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METHODOLOGICAL PROBLEMS OF DATA COLLECTION AND ANALYSIS IN THE MENTAL HEALTH SERVICES

by

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The basic problems of statistics in the field we are discussing may be summed up very briefly as:

(i)   what to count

(ii)   how to count

(iii)   what to do with the count.

In considering these problems we must distinguish carefully between data which are essential - for showing what the mental health services are doing, for example, and those which are mere luxuries for people with a lot of time, money and manpower. We must also distinguish between data which can be got accurately (hard data) and those into which subjective opinions may enter or which are very hard to define in such a way that only one interpretation may be placed on them (soft data). Then the amount of data collected must be balanced up against the resources which are available for processing it, and the amount of processed data must also be balanced up against the number of trained people who are available for interpreting it. If all the data from around the world which have been collected but not processed were put into a single heap, we should probably find a sizeable mountain as the result.

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And in this connection it is important to remember that <u>data should be up-to-date</u>. What happened 3 years ago may have a historical interest but what is happening now will be more useful for the planning and evaluation of services. 'What to count' should be specifically related to a particular problem; the accuracy with which data are collected is likely to be in inverse proportion to the number of items on the data-sheet. And once the data for answering a question have been obtained, there is no need to go on collecting them in a routine way, thus adding to the workload. It must be remembered also that the same services are not suitable for all countries alike, that patients and their reasons for seeking treatment vary between one culture or country and another and that the data collection system must be tailored to fit the individual, country or region within a country.

It is essential, therefore, to study the socio-demographic back-ground in any country, since this constitutes the environment in which the individual develops his illness, in which treatment will be given and to which he will return when his illness is over. Nowadays, in industria-lized countries, we expect the number of beds in psychiatric hospitals to decrease, and the numbers of patients treated in out-patient clinics and day-hospitals to grow. It is therefore interesting to notice that countries differ widely in the number of beds for mental illness per 1 000 population. For example Poland and Czechoslovakia, with similar geography and socialized medicine have 1.33 and 1.96 respectively, whereas Ireland has 5.96, Norway 7.48 and Sweden 8.82. A look at the map of Europe will show us that it would be difficult to develop day hospitals or even out-patient clinics in many mountainous parts of Norway or rural districts of

Sweden. This argument does not apply to Ireland, where a relatively large number of beds may be partly accounted for by the availability of cheap nursing labour in the religious orders. It is clear that we must know the background before we can plan the services or evaluate what they are doing.

As a first step, therefore, we shall go to the government office which is responsible for taking the national census of population which is done every 10 years; the last was likely to have been in 1970 or 1971; and find out what this tells us about such items as sex, age and marital structure, household composition, employment, educational levels and other factors. These data may be supplemented by information from other government departments concerned with trade, justice (for numbers and types of criminal offences), education, and the entry or exit of workers. The medical environment, in terms of numbers of health facility beds, qualified or auxiliary doctors, nurses, social workers, health visitors and other personnel, together with numbers of cases of infectious diseases, leading causes of death, perinatal, infant and maternal mortality rates, should be available from the Ministry or Department of Health. We cannot study mental disorders in isolation from other diseases as all severe physical illnesses or traumas have a psychiatric component.

So far as the psychiatric services are concerned, most countries have in the past concentrated on statistics of patients, without thinking of the buildings in which they are cared for, who treats or looks after them or even how they spend their time. Not only must we look at the patients, but also at the therapeutic staff - how many hours do they work, how many

patients do they have to look after, what is the relationship between the in-patient services and the ambulatory ones, where such exist? If statistics of such vital importance are to be collected, analyzed and interpreted, it is clear there will be little time for such esoteric details as patient's birth order in the family or whether either of his grandparents were treated for mental illness.

What then are the difficulties in the way of obtaining the necessary data? The first one is coverage. Unless a country has socialized medicine and little or no private practice it is extremely difficult to establish a list of all the facilities which should contribute to the statistics. At the governmental level apart from ministries of health and social welfare, responsibility may be shared by departments of justice (for mentally ill offenders), of education (for the mentally retarded) while research may be concentrated in a separate body. Responsibility may be delegated to regional and local bodies and in federated countries each individual member of the federation may have the entire responsibility for its mental health services. Even to get these different organizations into some kind of statistical uniformity will be a hard task.

