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REPORT ON
THE GROUP MEETING ON MENTAL HEALTH

Alexandria, 4 - 7 September 1972

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I THE PROCEEDINGS OF THE GROUP MEETING

The Meeting was held at the Regional Office for the Eastern Mediterranean of the World Health Organization from 4 - 7 September 1972, to exchange views on mental health problems of the Region and to draw up a programme for future regional all-round activities.

The Meeting was opened by Dr A.H. Taba, WHO Regional Director, who, in his address invited the Group to discuss the subjects of current interest in mental health and make useful recommendations, which would help to promote programmes in the field of mental health in this Region. He also drew attention to the importance of finding new practical ways and means of meeting growing mental health needs, stating that efforts should be directed towards establishing basic psychiatric data, which would lead to better planning of services. He emphasized the importance of developing preventive methods and techniques and of intensifying measures in areas related to childhood and adolescence.

The Meeting was attended by eight participants from Cyprus, Egypt, Iran, Lebanon, Pakistan and the Sudan, (see Annex II List of Participants). The WHO Secretariat was composed of Professor G.M. Carstairs, Temporary Adviser, Professor R. Giel, Consultant, Dr F.R. Hassler, Chief, Mental Health , Headquarters, and Dr T.A. Baasher, Regional Adviser on Mental Health; as well as Miss Rita McEwan, WHO Nurse Educator, High Institute of Nursing, Cairo, and Dr Samira Salama, her national counterpart.

II INTRODUCTION

The objectives of the Group Meeting on Mental Health were as follows :

1. to formulate general guidelines for the development of mental health services in the Region;

2. to make recommendations, which could help the Regional Office to draw up a programme for future Regional activities regarding Mental Health.

Drawing from the valuable material presented by the participants in their working papers(see Annex IV), and from the discussions that took place, some guidelines for the development of mental health services were prepared.

Although the general principles of psychiatric and mental health care were considered to have universal application, there was no doubt that their relevance was subject to the variety of cultural and socio-economic conditions existing in the twenty-two Member States of the Region.

A review of the present state of the mental health services (see chapter III) amply illustrated this point. Yet, these differences were more often apparent than real, and were caused by such factors as terminology, definitions and lack of information. For example, the various categories of personnel needed in the mental health services were basically the same all over the world. Nevertheless, differences in priorities between countries, and more particularly in the headings under which the categories of personnel were listed, often caused considerable confusion and divergence of opinion, It was hoped that such linguistic problems would not obscure the basic principles underlying :

- administration of mental health services,
- organization of mental health services,
- delivery of mental health care,
- utilization and training of manpower,
- mental health legislation,
- mental health research,

and that they would prevent those principally active in the field of mental health :

- the public health administrators,
- the professionals in the mental health services,
- University staff,
- the voluntary organizations,

from defining their respective roles in each of the areas listed above, and from co-ordinating their individual efforts.

III PRESENT STATE OF THE MENTAL HEALTH SERVICES IN THE REGION

Prior to the Meeting, information on the mental health services in the Region were collected by means of a questionnaire (see Annex V) which was sent to the twenty-two Governments. Only one country had not yet responded at the time of the Group Meeting.

The questionnaire contained four chapters : organization and administration, physical resources, manpower resources, and research. The findings of the survey are summarized in the Tables I, II and III (pages 3, 5 and 6 respectively). However, it should be mentioned that the information was collected at different levels and stored in different places. Confederated states may pose a special problem in this respect, because the information needed at state and national level is not of the same order.

TABLE I

MENTAL HEALTH ADMINISTRATION AND LEGISLATION

Country	Mental Health Unit or Department	Mental Health Legislation
Afghanistan	no response	no response
Bahrain	-	x
Cyprus	-	+ (1959)
Egypt	+	+ (1944)
Ethiopia	-	x
Iran	+	-
Iraq	+	-
Jordan	-	x
Kuwait	-	x
Lebanon	-	+
Libya	-	+ (1959)
Oman	-	-
Pakistan	-	+ (1912)
PDRY	-	-
Qatar	-	-
Saudi Arabia	-	x
Somalia	-	-
Sudan	+	x
Syria	-	x
Tunisia	-	+
United Arab Emirates	-	-
Yemen	-	-

(+) = countries with mental health unit or department in the Ministry of Health and/or mental health legislation

(x) = countries with special rules for mentally disturbed offenders

With regard to the items covered by the questionnaire, problems might have arisen about the exact interpretation of a question and the response it elicited. This review should therefore, be considered as provisional. Governments might wish to correct the findings or to supply additional information.

Table I showed that in very few countries are mental health services represented in the national health administration by a unit or department. This Table also indicated the lack of mental health legislation in the Region, although most of the countries seemed to have special regulations regarding the admission of mentally disturbed offenders to a mental hospital. However, even the existence of special regulations for mentally disturbed offenders did not necessarily mean that there were provisions for this category of patients, more often they were just admitted to a mental hospital and kept there in confinement.

Table II gave the numbers of mental hospital beds, also in relation to the population and to all hospital beds. Some countries had large, and others small mental hospitals. The numbers of beds per 1 000 population showed tremendous variation. The final column indicated that a low ratio for mental hospital tended to reflect a low number of hospital beds in general.

Only eleven countries reported having psychiatric beds in general hospitals; and only five had special institutions for the mentally retarded.

Although seventeen countries had psychiatric out-patient clinics, only three had more than one clinic per 100 000 population. the majority had fewer than one clinic per 500 000 population.

The evidence showed that of the approximately 190 million people in the Region very few have access to a psychiatric out-patient clinic. One could safely assume that, as a consequence, psychiatric after care of discharged patients was almost non-existent and that few people would receive psychiatric help at an early stage of their illness.

Table III showed the various categories of mental health workers given as rates per 100 000 population. As it was increasingly recognized by psychiatric epidemiologists that the incidence of mental illness did not vary much from country to country whatever its stage of development, the lack of trained personnel in most countries could not be ignored.

TABLE II

IN-PATIENT FACILITIES

(Mental hospital beds, absolute, and rates per 1 000 population and per 100 beds in all hospitals)

Countries	Number of Mental Hospitals	Number of beds	Number of beds per 1 000 population	% of all hospital beds
Afghanistan	(*)			
Bahrain	1	185	0.85	12
Cyprus	1	850	1.30	27
Egypt	5	6 284	0.18	12
Ethiopia	2	650	0.03	11
Iran	17	4 000	0.12	13
Iraq	2	1 584	0.17	10
Jordan	1	400	0.20	12
Kuwait	1	455	0.54	14
Lebanon	4	2 300	0.82	20
Libya	1	1 017	0.55	17
Oman	-	-	-	-
Pakistan	6	626	0.01	
PDRY	1	220	0.14	18
Qatar	-	-	-	-
Saudi Arabia	1	1 500	0.21	20
Somalia	2	316	0.07	7
Sudan	1	200	0.02	2
Syria	2	916	0.16	15
Tunisia	1	1 018	0.19	9
United Arab Emirates	-	-	-	-
Yemen	-	-	-	-

