the hospital or the health centre

4. Has the child lost his parents or has his mother gone away? Then try to find out who is looking after him. Is he well-fed and well cared-for? If not, get in touch with the family or the village chief or the religious authorities

5. Does the child have convulsions? Then see paragraph 3, page 212

6. Does the child have a stiffness in the arms or legs? The child cannot bend his arms and legs like the other children. If this is the case, send this child to the hospital or the health centre.

But, every time you see such children, explain clearly to the mothers and the teachers that they should help these children so that they become useful and happy people. Even if they only learn slowly, they should be kept in school and then they should be taught a job which is easy and which suits their taste and their ability.

5. IF FOR SEVERAL MONTHS OR YEARS, THE PATIENT HAS BEEN HAVING STRANGE IDEAS OR BEEN DOING STRANGE THINGS

For example:

For several years or months:

- the patient has been staying by himself and talking to himself most of the time
- he has been getting angry when no one has done anything to him
- he has been frightening other people in his family or in the village
- he has not been working or hardly working at all
- he has not been getting dressed or washing anymore.

You should look after these patients:

5.1 Firstly, you should find them. To do this; get in touch with the families, the village chief, the police, the village authorities or the authorities of your district

5.2 If the family has got rid of the patient, tell the family to take him back and to find him a little job in the village or in the district

5.3 Send the patient to the hospital or the health centre for him to be given some medicine

5.4 Each month, visit the patient in his home and make sure that:
1. the patient is taking his medicine regularly
2. he works regularly
3. he is happy with his family.

GROUP MEETING ON MENTAL HEALTH AND
MENTAL HEALTH LEGISLATION

Document No.10

Cairo 12 to 17 June 1976

MENTAL HEALTH LEGISLATION IN DEVELOPING COUNTRIES OF THE EASTERN MEDITERRANEAN REGION

C O R R I G E N D U M

Page 1 Paragraph 1, line 9 "This leaves 4 countries (Bahrain, Jordan, Kuwait and Qatar)

Page 3 Paragraph 3, line 16 "appeal is to the Director ..."

Page 11 Paragraph 7, line 2 "or geriatric patients. ..."

Page 14 Paragraph 3, line 7 "Damascus and Aleppo - four are in the private sector .

Table II Headings:

Legal basis	Application by	Medical Certificates	Other formalities	Discharge	Change of status

Table IV Headings:

Application by	Grounds	Medical Certificates	Decision making authority	Length of time	Discharge

Table VI Heading:

Authority responsible for administration of mental health services