In some countries quite a large proportion of hospital beds may be in non-governmental institutions. For example, in Greece, out of a total of 11 328 mental health beds, 66 per cent are in government hospital establishments, 9 per cent in private non-profit making ones and 25 per cent in private profit-making hospitals. It is usually very difficult to get statistical returns from private hospitals unless one is prepared to pay for them, as there is usually no means of compulsion to make statistical returns. The most likely inducement for them to take part is to offer them a free feed-back of statistics, which in this case must be exact, prompt and containing useful information.

What is difficult in the case of hospitals and organized ambulatory services becomes increasingly so when we are dealing with individuals such as private psychiatrists and native healers, who are not usually used to keeping formal records. Another problem of coverage is that services for certain groups of patients, for example drug - or alcohol addicts, may be given by an entirely different body from the ones providing other psychiatric services and hence outside the data collection system. Nowadays, also, there is a growing tendency to look after mental patients in psychiatric units in general hospitals. Here they are likely to be included in the general hospital statistics, which are usually produced according to the diagnosis on discharge. It will then be almost impossible to distinguish them from others who are being treated for a psychiatric disorder (for example post-partum psychosis) consequent upon a physical condition for which they were admitted.

As if all these problems were not enough, we are nowadays faced with another, in that the borders of psychiatry are reaching out to embrace people who at one time would not have been regarded as suitable subjects for psychiatric care. Very often it is not one problem but a group of problems which finally brings them to attention. These are the people with inadequate personalities, emotional problems, behaviour disorders such as truanting from school or having a bad work history, delinquency such as petty theft, unaccepted sexual deviations, heavy drinking not amounting to alcoholism, etc. These patients differ from the classic psychotic or neurotic patients with their more clearly defined diagnoses. Such people have the characteristics of what are called 'misfits' in urbanized industrial societies although they may be merely regarded as nuisances in rural ones. But since most countries are now on the way to becoming industrialized the

assessment of the number of such social casualities becomes important.
We are therefore faced with the problem of getting them into the coverage
of our statistical reporting system without at the same time overestima-
ting their numbers by counting them several times over in a variety of
different services.

The first step in developing a data system being to decide what to
count, the second step is to define the items to be counted, so that
everyone taking part counts the same things. This is not so easy, either.
Take hospitals for example. We think of patients, doctors, nurses and
at one time all these people lived together on the premises, but not now.
Is a resident doctor an integral part of the definition of what is a
hospital? What about a rehabilitation unit - it may have resident
doctors, nurses, and patients or ex-patients - is it to be classed as a
hospital or not?

In general morbidity statistics it can be assumed that, with few
exceptions such as the newborn or people admitted for investigations such
as lumbar punctures, persons admitted to hospital will have an illness
or an injury. In mental health statistics a decision has to be made about
the unit of counting, there are three possibilities at least:

    (1)   persons with a diagnosis of mental illness

    (2)   persons being treated in a facility designated for
          the treatment of mental illness

    (3)   persons being treated by a psychiatrist.

If we first consider the people who are in a facility designated
for the treatment of mental illness, e.g. by taking a census of psychia-
tric hospital patients on a given day, we shall be faced with the fact that

large mental hospitals contain a number of people who are no longer
ill but are there because they have nowhere else to go. Similarly
many people who come to a psychiatric out-patient clinic may do so for
an opinion and they do not receive a psychiatric diagnosis because they
are not mentally ill. Adolescents may be sent by the magistrates of
juvenile courts for an opinion as to whether they are psychiatrically ill
or just bad. However, if those people in a mental hospital who are not
mentally ill require treatment for a physical illness, they will usually
get this from one of the hospital psychiatrists; so that we could not
define the mentally ill by the fact that they are treated by a psychia-
trist. For young children, too, it is likely that mental illness will
be treated by a paediatrician.

There is the same kind of problem with beds. Table II of the
report of the Group Meeting on Mental Health (Alexandria, 1972), shows
that of those countries which reported, Cyprus, with 1.30,had the highest
number of beds per 1 000 population, whereas Egypt had 0.18, Lebanon
0.82 and Tunisia 0.19. We should want to know whether the mental
hospitals in Cyprus and the Lebanon had included beds occupied by people
who were not mentally ill, but mentally retarded, whereas Tunisia and
Egypt had not. Our experience with European countries has shown that
if the mentally retarded are treated in the same hospitals and mixed in
with the mentally ill, all beds will be counted as 'mental beds' and
the hospitals as 'mental hospitals', whereas if they are treated in
separate institutions, the beds occupied by the mentally retarded will
not be so counted.