(*) = no response

TABLE III

MENTAL HEALTH WORKERS, RATES PER 100 000 POPULATION

Countries	General Physi-cians	Psychia-trists	Psycho-logists	Social Workers	Psychi-atric Nurses	Auxil. Nurses	Thera-pists	Tea-chers
Afghanistan	(*)							
Bahrain	2.40	1.40	-	0.50	3.8	12.40	-	-
Cyprus	-	2.00	0.32	0.32	11.0	2.00	0.32	-
Egypt	0.90	0.30	0.10	0.18	-	2.60	0.10	0.90
Ethiopia	-	0.02	-	-	less than 0.01	0.33	0.01	-
Iran	(*)							
Iraq	0.30	0.18	-	0.11	0.07	0.10	0.03	0.25
Jordan	0.30	0.09	0.09	0.38	0.04	1.20	0.60	0.09
Kuwait	-	1.70	1.10	29.20	19.00	17.40	4.00	5.60
Lebanon	-	0.90	0.20	0.20	1.10	6.80	0.20	1.30
Libya	-	0.34	0.50	0.20	1.00	1.10	-	-
Oman	-	-	-	-	-	-	-	-
Pakistan	-	0.06	0.02	0.02	0.01	0.25	-	-
PDRY	-	0.07	0.07	0.07	0.50	0.20	-	-
Qatar	-	2.50	-	-	-	5.00	-	-
S. Arabia	0.18	0.08	-	0.02	0.02	-	-	-
Somalia	0.07	0.05	-	0.06	0.02	0.27	-	-
Sudan	0.16	0.06	0.02	-	0.01	-	-	-
Syria	-	0.14	-	-	-	-	-	-
Tunisia	-	0.17	-	0.06	2.40	3.80	1.40	-
United Arab Emirates	-	-	-	-	-	-	-	-
Yemen	-	-	-	-	-	-	-	-

(*) = no response

Another aspect of this lack of trained manpower in the Region was the imbalance between the different categories of mental health workers. In some countries there were in fact more psychiatrists than trained psychiatric nurses, in some the numbers were almost equal, while in others the ratio was a more natural one (See Table III).

A review of the numbers of psychiatrists, psychologists, social workers, and psychiatric nurses at present being trained either abroad or in their own country, indicated a state of affairs which would need redress. Only five out of twenty-two countries reported that doctors were being trained in psychiatry. Two countries appeared to have trainees in psychiatric nursing and none reported trainees in psychiatric social work. It is, however, likely that information about people being trained, particularly about those who went abroad, was rather deficient. Yet, even though the picture presented here may be incomplete, action would appear to be essential to improve the position in the future.

Against the background of high morbidity and mortality from infectious diseases and malnutrition this apparent lack of urgency in the development of mental health services might have been justified; but with the advance of public health, with our increasing ability to control epidemics and following the often successful mass campaigns against endemic infectious diseases, Governments might consider a reassessment of priorities in the field of public health. In times of war, famine or similar disaster, mortality could still be a good indicator of the amount of energy and finance to be spent on prevention and management of these calamities. However, with the universal trend towards industrialization and urbanization it was advisable to look for more appropriate means of measuring the consequences of being ill, such as :

- patient-consulting rates (average number of patients consulting doctors per 1 000 population,
- consultation rates (average number of consultations per 1 000 population),
- absenteeism from school or work because of illness,
- rates of hospitalization.

First of all, population surveys in Iran (*) and Ethiopia (**) had shown that at least ten per cent of people aged fifteen years and over, were suffering

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(*) Bash K.W. and J. Bash Liechti (1969) Social Psychiat. 4, 137
(**) Giel R. and J.N. van Luijk (1969) Brit. J. Psychiat. 115, 149

from some form of psychological disturbance. This did not necessarily mean that all should receive psychiatric treatment, but patterns of consultation in the developed countries hint at what may be awaiting the developing nations. In England and Wales, it was found that the psychoneurotic disorders ranked fourth to common cold, arthritis or rheumatism, and bronchitis, in the average number of patients consulting doctors per 1 000 patients on the general practitioners' lists. They ranked third to bronchitis and arthritis or rheumatism, in the average number of consultations per 1 000 patients on the doctors' lists.

As soon as medical provisions become easily accessible, even a developing country begins to follow this pattern of consultation. In the rural district of Ethiopia 19.5 per cent of patients attended the community health centre with a psychological disturbance, compared with 17.1 per cent coming with an infectious disease.

The annual patient-consulting rate for psychiatric illness was 148 per 1 000 of the population at risk. In a survey in London** the comparable rate was 139 per 1 000. It is thus apparent that the developing nations also had to reckon with this kind of strain on their health services.

Absence from work because of psychological disturbances, which in the developed nations could be responsible for 25 to 33 per cent of all industrial absenteeism,* had not yet been assessed in the developing nations. But there was no reason to believe that the industrialized and urbanized areas in the Region would be spared this pattern of absenteeism.

With so few mental hospitals in the Region, hospitalization rates, because of mental illness did not seem of great importance. Yet, if one considered the average loss of productive years associated with the often chronic mental disorders the effects could be staggering. In many hospitals approximately fifty per cent of the patients had been hospitalized for more than five years, and often much longer.

Unfortunately, few public health administrators were aware of the magnitude of the mental health problems, and therefore were not sufficiently prepared for the impact of these problems, which will undoubtedly become strikingly apparent in this Region, as they have in other countries.

(*) Winslow C.E.A. (1951) The cost of sickness and the price of health WHO Monograph Series.

(**) Shepherd M., Cooper B., Brown A.C., and Kalton G.W. (1966) Psychiatric Illness in General Practice, London

IV GUIDELINES FOR THE DEVELOPMENT OF MENTAL HEALTH SERVICES

1. Administration of mental health services

Creation of a mental health agency of major status in the Ministry or department of health was already recommended by the WHO Expert Committee in 1949 (WHO Technical Report Series No.223 "Programme Development on the Mental Health Field", 1961). As the survey carried out had shown, in 1972 only four out of twenty-two countries in the Region had such an Agency.

Without a central unit or department in the Ministry of Health, it was impossible to develop mental health programmes, to co-ordinate the activities of the existing mental health services and to integrate the delivery of mental health care with that of over all health care.

Usually, mental health activities involve other Ministries (Social Affairs, Education, Labour, Culture, Internal Affairs and Justice). Particularly with regard to the wider field of mental health work providing for the psychological well-being of people, the activities were bound to overlap. Communication between the Ministries and co-ordination of their respective activities was a necessary requirement. One way of arriving at the co-ordination of mental health activities, including those of the voluntary associations, was the establishment of a National Co-ordinating Committee for Mental Health, in order to enlist the advice of collaborators from members of all these disciplines (professional, non-professional, representatives of the Ministries, the mental health services, the Universities and the voluntary associations).

The mental health department or unit in the ministry of health should be headed by a psychiatrist or other professional of proven competence in mental health work. The department should be staffed by people representing psychiatric nursing, social work and psychology, and by people versed in administration, economics and the Law. Its responsibilities should include :

- drawing up explicit mental health plans stating objectives which should be achieved within stated periods of time;
- advising the Ministry of Health on the specific provisions for mental health activities in its annual budget;
- establishing requirements for the building and staffing of mental health facilities;
- setting norms for the training of mental health personnel and their diplomas;

- advising the Government on mental health legislation; and following up its application;
- collecting and presenting mental health statistics.