Countries which collect statistics of numbers of admissions to
mental hospitals often like to separate first admissions from non-first

admissions. Here again, definition is necessary. In a study of the 'Availability of Statistics of Patients admitted to Psychiatric Services' (WHO, 1973), out of 73 member states and territories which replied to the enquiry, 37 said they separated first admissions, but only 27 of them could give the definition of a first admission which they used. Some of the definitions which were used were as follows:

"First admission to a psychiatric hospital in the country"

"First admission to the hospital of admission"

"First registration as an in-patient to receive care in a psychiatric centre in this state"

"Admitted the first time for a first attack".

We can see that these definitions are not going to produce statistics which will be comparable between countries. They do however, illustrate the point that whatever is to be collected should be carefully defined. And if we try to get into such areas as household composition we are faced with a wide range of cross-cultural definitions. Mental illness, we are often told, is related to over-crowding, and so we assiduously collect data about the average number of persons per room, but what does this mean in India when at night-fall beds are set up in the open on a flat roof and each person has more space than he would have in an average European bedroom?

An examination of the data collection sheets will show many similar items which are difficult to define and to interpret. Religion, an item often collected, is a case in point. The difference between a religion and a philosophy may be hard to state. Asked for his religion a person may state the name of a sect with which he was affiliated in infancy but

with which he now has nothing to do. Are we to use such numbers in
calculating admission rates to mental hospitals among religious groups?
It might be much more relevant to his mental ill health to ask if the
patient had recently changed his religion or whether he had guilt feelings
about not practising it. Occupation is similarly difficult to handle.
In the first place the same name may be given to occupations whose work-
content has changed entirely. Some occupations cease to exist and others
take their place. And in any case, what may be important for our subject
is not so much the work itself as the conditions in which it is done,
alone or as part of a group, for example. In England labourers in general
have very high admission rates to mental hospitals, but dock labourers have
among the lowest rates of all workers. These men have a status, as they
are registered with the Dock Labour Board, they work in groups and sons
are entitled to follow their fathers into this occupation. From the metho-
dological point of view, there is not a great deal of point in recording
mere 'labels' for all patients. More will be gained from small studies
on sample populations in which much more detailed questions can be asked.

This brings us to the important consideration of what statistics need
to be collected annually and which need only be collected from time to
time. Can we afford to fill in a data-sheet for each patient admitted?
Ideally this is desirable, because the data can first be used to prepare
annual statistics of admissions and discharges and then the sheets for each
individual patient can be brought together where he has had several admissions
and discharges and used to form a register from which continuous history
studies (otherwise called cohort studies or longitudinal studies) can be
done. It is economical to use the same data-sheet for several purposes.

However, the WHO study referred to above showed that five WHO member states from this Region replied to the questionnaire on mental health statistics; of these Cyprus and Jordan stated that they had a full-time university-trained statistician, Bahrain a part-time one and presumably Kuwait and Qatar had none. It may be assumed that those states who did not reply were not any better off for statistical help. In such circumstances it is possible to use the hospital admission register to count the numbers of admissions and discharges during the calendar year, and to take a census of hospital patients, say on December 31.

This may be done by ruling out sheets of paper with the same number of lines to a page - 20 is a good number, for example:

In-patient Census			31 December 1973		Ward..................	
Patient's Number	Sex M/F	Age	Date of Admission	Length of stay	Diagnosis	Code
1	M	23	2/3/1973	Under 1 yr	Anxiety neurosis	300.0
2	M	44	12/9/1950	23 yrs +	Paranoid schizophrenia	295.3

The data can then be ticked out into the usual kind of tables and will tell us:

1) the sex-age distribution of the hospital population,

2) how many acute patients - under 1 year, medium stay - 1-2 years and potential long-stay patients - 2 years and over,

3) the diagnostic composition of the patients.

Each of these items can be crossed with the others, telling us for instance what diagnostic groups there are among the long-stay patients, or what diagnosis is most common for each age-group.

By repeating such a Census at the end of each year, or even each 2 years, the basis of comparison is obtained. We can see whether the potential long-stay population is decreasing, as it should do unless we are filling up vacant psychiatric beds, for example with purely geriatric patients, or how the age composition is changing, for example by more children and adolescents being in hospital.

This simple method of obtaining answers to vital questions about the hospital populations - and in many economically developing countries hospitals are likely to bear the larger part of the patient-load for some time to come - has a number of advantages. It is easy to get a census sheet filled in on each ward; no difficult calculations have to be made; the data can quickly be analyzed by hand, so that no card-punching or computers are necessary, and at a central point the data for wards and then hospitals can be added up for a national total. And let no one despise hand-counting. India used this method for her 1951 National Census of Population and got her tables out as soon as any country with the latest mechanical device.

There are a number of considerations which are important when we come to the question of 'how to count'. This means arranging the data sheet in such a way that it is perfectly clear what has to be filled in. We must always keep in mind the motto - 'Save work, increase accuracy'. These two precepts can be taken separately, but they can also be taken to mean that if we save work we can increase accuracy. One way to save work is by pre-coding: then the person filling in the sheet has only to tick the code for the response he selects. In this case the items in any box must all involve completely separate possibilities, for example, for patients leaving hospital we may want to know where they are going:

Correct	Incorrect
1. Died	1. Died
2. **Transfer** to another hospital	2. Autopsy
3. Own home	3. Transfer to another hospital
4. Hostel, pension, home, etc.	4. Own home
5. Other	5. Hostel, pension, home, etc.
	6. Other

The second example is incorrect because 'died' and 'autopsy' are not mutually exclusive.

The items here are already coded, and whichever one has been selected has only to be transferred into the statistical system. It is useful to remember that each time something is copied, there is the possibility of making a mistake, so that by reducing writing and copying to a minimum we are both saving work and increasing accuracy.

The item that is most likely to have to be written is the diagnosis and hence the box that is provided for recording the diagnosis must have sufficient room for writing, a counsel that is often overlooked. Items must be so clearly defined that all who have to supply information do it in the same way. It is possible that the patient may have more than one psychiatric condition, e.g. schizophrenia and acute alcoholism.

or depressive reaction in a cyclothymic personality

or situational maladjustment in a feeble-minded child.

To ensure that everyone records the diagnosis in the same way, the recording scheme must be laid down. For example, if we want to know which diagnostic entity brought the patient into hospital, this may well be alcoholism in the first case, rather than schizophrenia although the latter is stated first in writing down the diagnosis.

The question of 'how to count' is of considerable importance if we are using individual patient data sheets which will also be used to form a register. Usually in mental disorder statistics only one diagnosis is shown for each person in the tabulations. We might start off with a group of schizophrenics, some of whom also had mental retardation, or epilepsy or a physical handicap such as spasticity. Supposing 10 per cent of this group were still in hospital at the end of two years from their date of admission, we should want to know whether they were there because they were schizophrenic or not. In fact some of them might no longer show schizophrenic symptoms, but once admitted to hospital their families might refuse to have them back because their retardation, epilepsy or spasticity presented difficulties at home.

To overcome this kind of difficulty with recording diagnosis, WHO has, since 1965 been developing a system for recording the diagnosis on different axes, such as:

(1) Clinical condition for which patient admitted

(2) Intelligence level

(3) Physical condition thought to be associated with (1)

(4) Social or family conditions

This system has been rather extensively tried out for children's psychiatric disorders, and is especially useful where it is the parents' problems which have brought the child to attention, or where, investigating the complaints of a wife, we find that it is the husband who is the sick person. It does enable several diagnoses for the same individual to be handled at once, and it avoids the difficulty of having to select one of several diagnostic labels while ignoring the others.

Since one of the tasks of statistics is to show what is happening to groups, the more adequately we describe the groups, the better we shall understand what is happening, as mirrored in the statistics.

What has been said for hospital in-patients, applies equally well to out-patients, day-patients, people attending day-training centres or any other form of facility for care, treatment and rehabilitation. However, in the case of out-patient clinics the weight of numbers attending is usually so great that it would be impossible to keep individual data sheets all the time. There is also the difficulty that many people only come once to an Out-patient Clinic, and we must therefore ask ourselves how much data can usefully be collected for such people. A recent study (Brooke, 1973) was carried out in 23 clinics, and in addition 5 Dutch and 9 Bavarian neuropsychiatrists in private practice or linked to health agencies took part. It was found that in a period of 3 months from registration as out-patients the majority did not have more than a total of four interviews with clinic personnel. In the Irish clinic nearly one-fifth only attended once, and in the Zagreb clinic 21 per cent.