The collection of data came at the bottom of this list of responsibilities of a mental health unit or department in the Ministry of Health, yet the existence of basic information regarding the numbers of psychiatric beds and out-patient clinics, their geographic distribution, number of admissions, discharges and out-patient contacts, and manpower resources both in the field and under training was essential for the proper undertaking of the other responsibilities listed.

2. Organization of mental health services

In the organization (*) (**) of mental health services the following objectives were universally accepted :

(a) a movement away from the large institutional type of service towards smaller units preferably in district general hospitals, and various forms of out-patient care;

(b) a movement towards differentiation of care for different categories of patients (age groups, mentally retarded, mentally-ill offenders, drug and alcohol dependents, etc.);

(c) an attempt to meet the needs of a mentally disturbed person at all stages of his illness;

(d) the integration of mental health activities with all other public health activities.

These objectives implied the development of a chain of facilities ranging from dispensaries and community health centres, through units in general hospitals and psychiatric out-patient clinics to mental hospitals and after care facilities, e.g. rehabilitation centres, halfway houses and hostels for the mentally handicapped.

The consequences for the patient and his relatives were : an increased awareness about the early stages of mental illness or mental handicaps, and a change of roles and expectations with regard to the later stages of illness and to rehabilitation. This could only be achieved through mental health education of the public, teachers, religious leaders and general practitioners.

(*) WHO Technical Report Series No.233 Geneva 1961
(**) EURO 4200 - Report of the Regional Office for Europe, WHO Copenhagen 1970

The fundamental requirements for the mental health services were : provisions for the early detection and treatment of cases and for continuity of care of a patient; flexibility in the structure and utilization of the various components of the service; promotion of community and family support to avoid segregation and isolation of patients; integration of mental health in the work of the overall health services.

The implication for the mental health worker were : an increased mobility on his or her part. First, he should be able to function in in- as well as in out-patient services, in preventive as well as in rehabilitative roles. His obligations should be to the population at risk, rather than to a specific type of institution in the mental health service. Second, he should be capable of shifting his attention from patients to people who had to deal with patients. He should be equipped not only to treat, but also to educate, advise and supervise others.

There was no point in introducing mental health work in remote health centres and clinics, unless the psychiatrist, the psychiatric nurse and the social worker were prepared to conduct a regular follow-up.

3. Priorities in the delivery of mental health care

Nearly all countries in the Region reported having at least one mental hospital. The number of beds per 1 000 population ranges from 0.01 in Pakistan to 1.3 in Cyprus. In the European Region * it ranged from 0.2 in Turkey, to 5.9 in Ireland.

In 1952 the Expert Committee ** pointed out in its discussions on the mental hospital that a certain minimum of psychiatric beds, estimated at one per 10 000 population, was essential for the care of the mentally sick who were a danger to themselves or to others. Quite a number of countries in the Region already had achieved this goal. Therefore, increasing the number of mental hospital beds and aspiring at outmoded European rates should be discouraged, and more priority should be given to the improvement of the existing hospitals. First, attention should be paid not only to the psychiatric but also to the physiological and social needs of the in-patients, enabling them to escape from the bare minimum of survival and to start leading a more useful life. Occupational therapy, holiday camps, social events with male and female patients participating, and contact with relatives could serve this purpose.

Second, attempts at rehabilitation should prevent chronicity and decrease the population institutionalized for long periods.

(*) EURO 5405 II Regional Office for Europe 1971
(**) WHO Technical Report Series No.73 1953

Budgetary limitations would force Governments to make a choice and to compromise, in which case they should concentrate on facilities closest to the community. As had been shown before, the number of psychiatric units in general hospitals in the Region was extremely low. Their establishment was more often a matter of staffing than of building and therefore heavily depending on the training of psychiatrists and psychiatric nurses.

Most obvious, however, was the absence of psychiatric out-patient clinics; the majority of the countries in the Region having less than one clinic per 500 000 of the population. In the European Region, the number ranged from 0.3 in Greece to 6.9 per 100 000 in Ireland. The establishment of psychiatric out-patient clinics with a proper geographical distribution should have first priority.

The functions of such a psychiatric clinic or mental health centre might differ from Region to Region. Each would have its own health problems and requirements, depending on whether it is rural, industrial, residential or other. Concepts of illness, patterns of seeking relief from symptoms and problems, might vary and therefore would demand a different approach. The establishment of a mental health centre should be preceded by a survey to collect demographical, sociological and epidemiological data on the population it was going to serve and to supply information on the local resources, whether medical or traditional, which could contribute to or might have to be reached through programmes of mental health education. The problem of instituting a clinic fee should be considered. Free access to a mental health centre might invite people to come in such overwhelming numbers that proper treatment was no longer possible, and in many cases not even necessary. A clinic fee might induce people to accept some responsibility in the treatment. On the other hand, in some Regions it might form an impediment to treatment, particularly of poor and chronically disabled patients.

Other areas for the delivery of mental health care requiring attention were :

- provisions for mentally disturbed offenders;
- facilities for mentally disturbed children;
- centres for people dependent on drugs or alcohol;
- facilities for the mentally retarded.

One country in the Region reported having separate institution for mentally disturbed offenders; four indicated having a special unit in prison, and seven appeared to have institutions for juvenile delinquents.

Often these institutions or units offered little more than separate custodial care, rarely did they also offer treatment.

Because of increased life expectation, more awareness on the part of the parents and the spread of literacy and basic school education, the problem of mental retardation was a growing one. Special measures were needed to cope with it.

(a) Preventive measures should aim at the prevention or treatment of infectious diseases, genetic counselling, pre- and peri-natal care and screening for factors which cause prematurity.

(b) Educating and counselling parents could help to keep mentally retarded children away from the institutions; if hospitalization is unavoidable it should be in separate institutions.

(c) Shortage of personnel should be met by involving teachers by means of in-service training.

(d) Long-term administration of psychotropic drugs should be available.

(e) Professional people should engage themselves in the work of voluntary organizations.

4. Utilization and training of manpower

The need for mobility and flexibility of the mental health worker has already been commented upon. With the apparent and often extreme shortage of trained personnel in most countries of the Region, the emphasis in their work should be on teaching others, and on advising and supervising people already engaged in health work. This change in the attitude of psychiatrists, psychiatric nurses and social workers would not easily be achieved. Traditionally, higher status was derived from direct, curative contact with patients.

A. Training of psychiatrists

With a few exceptions, most countries in the Region have relied almost exclusively on sending doctors overseas for specialist training in psychiatry. As only two countries offered post-graduate training, there was obviously no alternative to sending graduates abroad. The disadvantage of such training was that it divorced the trainee from the realities of practice in his own culture so that many were not willing after training to work in their home country. The following measures could to some extent counter the resulting "brain drain" :

- the young graduate should not begin specialized training without the experience of a few years of general practice in his own country;

- entrants to the speciality should receive an initial period of basic clinical training under the supervision of senior psychiatrists in their own country, before being seconded for more advance post-graduate training abroad;

- governments should only sponsor such advanced training in centres abroad, which have demonstrated a special interest in the mental health problems of developing countries.