Statistics of out-patient attendances may therefore be tackled in one of several ways:

(1) a simple list of sex and age of those attending, together with a note of whether or not a diagnosis was made and which type of personnel the patient saw. This will give information about the total workload and the way it is distributed among the personnel. Seasonal variations can also be estimated.

(2) an intensive study in selected clinics, using individual data sheets, but lasting only a short period of time, for example finishing when a

defined number of patients have been included, as in the European

Regional study.

(3) a combination of (1) and (2), using the individual data sheet

only at the third visit of a series.

Statistics of day-hospital or day-centre patients are usually

easier to collect because the patients come on fixed days, so that a

count of total attendances may be got from the first and last dates

and the number of times weekly that the patient attends.

Fresh problems arise when we start to think of the persons who are

looking after the patients.   Table III of the report on the Group

Meeting shows the numbers of mental health workers per 100 000 population

and contains some curious anomalies.   Take nurses for example.   We

have in the questionnaire:

Psychiatric nurses, professional) in Full-time Government Service

Mental health assistants   )   Part-time Government Service

Auxiliary nursing personnel   )   Private practice only

Mental health assistants are not distinguished in Table III, so

it is not clear whether or not they may have been counted in with either

of the two nursing groups.   We have the following data for psychiatric

and auxiliary nurses per 100 000 population and the ratio of auxiliary to

psychiatric

Country	Psych.	Aux.	Ratio	Country	Psych.	Aux.	Ratio
Bahrain	3.8	12.4	3.3	Lebanon	1.1	6.8	6.2
Cyprus	11.0	2.0	.18	Libya	1.0	1.1	1.1
Iraq	.07	.10	1.4	Pakistan	.01	.25	25
Jordan	.04	1.2'	30	Somalia	.02	.27	13.5
Kuwait	19.0	17.4	.92	Tunisia	2.4	3.8	1.6

Although some of these high ratios may be due to a lack of trained

personnel, we should also want to know whether there were also any qualified

psychiatric nurses working in private clinics.   The constitution of the
population must also be taken into account in looking at such figures.
In many developing countries a large proportion of the population may
be in the younger age groups, where there is less mental illness, so
that it would not be wise to compare the ratios in developing countries
with those for industrialized countries where a large part of the
population is in age groups more prone to psychiatric diseases.   Two
different ways of presenting the data can be useful:

(1)   the number of beds or patients in relation to each of the types of
      personnel

(2)   the number of paramedical personnel to one psychiatrist.   When
Table III of the Report referred to above is put in this form we have a
better idea of the staff supporting one psychiatrist, i.e. the composition
of the therapeutic team.

Country	Psychologists	Social workers	Psychiatric nurses	Auxiliary nurses	Therapists	Teachers
Bahrain	-	.36	2.7	8.9	-	
Cyprus	.16	.16	5.5	1.0	.16	
Egypt	.33	.60	-	8.7	.33	3.0
Ethiopia	-	-	less than 5	16.5	.50	-
Iraq	-	.61	.39	.56	.17	1.4
Jordan	1.0	4.2	.44	13.3	6.7	1.0
Kuwait	.59	17.2	11.2	10.2	2.4	3.3
Lebanon	.22	.22	1.2	7.6	.22	1.4
Libya	1.5	.59	2.9	3.2	-	-
Pakistan	.33	.33	.17	.42		-
PDRY	1.0	1.0	7.2	2.9	-	
Qatar	-	-		2.0	-	-
S. Arabia	-	.25	.25	-	-	-
Somalia	-	1.2	.4	5.4	-	-
Sudan	.33	-	.17	-	-	-
Tunisia	-	.35	14.1	22.3	8.2	-

Arranged in this way, the data show that the average psychiatrist in
Kuwait is well supported by a variety of paramedical staff, whereas his colleague

in Qatar can only call, on average, upon 2 auxiliary nurses. In order
to understand better what the statistics represent, we should need to
know exactly what each type of worker does. For example what are the
tasks undertaken by psychiatric nurses and therapists respectively in
Jordan as compared with the same type of personnel in Cyprus'or the
Democratic Yemen; are their roles overlapping, so that a shortage of one
category of trained personnel is being compensated for by the use of another
category for carrying out similar tasks? It is very essential, when
trained workers are in short supply to know just what can be entrusted to
any particular group so that they may do tasks of the maximum difficulty
of which they are capable.

There remains to be discussed the question of how to get statistical
work done willingly, accurately and promptly, and for this we have to
motivate those who are going to do the work at all levels. The place to
start is therefore at the bottom. A person in a central government
department who wants to obtain psychiatric statistics must not limit
himself to sending out a set of forms, be they accompanied by instructions
of the utmost clarity. He must preferably visit the hospital or clinic,
and not only' talk to the superintendent, but also to everyone, down to
the least important clerk, who will have to contribute anything to data
collection. It is essential that everyone shall understand what he has
to do and why he has to do it. Secondly, a worker should see a return
for his labours, in the form of a feed-back of statistics, which is not
only promptly forthcoming, but also in a form which he can understand.
Graphs are often better than tables for this purpose. There are few
things so likely to produce faulty statistical data as bunches of forms
which disappear into a data-processing centre and are never heard of again.

Thirdly, the statistical system should be kept constantly under review and changed to meet changing circumstances. If a surgical procedure such as leucotomy is no longer in general use, there is no point in sending out forms asking how many leucotomies have been done in the last year. Statisticians need to become much less conservative and rigid in the presentation of data. It is well to remember that one figure is much more easily understood than a series, so that a standardized rate of admission to mental hospitals, for example, can be more easily grasped, for comparative purposes, than a distribution of rates specific for sex and age. We must be continually searching for new and better ways of processing and presenting data. People are interested in what is happening to them, so that more studies of regional variations within countries are required, but they are not always available, nor presented in suitable forms for comparison. Finally, in statistics a golden rule is 'Never collect any data unless you know exactly what you are going to use them for'.

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WHO SEMINAR ON ORGANIZATION OF MENTAL HEALTH SERVICES

QUESTIONNAIRE ON MENTAL HEALTH SERVICES

Objectives of the questionnaire

- collection of information on existing resources utilized for mental health services

- appraisal of the current situation of mental health services

- drawing-up of future programmes in the light of collected data.

The questionnaire was divided into five parts:

    I   Organization and administration

   II   Physical facilities

  III   Manpower resources

   IV   Mental health research

    V   Additional data

PART I   Organization and Administration

A.   National Authority

   1   Position

       -   1 country out of 3 has a separate MHS set-up in the Government

           All within Ministry of Health

       -   Where there is no separate set-up, MHS are under:

           (a)   general public health administrator (majority)
           (b)   consultant psychiatrist   (1 country with a council of psychiatrists)
           (c)   superintendent.

        Others with none.

2 Related Advisory Body

- permanent official advisory body 16 per cent
- ad hoc advisers 26 per cent
- without external advice 37 per cent
- no policy yet 5 per cent
- no reply 16 per cent

3 Organization

Staffing and functional chart from 1 country

Summaries from 8 countries

4 Policy

- 1 country out of 3 has a formulated statement on a national policy on MHS
- most sent a copy of the programme
- 5 out of 6 gave summaries of the programme.

Analysis of Programmes

Programme	Country
In-patient care	
1. Construction of mental hospitals	Iraq Jordan
2. Short hospitalization	Bahrain
3. In-patient units in general hospitals	Iraq Saudi Arabia
Out-patient care	
Out-patient clinics attached to general hospitals	Saudi Arabia
Community mental health services	
in every part of the country	Iran
Coverage	
extend the services all over the country	Bahrain
Standardization	
of mental health services	Iran
Research	
various programmes	Iran

Training   Country

-   mental health staff   Bahrain
                                                            Iran

-   medical teams and public   Bahrain

-   young graduates   Iraq

-   nurses   Iraq

To establish a school of psychiatric nursing.

Summary of Recent Programmes

A. BAHRAIN

    1. Immediate physical treatment

    2. Short-term hospitalization

    3. Rehabilitation
            Education
            Manual skills

    4. Extend services all over the country

    5. Arrange to train staff

    6. Arrange to educate
            medical teams
            public -- to cooperate

B. JORDAN

    3-year Plan

    Objectives:

    1. Organization of administrative and technical facilities

    2. Raising standards of MHS by:
            training of all categories of psychiatric staff

    3. Motivating doctors to specialize in psychological medicine

    4. Providing MHS for sectors that still lack the ideal care
        CARE FOR THE SUBNORMAL

    Programme:
        Construction of a new modern hospital with facilities for
        in-patient services, out-patient services, day care.