Ultimately, one or more countries in the Region should develop post-graduate training programmes, perhaps with the help of foreign teachers and external examiners.

B. Psychiatric under-graduate medical education

The subject had been extensively treated in the Report of the WHO Seminar on the Place of Psychiatry in Medical Education (Alexandria, July 1970, EM/MENT/43 EM/Ed.Tr./213 EMRO 0112).

C. Training of allied professionals

It was clear that for many years to come the numbers of professionally qualified psychiatrists, psychologists, psychiatric social workers and psychiatric nurses would not be sufficient for them to offer mental health care and mental health education directly to the population as a whole. These tasks would have to be shared with members of other professions.

Therefore, teaching on mental health and personality development should be given an important place in the basic training not only of all doctors but also of all psychologists, nurses, social workers and teachers. The subjects of mental health and personality development should also be included in programmes for adult education in general, and parent education in particular. Radio talks on mental health could stir the interest of the public.

Training and advising maternal and child health workers might stimulate them to give some attention to the mental health problems of the mothers and children attending their clinics.

As the Koran also includes statements on mental health problems such as suicide, homosexuality, alcoholism and other topics on human relationships, modern psychological insight into these matters might be of interest to religious leaders. Discussion groups could be started with religious people to enlist their support in reaching the people.

D. Training of nurses

The role of the nurse in mental health work, and particularly in psychiatric care, was a special one because of her more constant contact with the patient. Nowadays, the work of the nurse was much less specifically geared to the task of nursing the patient. Reorientation of the objectives of the mental hospital towards rehabilitation and restoration of the patient to the community had resulted in changes of the role of the nursing staff. More emphasis had to be given to the task of socially stimulating a patient to prevent further deterioration. If the nurse was going to engage in extra-mural work, mental health education and rehabilitation might even take most of her time. Obviously, this change in role should be reflected in the training programmes.

In view of the extreme shortage of trained nurses of all levels, but especially of psychiatrically trained nurses, the following objectives should have priority :

(a) the training of psychiatric nursing educators;

(b) the inclusion of teaching and experience in psychiatric nursing in the teaching programmes of general nurses and nursing assistants.

Psychiatric nursing education should be developed in four phases :

PHASE I : In one or more mental hospitals a Hospital Department of Psychiatric Nursing Education should be created. The staff should comprise psychiatric nursing educators and clinical instructors. To safeguard the training programmes, the department should be independent of demands for nursing service, and its head should be directly responsible to the director of the hospital on the same level as the matron.

The department should carry responsibility for :

- the teaching of psychiatric nursing to students from general nursing programmes;
- in-service psychiatric nursing programmes for :

  (a) staff in the mental health services,

(b) staff in other health services, i.e. public health and maternal and child health.

The requirements for such a hospital department of psychiatric nursing education should be the following :

- consent of the ministry of public health, and the hospital director;
- allocation of a budget;
- hospital wards maintained at approved standards.

PHASE II : Graduates from university and diploma schools of nursing should be selected for preparation as teachers and clinical instructors. They should have completed a programme of basic nursing education at the highest level available in the country; specialization in psychiatric nursing; and preparation for teaching, including if necessary a period of study abroad in order to familiarize themselves with current patterns of psychiatric nursing care. Their responsibilities would be the following :

- Providing staff for the hospital department of psychiatric nursing education;
- advising and approving appropriate clinical areas for psychiatric nursing experience;
- teaching mental health and psychiatric nursing in basic nursing programmes;
- developing and teaching in post-basic and in-service education programmes conducted by the department.

PHASE III : The development of in-service education programmes.

The purpose of the in-service education programme would be :

- to improve the nursing care offered to persons who are emotionally ill;
- to extend such care to the community through a variety of services in which nurses are employed;
- to provide nursing staff who could assist in the early detection of mental ill health and in curative and rehabilitation services.

Candidates for in-service education would be :

- nurses in key positions in psychiatric hospitals who do not have psychiatric nursing preparation;
- existing nursing staff in psychiatric units and out-patient departments in general hospitals;
- nursing staff of rural health centres;
- nurses in key positions in public health, maternal and child health.

PHASE IV : The development of basic nursing curricula.

The purpose was to ensure that all nurses had some knowledge of basic mental health and psychiatric nursing principles, and clinical psychiatric nursing experience as part of their basic education. It was suggested that nursing educators at ministry, university or other level together with psychiatric nursing educators form a group for the express purpose of developing the mental health and psychiatric nursing content of basic two or three years nursing programmes and to ensure that clinical experience in psychiatric nursing was part of the requirement. Studies of particular value to all nurses were the areas of :

- communication and interpersonal relationships;
- group dynamics and function;
- human growth and personality development;
- patterns of behaviour in health and illness;
- basic principles of psychiatric nursing;
- therapies which require nursing participation, social, psychological, physical and chemo-therapeutic.

The principle underlying the training of nurses was that it was not considered necessary to train large numbers of psychiatric nurses, if all nurses have mental health and psychiatric nursing included in the basic curricula.

D. The training of auxiliaries

In countries where professionally qualified personnel of all categories were in very short supply, considerable reliance has to be placed on the contribution which could be made by less highly trained staff, working under professional staff. As a first step a list should be made of the tasks for which there was a shortage of personnel, i.e. nursing,

occupational, recreational and industrial therapy, social therapy, teaching, etc. This would help to give an exact description of the work to be performed by an auxiliary. Next, information should be collected on the kind of people who could do the job, the minimum education they should have had and their availability in the country.

Following this, training programmes should be developed enabling the auxiliary staff to meet their obligations with confidence.

The best location for training would be a psychiatric unit in a general hospital or a mental hospital, provided its standards were maintained at a sufficiently high level and preferably attached to a University. Centralization of the programming of training would meet the need to formulate the basic requirements of the courses. If the available candidates were selected into the following categories :

1. fully or as fully trained as possible,

2. partially trained either academically, or practically,

3. untrained but suitable candidates for training,

and if the content of the training courses was adjusted to these levels of education, the likelihood of failure would be kept as small as possible.

More or less the same principles applied to the employment of voluntary workers. They should be properly selected as to the tasks they could perform. At the same time it was essential that they should have supervision from or access to the advice of prefessional staff.

5. Mental health legislation

In Chapter II the deficiencies of mental health legislation in the Region had already been outlined.

Mental health legislation served to protect the patient as well as the community, the doctor carrying on his profession and the mentally disturbed offender before the Court. It would formulate the standards for and exercise control of the operation of mental hospitals and other psychiatric facilities.

It set the rules for the protection of the relationships and possessions of people who could no longer be considered as acting in a responsible way.

The Law relating to mental illness must be credible, must command the respect not only of those who had to enforce it, but also of those whom it professionally involved.