B. **IRAN**

1. Standardization of all MHS in the country

2. Development of Community Mental Health Services in every part of the country.

3. Performing various mental health research programmes

4. Training of manpower

C. **IRAQ**

1. To attract the young graduates to the field of psychiatry

2. To establish psychiatric units in three teaching hospitals

3. To establish a School of Psychiatric Nursing

4. To establish three mental hospitals, each with 300 beds.

- -

B. Other National Authorities

Half the countries gave information

Half stated none or not applicable

Ministries concerned:

Social Affairs	5
Education	4
Interior	3
Justice	2
Municipalities, etc.	1

Social Affairs

- Institutes for mentally retarded

- Institutes for juvenile delinquents

- Hostels

- Homes

- Social investigation reports

- Surveys

Ministry of Education

- special classes

- special schools

- school counselling

- special treatment facilities

- youth organizations and recreational activities

Ministry of the Interior

- care of disturbed offenders
- care of mentally retarded children

Ministry of Justice

- care of juvenile delinquents
- care of "criminal mental patients"

Municipalities

- orphanages
- aged, etc.

C. Voluntary Mental Health Associations

1 country out of 3 has an MHA.
Majority professional groups.
Few multidisciplinary.

Role.

promotion of mental health

- special care for mentally retarded
                        physically handicapped
                        epileptics
                        prisoners and their families
                        youth

D. Co-ordination

1 country out of 5 has interministerial or interdepartmental committees.
Special committees for:

- narcotic control
- mental subnormality
- juvenile delinquency

E. Judicial Provisions

Admission procedure, relevant laws and regulations.

   84 per cent have provisions
   16 per cent do not have

- voluntary
- involuntary

(continued)

Country	Provision
Bahrain	Compulsory Order
Cyprus	Mental Patients Law 1931
Ethiopia	Mental Health Legislation
Iran	Traditional way Department of Legal Medicine
Jordan	Court Order
Libya	Law No. 11, 1959 Committee of Three
Pakistan	Lunacy Act of 1912
Somalia	Rules and Regulations by Ministry of Justice and Religious Affairs
Sudan	Mental Health Act
Tunisia	Public Law 1959

Current Research Projects

Subject	Type of Research	Country
1. General surveys	– In- and out-patient population	Qatar
	– Incidence and distribution of psychiatric diseases	Ethiopia
	– Incidence of psychiatric illness	Jordan
	– Pattern of mental illness	Somalia
2. Neuroses	– Culture-bound (in women)	Qatar'
	– School phobia	Jordan
3. Schizophrenia	– Biochemistry	Lebanon
4. Drug depend- ence	– Treatment	Iran
	– Abnormal E.E.G. pattern	Sudan
Alcoholism	– in urban population	Sudan
5. Rehabilitatn	– General	Pakistan
6. Physically ill persons	– Emotional disturbances	Iran

QUESTIONNAIRE ON MENTAL HEALTH SERVICES

ref PART II

OUT-PATIENT FACILITIES

Country	Population	No. of Clinics	No. of Clinics per million popn.
Afghanistan	17 880 000	1	0.06
Bahrain	220 000	3	13.6
Cyprus	650 000	14	21.5
Dem. Yemen	1 510 000	-	-
Egypt	34 840 000	-	-
Ethiopia	25 930 000	2	0.08
Iran	30 550 000	115	3.7
Iraq	10 070 000	7	0.7
Jordan	2 470 000	3	1.2
Kuwait	910 000	2	2.2
Lebanon	2 960 000	2	0.7
Libyan A.R.	2 080 000	7	3.4
Oman	-	-	-
Pakistan	64 892 000	...	...
Qatar	120 000	1	12.5
Saudi Arabia	8 000 000	5	0.6
Smmalia	2 940 000	3	1.0
Sudan	16 490 000	7	0.4
Syrian A.R.	6 680 000	2	0.3
Tunisia	5 380 000	2	0.4
U.A. Emirates	200 000		
Yemen	6 060 000		

QUESTIONNAIRE ON MENTAL HEALTH SERVICES

ref PART III

Number of Psychiatrists following training course in Psychiatry

Country	Within the country	Abroad
Afghanistan	–	–
Bahrain	–	3
Cyprus	–	3
Ethiopia	–	–
Iran	12	30
Iraq	14	15
Jordan	4	?
Kuwait	–	–
Lebanon	1	5
Libya	–	–
Pakistan	–	100 +
Qatar	–	–
Saudi Arabia	–	–
Somalia	–	1
Sudan	4	7
Syria	1	–
Tunisia	–	–
U.A.Emirates	–	–
Yemen	–	–
TOTAL	36	166 +