In its Technical Report No.98, 1955, on "Legislation affecting Psychiatric Treatment", the WHO Expert Committee stated that legislation should meet the following needs :

1. Recruitment and training of the essential professional and auxiliary staff;

2. provision of care and treatment institutions;

3. establishment of measures permitting treatment of patients who were unaware of their condition or who were dangerous, and which would ensure guardianship and medical supervision when the patient's state called for this.

4. setting up of specialized health service, i.e. a community psychiatric service.

The Committee was of the opinion that "the fundamental problems of psychiatric treatment and mental health were the same in all countries, whatever their structure or degree of economic development.

What was required in all cases was :

1. to provide means of treatment and care (prevention, training of personnel, organization of facilities for care and treatment);

2. to protect the civil rights of the mentally-ill and mentally disabled whose capacity for social autonomy was inadequate or who showed themselves to be a danger to law and order.

Although the fundamental problems were the same, the ways in which they were dealt with should vary according to the type of social structure.

Ideas concerning mental illness varied from one country to another and even within one and the same society they changed from one period to another. In the first place, the law should be in keeping with the cultural and legal traditions of the society concerned. However, this involved the risk of perpetuating the customary usages and thus opposing change.

It would seem that this danger might be avoided by advocating legal provisions which, while being adapted to the present stage of development of a society, left the way open for future changes. For this reason, it was desirable, at every stage of development, to introduce the basic elements of the following stage and in that following stage, to modify the function of the preceding institutions".

According to the modern concepts of mental health care, the law should not be primarily directed towards the protection of society, nor should it be overprotective of the patient. In addition, its terminology should be clear, up-to-date, and neutral with regard to the stigmatization of the mentally-ill.

It was hoped that further guidelines on mental health legislation would shortly be available, in the Report on a WHO Consultation held in Geneva in August 1972.

6. Mental health research

At present two major areas of mental health research could be distinguished :

(a) Clinical research : dealing with the etiology, patho-physiology, biochemistry, and psychopathology of mental disorders, as well as the diagnosis, assessment of severity, the classification, the course and the response to treatment of the diseases.

(b) Epidemiological research : Focusing not only on the epidemiological study of populations and their needs and attitudes, but also on the operation of existing mental health services. It tried to answer such questions as : What kinds of mental diseases are prevalent and which population groups are affected ? What kind of people currently avail themselves of psychiatric help ? In which way are services planned or organized, and which resources are available, for instance manpower and mental health facilities ?

The first area of research was more often of interest to the individual clinical worker, for example, in a University hospital. The second area was or should be the concern of Governments interested in planning and developing mental health services on a sound basis. One of the first priorities in this kind of research should be the collection of uniform data regarding the existing mental health services : the number of psychiatric beds and out-patient clinics, number of discharges from hospital, number of out-patient contacts, number of staff in the various categories of mental health workers, all according to their geographical distribution and expressed in population rates related to the area.

At this moment, information about research, whether clinical or epidemiological currently being carried out in the Region was largely lacking. It would be to the advantage of the countries in the Region, if they could succeed in compiling and exchanging information on the subject of mental health research. Following this, it might even be possible to attempt to co-ordinate some research activities.

Unfortunately, mental health workers keen on doing research, were often forced by the circumstances to visit the technically more advanced nations to pursue their interest. The disadvantages of this situation were obvious. First, their native country would not benefit from their efforts while they were abroad. Second, once they became accustomed to the sophisticated scientific entourage of the technically more advanced country, it would be difficult for them to transfer their attainments to the more down-to-earth situation back home. They either stayed abroad or on return they might abandon research.

The alternative would be for a Government, or university, to invite scientists from abroad for the specific purpose of developing a research programme locally, and with the help of indigenous professionals who should then be exempted from routine duties. This strategy might avert the "brain drain", bring expertise to the country, and be cheaper in the end. It would necessitate the collaboration of Government officials and university staff in determining and formulating priorities in mental health research.

Epidemiological surveys had been conducted in Iran and Ethiopia, along these lines.

V FOLLOW-UP OF THE GROUP MEETING

The objectives and principles for mental health work explained in the preceding pages are the result of the deliberations of the experts assembled in the Group Meeting. The participants were well aware of the fact that their conclusions and recommendations, emphasizing the need for mental health activities in the Region, would remain ineffective without any follow-up programme. They perceived the role of the Regional Office as central and of the utmost importance in this respect.

The following proposals could serve as a programme for follow-up by the Regional Office and the countries of the Region :

1. This Report should be given a wide distribution in the Region, inviting Governments to comment, add or amend, and to send it to national professional

associations for discussion. Introduction of the Report at the Third Pan African Psychiatric Conference to be held in November 1972 in Khartoum could be a first step.

Next, the Regional Office might consider organizing a Conference, with participants particularly from countries which are in an early stage of development of their mental health services to discuss the content of the Report and its implementation.

2. The Regional Office should continue its survey of the mental health services in the Region, by means of a questionnaire. First, a report on the present findings should be produced and circulated to Governments for amendments and additions. On the basis of this a new questionnaire should be designed with more explicitly defined items.

This questionnaire should then be sent to the countries to up-date and expand the information on the mental health services in the Region.

The purpose of such an exercise would not so much be to inform the Regional Office on the situation in the Region, as to stimulate the individual countries into collecting data which were a basic requirement for the planning of mental health services.

3. As soon as the new guidelines on mental health legislation became available they should be circulated by the Regional Office, after which a Seminar on Mental Health Legislation could be held.

4. The Regional Office or the individual countries should organize meetings on specific topics which needed urgent attention from the Governments in the Region. These should include the following :

- treatment and care of mentally-ill offenders;
- the problem of drug dependence;
- prevention and care in mental retardation;
- the training of auxiliaries.

5. The Regional Office could try to collect information on mental health research in the Region in order to compile a bibliography which could then be circulated.

VI CONCLUSIONS AND RECOMMENDATIONS

The recent survey of Mental Health Services in the Region revealed great inequalities of provisions in this field among member countries, and some

conspicious deficiencies both in trained manpower and in facilities. In the following recommendations of the Group attention was drawn to a number of particular areas in which there was a pressing need for action.

1. Mental Health administrative organization at Government level

The Group RECOMMENDED that there should be a MENTAL HEALTH DEPARTMENT or UNIT headed by a psychiatrist or other professional of proven competence in Mental Health work, in each country's Ministry of Public Health. This Department's responsibilities would include planning hospital, out-patient and other forms of medical care for the mentally afflicted, public education on Mental Health, the collection, analysis and publication of statistics relating to these activities. It should be guided in its work by a non-governmental Advisory Committee composed of experienced workers from different mental health fields.

Since Mental Health care necessarily involved other professions and disciplines in addition to medicine and psychiatry (for example, Maternal and Child Health, Education, Social Welfare, the Police, the Prisons, Voluntary Agencies and Religious Leaders) the Group RECOMMENDED that the Department of Mental Health should take the initiative in organizing National Co-ordinating Committees for MENTAL HEALTH and for MENTAL RETARDATION, in order to enlist the advice of collaborators from members of all these disciplines and to ensure co-ordination of services.

2. Programme planning to meet urgant needs

The Group RECOMMENDED that in every member country the Mental Health Department should draw up explicit plans stating the objectives which should be achieved within stated periods of time (e.g. Five-year and Ten-year plans).

In order that these plans could be effectively realized, the Group CONSIDERED IT ESSENTIAL that each country's Ministry of Health should make specific provision for Mental Health activities in its annual budget. This allocation would increase with the subsequent development of the Mental Health Services.

The Group also REQUESTED the WHO Regional Office to circulate a Five-year Plan, indicating the topics which WHO will select for particular attention during the next few years.

3. Mental Health Services

The Group underlined the fact that at present the mental health services in most countries did not meet the needs of the mentally disturbed person at all stages of his illness. Therefore, the Group RECOMMENDED : The development of a chain of facilities ranging from community health centres with mental health activities through psychiatric units in general hospitals and psychiatric out-patient clinics, or Community Mental Health Centres to mental hospitals, rehabilitation centres and adequate facilities for the mentally handicapped.

Although it might be necessary to improve the existing mental hospitals and other institutions, emphasis should be on the development of first line facilities in close proximity to the patients' own community. The Group also wanted to draw the attention of Governments to the principle of differentiated care for specific categories of patients such as mentally ill offenders, people dependent on drugs or alcohol, and the mentally retarded. The Group recommended the development of special mental health services for these specific categories of patients as a matter of urgency.

4. Manpower and Training

Almost every country in this Region showed an extreme shortage of trained personnel in both professional and non-professional roles in mental health work. Attention had been drawn to the need for more training in mental health in the following areas :

A. Training of psychiatrists

Hitherto most countries in the Region, with few exceptions relied almost exclusively on sending doctors overseas for specialist training in psychiatry. The Group, being acutely aware of the disadvantages, as well as the value of such training (which divorces trainees from the realities of practice in their own culture while preparing them for a career in the psychiatric services of the host country, and hence promotes the Brain Drain) strongly RECOMMENDED that entrants to this speciality should receive an initial period of basic clinical training under the supervision of senior psychiatrists in their own country, before being seconded for more advanced training abroad . Placement for such advanced training should preferentially be made in centres which have demonstrated a special interest in the mental health problems of developong countries.

It was hoped that ultimately centres within the Region would be able to offer theoretical as well as practical training to the great majority of trainees in psychiatry.

B. Psychiatric Undergraduate Medical Education

Recognizing the importance of adding competence in Mental Health care to the basic training of all doctors, the Group ENDORSED the recommendations of the WHO Seminar on the place of Psychiatry in Medical Education (EM/MENT/43 EM/Ed.Tr./213) and URGED the Governments and Medical Schools of this Region to implement these recommendations. It REQUESTED the WHO Regional Office to carry out a formal inquiry in order to ascertain to what extent MEDICAL Schools had already fulfilled these recommendations.

C. Training of allied professionals

It was clear that for many years to come the numbers of professionally qualified psychiatrists, psychologists, psychiatric social workers and psychiatric nurses would not be sufficient for them to offer mental health care and mental health education direct to the population as a whole : these tasks would have to be shared with members of other professions. The Group therefore RECOMMENDED that teaching on Mental Health and Personality Development should be given an important place in the basic training not only of all doctors but also of all psychologists, nurses, social workers and teachers, and that these subjects should also be included in programmes for Adult Education in general, and Parent Education in particular.

D. Training of Nurses

In view of the extreme shortage of trained nurses of all kinds - but especially of psychiatrically trained nurses - the Group RECOMMENDED the creation of one or more Hospital Department of Psychiatric Nursing Education, each associated with a psychiatric hospital and a Medical School.

Although some Mental Health instruction and some clinical experience in psychiatric nursing was included in basic nursing curricula this could not be effectively implemented because of the lack of nurses with basic psychiatric preparation.

It was not considered necessary to train large numbers of psychiatric nurses; instead the Group RECOMMENDED that selected Nurse Educators and Clinical Instructors should be given specialized training in this field, if necessary a period of study abroad in order to familiarise themselves with current patterns of psychiatric nursing care.

These Psychiatric Nurse Educators working in a Hospital Department of Psychiatric Nursing Education could then contribute to the teaching of

general nurses and also to the in-service training of Nurses and Nursing Assistants employed in all branches of both the General and the Mental Health Nursing Services.

E. Training of Auxiliaries

In situations where professionally qualified personnel of all categories were in very short supply, considerable reliance had to be placed on the contribution which could be made by less highly trained staff, working under professional supervision.

The Group RECOMMENDED that training for different groups of such personnel should be designed to match their level of education, and to equip them to carry out specific tasks within their competence. The Group further RECOMMENDED that such training should be given in the personnel's normal place of employment. Their teachers, who may be Psychiatrists, Nurse Educators or other professionals, should be seconded for short periods to a centre in the Region (such as the Asfurieh Hospital, Beirut) for courses in the techniques of teaching auxiliary personnel.

5. Mental Health Legislation

The Group NOTED that in many countries of the Region Mental Health Laws are either out of date or non-existent. The lack of modern legislation in this field hampered the development of advanced patterns of Mental Health Care and could result in unnecessary suffering for mentally ill offenders. The Group, therefore, RECOMMENDED that the WHO Regional Office should consider devoting particular attention to this topic at an early date, with a view to prompting Governments of Member Countries to review their legislation in this area. It was noted that general guidelines for Legislation affecting Psychiatric Treatment were indicated in the WHO Technical Report Series No.98 in 1955, and that further guidelines on this topic should be available shortly, in the Report of a Consultation held in Geneva in August 1972.

6. Research

The Group ACKNOWLEDGED the lack of information about, the scarcity of, and the lack of co-ordination in Mental Health Research in the Region. Therefore, it RECOMMENDED that national Governments take an interest in establishing priorities and in stimulating, and supporting Mental Health Research. The Group would like to underline the absence of often the most basic epidemiological data regarding psychiatric illness, and the activities of the existing mental health facilities, it therefore RECOMMENDED the prosecution of epidemiological research as a matter of priority.

A preliminary survey (which was to be repeated with modifications designed to improve the reliability of the data) had already yielded valuable information, e.g. the great inequality of provision for mental health care in the Region's Member countries, the general insufficiency of trained personnel and the lack of up-to-date mental health legislation in most countries. The survey also revealed that basic information in this field was not readily available even to the Health Planners in a majority of the countries. The Group, therefore, RECOMMENDED that basic statistical data should be collected in each country, to monitor activities in mental health care.

7. Follow-up of Recommendations

The Group CONSIDERED the present Meeting a turning point in the development of mental health programmes in the Region. Therefore, the Group would like to stress the need for a follow-up meeting. It perceived the role of the Regional Office as central and of the utmost importance.

While appreciating the excellence of the recommendations which had been formulated by previous WHO Expert Committees and Seminars on Mental Health, the Group noted that in many cases these recommendations had not been acted upon. The Group therefore RECOMMENDED that advisers and administrators in Mental Health in all Member Countries should urge their respective Governments to give effect to these recommendations. The Group further RECOMMENDED that the WHO Regional Office should carry out follow-up surveys, organize review meetings and stimulate research in order to assess the degree to which the recommendations of this Meeting (and its predecessors) had been implemented.

As an immediate objective the Group RECOMMENDED that the Regional Office continue its efforts to collect information on the existing mental health services and activities in the Region, and that it present the findings to the national Governments for discussion and further elaboration.

ANNEX I

AGENDA

I Opening of the Meeting by the Regional Director.

II Election of Chairman, Vice-Chairman and a Rapporteur.

III Introduction : Group Meeting of Mental Health Specialists.

IV REVIEW OF THE STATE OF MENTAL HEALTH SERVICES IN THE COUNTRIES OF THE EASTERN MEDITERRANEAN REGION

V
a) General principles of programme developments in Mental Health.
b) Goals and criteria.
c) Obstacles.
d) Priorities.

VI MENTAL HEALTH SERVICES

a) Needs and demands for services.
b) General psychiatric facilities.
c) Comprehensive mental health services.
d) Special problems.

VII TRAINING OF PERSONNEL

a) Professional. b) Auxiliary.

VIII RESEARCH

IX Other items.

X Conclusions.

XI Recommendations.

XII Closing Session.

ANNEX II

LIST OF PARTICIPANTS, WHO SECRETARIAT AND RESOURCE PERSONNEL

PARTICIPANTS

CYPRUS	Dr P. Matsas Specialist Psychiatrist Medical Superindendent of the Psychiatric Institutions Ministry of Health Nicosia
EGYPT	Dr A.M.F. Okasha Assistant Professor of Psychiatry Faculty of Medicine Ein Shams University Cairo
	Dr Ahmed Wagdi Consultant Ministry of Health Cairo
IRAN	Dr H. Davidian Professor of Psychiatry University of Teheran Teheran
	Dr M.H. Sahebo's-Zamani Chief, Mental Health Section Ministry of Public Health Teheran
LEBANON	Dr A.S. Manugian Physician Superintendent The Lebanon Hospital for Mental and Nervous Disorders Beirut

PAKISTAN	Dr K.Z. Hassan Professor of Neurology Jinnah Postgraduate Medical Centre Karachi
SUDAN	Dr H. El R. Soliman Senior Psychiatrist Clinic for Nervous Disorders Khartoum-North

WHO SECRETARIAT

Dr A. H. Taba	Director	WHO Regional Office for the Eastern Mediterranean
Dr T.A. Baasher	Regional Adviser on Mental Health, Secretary of the Group Meeting	WHO Regional Office for the Eastern Mediterranean
Dr F.R. Hassler	Chief, Mental Health	World Health Organization, Headquarters, Geneva
Prof. R. Giel	Consultant	Professor of Social Psychiatry University Hospital Groningen The Netherlands
Prof. G.M. Carstairs	Temporary Adviser	Department of Psychological Medicine, Royal Edinburgh Hospital, Edinburgh
Miss C. Cartoudis	Conference Officer	WHO Regional Office for the Eastern Mediterranean
Mrs A. Economakis	Secretary	WHO Regional Office for the Eastern Mediterranean

RESOURCE PERSONNEL

Miss Rita Mc Ewan
WHO Nurse Educator
High Institute of Nursing
Cairo

Dr Samira Salama
Nurse Educator
(psychiatric nursing)
High Institute of Nursing
Cairo

ANNEX III

PROGRAMME

MONDAY 4 September 1972 - ALEXANDRIA - EMRO

8.30 a.m. - 9.30 a.m. - Registration of Participants

9.30 a.m. - 11.00 a.m. - Opening of the Meeting by Dr A.H. Taba, WHO Director, Eastern Mediterranean Region

- Election of Chairman, a Vice-Chairman and a Rapporteur

- Adoption of the Agenda

- Programme of work

- Introduction and objectives by Dr T.A. Baasher

11.00 a.m. - 11.30 a.m. - Recess

11.30 a.m. - 12.00 noon - "REVIEW OF STATE OF MENTAL HEALTH SERVICES IN THE COUNTRIES OF THE REGION" by WHO Secretariat to be presented by Dr T.A. Baasher Doct./4

- Discussions

12.00 noon - 12.30 p.m. - "GENERAL PRINCIPLES OF PROGRAMME DEVELOPMENT IN MENTAL HEALTH WORK"

- Modern trends in mental health work by Dr G.M. Carstairs Doct./5

17.30 p.m. - 19.00 p.m. - Steering Committee

TUESDAY 5 September

9.00 a.m. - 9.45 a.m.	- Organization and administration of psychiatric services, by Dr A. Wagdi Doct./7
	- Discussions
9.45 a.m. - 10.30 a.m.	- (a) "NEEDS AND DEMANDS FOR SERVICES"
	- (b) "GENERAL PSYCHIATRIC FACILITIES"
	- (c) "COMPREHENSIVE MENTAL HEALTH SERVICES" To be introduced by Professor R. Giel and Dr T.A. Baasher
10.30 a.m. - 11.00 a.m.	- Community mental health care, by Dr M.H. Sahebo's Zamani Doct./8
	- Discussions
11.00 a.m. - 11.30 a.m.	- Recess
11.30 a.m. - 12.00 noon	- The care of the mentally retarded, by Dr K.Z. Hasan Doct./14
	- Discussions
12.00 noon - 12.30 p.m.	- Problems of drug dependence, by Dr H. El R. Soliman Doct./15
	- Discussions
12.30 p.m. - 12.45 p.m.	- Recess
12.45 p.m. - 13.30 p.m.	- Mental patients and the Law, by Dr P. Matsas Doct./12
	- Discussions

WEDNESDAY 6 September

8.30 a.m. - 9.00 a.m.	- Steering Committee
9.00 a.m. - 10.00 a.m.	- "TRAINING OF PERSONNEL"
	(a) "PROFESSIONAL"
	- Teaching and Training of preventive psychiatry, by Dr H. Davidian Doct./9

WEDNESDAY 6 September (cont'd)

- Discussions

10.00 a.m. - 10.15 a.m. - Recess

10.15 a.m. - 11.15 a.m. - Training of mental health nurses, by Miss R. McEwan and Dr S. Salama Doct./10

11.15 a.m. - 12.00 noon (b) "AUXILIARY"

- Training of mental health auxiliaries, by Dr A.S. Manugian Doct./11

12.00 noon - 13.00 p.m. - "RESEARCH"

- Research in mental health work, by Dr F.R. Hassler Doct./13

- Discussions

13.00 p.m. - Other items

Afternoon free

THURSDAY 7 September

8.30 a.m. - 9.00 a.m. - Steering Committee

9.00 a.m. - 10.00 a.m. - "SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS"

10.00 a.m. - 10.30 a.m. - Recess

10.30 a.m. - Discussion and approval of above

- Closing session

ANNEX IV

LIST OF BASIC DOCUMENTS

PROVISIONAL AGENDA	EM/GR.MT.MH./1
PROGRAMME OF THE GROUP MEETING	EM/GR.MT.MH./2
LIST OF PARTICIPANTS	EM/GR.MT.MH./3
REVIEW OF STATE OF MENTAL HEALTH SERVICES IN THE COUNTRIES OF THE EASTERN MEDITERRANEAN REGION by Dr T.A. Baasher, Regional Adviser on Mental Health	EM/GR.MT.MH./4
MODERN TRENDS IN MENTAL HEALTH WORK by Prof. G.M. Carstairs, Department of Psychological Medicine, Royal Edinburgh Hospital	EM/GR.MT.MH./5
PROBLEMS OF PROGRAMME DEVELOPMENT IN MENTAL HEALTH FIELD WITH SPECIAL REFERENCE TO DEVELOPING COUNTRIES by Dr R. Giel, Psychiatrische Universiteits Kliniek, Groningen	EM/GR.MT.MH./6
ORGANIZATION AND ADMINISTRATION OF PSYCHIATRIC SERVICES by Dr A. Wagdi, Consultant Ministry of Health, Cairo	EM/GR.MT.MH./7
COMMUNITY MENTAL HEALTH CARE by Dr M.H. Sahebo's-Zamani, Chief, Mental Health Section, Ministry of Public Health, Teheran	EM/GR.MT.MH./8
TEACHING AND TRAINING OF PREVENTIVE PSYCHIATRY by Dr H. Davidian, Professor of Psychiatry, University of Teheran	EM/GR.MT.MH./9
TRAINING OF MENTAL HEALTH NURSES by Miss McEwan, WHO Nurse Educator and Dr S. Salama, High Institute of Nursing, Cairo	EM/GR.MT.MH./10
TRAINING OF MENTAL HEALTH AUXILIARIES by Dr A.S. Manugian, Physician Superintendent, Lebanon Hospital for Mental and Nervous Disorders, Beirut	EM/GR.MT.MH./11
MENTAL PATIENTS AND THE LAW by Dr P. Matsas, Medical Superintendent of Psychiatric Institutions, Nicosia	EM/GR.MT.MH./12
RESEARCH IN MENTAL HEALTH WORK by Dr F.R. Hassler, Chief, Mental Health, WHO Headquarters, Geneva	EM/GR.MT.MH./13

THE CARE OF THE MENTALLY RETARDED by Dr K.Z. Hassan, Professor of Neurology, Jinnah Postgraduate Medical Centre, Karachi	EM/GR.MT.MH./14
PROBLEMS OF DRUG DEPENDENCE by Dr H. El R. Soliman, Senior Psychiatrist Clinic for Nervous Disorders, Khartoum	EM/GR.MT.MH./15
PRIORITIES IN PROGRAMME DEVELOPMENT IN MENTAL HEALTH by Dr A.M.F. Okasha, Senior Lecturer in Psychiatry, Ein Shams University, Cairo	EM/GR.MT.MH./16

LIST OF BACKGROUND MATERIAL

SOCIAL PSYCHIATRY AND COMMUNITY ATTITUDES	TRS No.177
THE ROLE OF PUBLIC HEALTH OFFICERS AND GENERAL PRACTITIONERS IN MENTAL HEALTH CARE	TRS No.235
TRAINING OF PSYCHIATRISTS	TRS No.252
RESEARCH IN PSYCHOPHARMACOLOGY	TRS No.371
NEUROPHYSIOLOGICAL AND BEHAVIOURAL RESEARCH IN PSYCHIATRY	TRS No.381
ORGANIZATION OF SERVICES FOR THE MENTALLY RETARDED	TRS No.392
BIOLOGICAL RESEARCH IN SCHIZOPHRENIA	TRS No.450
TEACHING OF PSYCHIATRY AND MENTAL HEALTH	PHP No. 9
REPORT OF THE SEMINAR ON THE PLACE OF PSYCHIATRY IN MEDICAL EDUCATION, ALEXANDRIA, 8 - 15 July 1970	EM/MENT/43 EM/Ed.Tr./213 EMRO 0112/R
THE WHO MENTAL HEALTH PROGRAMME : 1949 - 1972	
REPORT ON A VISIT TO CAIRO PART I - 22 - 27 June 1972, by Dr T.A. Baasher, Regional Adviser on Mental Health	EM/MENT/47 EGYPT 5401/R (ex 0007)
REPORT ON MENTAL HEALTH ACTIVITIES IN LEBANON , 10 - 17 May 1972, by Dr T.A. Baasher, Regional Adviser on Mental Health.	EM/MENT/48 LEBANON 5401/R (ex 0043)

ANNEX V

GROUP MEETING ON MENTAL HEALTH

Alexandria, 4 - 7 September 1972

Questionnaire

REVIEW OF THE STATE OF MENTAL HEALTH SERVICES

IN THE COUNTRY OF.....

PART I

ORGANIZATION AND ADMINISTRATION

(Please give below an account of the present organization and administration of mental health services in your country, at the national and local levels.)

PART II

PHYSICAL RESOURCES

1. General Mental Health Services, In-patients

(Data for the Year 19..)

Name of Institution	1 Category	2 Affiliation	Location	No. of Beds	No. Admissions per year		Average Stay (in wks.)
					First adm.	Readm.	

1. Indicate if : A = Psychiatric hospital
   B = Psychiatric unit in general hospital
   C = Other services (nursing homes, hostels, etc.)
2. Indicate if governmental (G), or non-governmental (NG).

Please give below name and address of chief of staff (at least for the big units) :

2. General Mental Health Services, Out-patients

(Data for the Year 19...)

Name of Clinic	Type [1]	Affiliation [2]	Location	Average Yearly No.	
				First visits	Total visits

1. Indicate if (attached) to in-patient service, or (separate).

3. Specialized Mental Health Services

(Data for the Year 19..)

Name of Institution	Kind of Service [1]	Affiliation [2]	Location	Services Available		
				In-patient services		OPD (No. first attend.)
				No. of beds	No. first adm.	

1. Enter alphabet indicating service for :
   - A mentally retarded
   - B epileptics
   - C alcoholics and drug addicts
   - D mentally disordered offenders
   - E agedmentally ill
   - F day patient service (day hosp., sheltered workshop, etc.)

2. Indicate if governmental (G) or non-governmental (NG).

PART III

MANPOWER RESOURCES IN MENTAL HEALTH SERVICES

(Data for the Year 19..)

Category of Staff	Existing Trained Staff				No. Under Training for the Specialty	
	No.	Place of Work				
		FT Govt. Serv.	PT Govt. Serv.	Private practice only	Within country	Outside country
A Total physicians, of which :					—	—
B Psychiatrists						
C Medical psychologists						
D Social workers						
E Psychiatric nurses, professional						
F Mental health assistants						
G Auxiliary nursing personnel						
H Therapists (vocational, etc.)					—	—
I Teachers (for mentally retarded, etc.)					—	—
J All others (custodials, guards, etc.)					—	—

(Please indicate below the minimum qualification requirements for each of the

PART IV

1. RESEARCH

(Please summarize the research activities in the field of mental health whether carried out previously or now in progress. Kindly list the published material and send reprints if available) :

2. REPORTS

(Please list the titles of administrative reports published by the Mental Health Administration, and send copies if available) :

3. FUTURE PLANS

(Please give a summary of future developments in Mental Health Services) :