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INTER-REGIONAL SEMINAR ON

ORGANIZATION OF THE MENTAL HEALTH SERVICES

Addis Ababa, 27 November - 4 December 1973

A Group of Participants who attended the Inter-Regional Seminar on the Organization of Mental Health Services Held in Addis Ababa from 27 November - 4 December 1973

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I THE PROCEEDINGS OF THE SEMINAR

The Inter-regional Seminar was held at Africa Hall in Addis Ababa, from 27 November to 4 December 1973, to discuss the organization of mental health services and to draw up recommendations relating to this important topic, for the governments of Member States of the World Health Organization.

The Seminar was opened by the Vice-Minister of Public Health, H.E. Ato Johannes Wolde Gerima, who read the following message from the Minister of Public Health :

MESSAGE OF H.E. ATO KETEMA ABEBA, MINISTER OF PUBLIC HEALTH, ETHIOPIA

" It is indeed a great pleasure for me to welcome you all to Addis Ababa and to open this Seminar on mental health services. I should like to extend special words of welcome to those of you who are here in Ethiopia for the first time, and I hope that you will all enjoy your stay in our country.

Rapid technological change in practically all fields of human endeavour is perhaps the most conspicuous feature of the world to-day. Political, economic and social changes have often accompanied or preceded technological change. Even in those parts of the world where technological change is not so conspicuous, industrial and economic changes have caused a substantial departure from traditional life and social value. Some of these changes in social value are desirable and they are brought about through deliberate effort; while other changes are not so desirable but they are unavoidable. This constitutes a dilemma facing societies and governments in developing countries; it is a dilemma that the industrialized countries have been facing for many years.

This dilemma is even further aggravated by the fact that developing countries have meagre resources to meet a great multitude of problems. Even within the health sector the need to provide primary health care and the struggle to control communicable diseases practically exhausts available resources. Consequently, little attention has hitherto been paid to mental health. This is not surprising in view of the high morbidity and mortality from communicable diseases and malnutrition. However, with advances in medical science, with effective preventive public health measures against the endemic diseases and with improvement in the economic conditions, mental health may well turn out to be one of the major areas of public health.

Already the last few decades have witnessed an appreciable change for the better in the approach to and care of mental illness. The punitive and ostracizing attitude has begun to give way to humanitarian concern and sympathy for the mental patient. Where once there was no hope for the mental patient or even for the emotionally disturbed, there is now not only hope but also a chance for cure and return to productive life thanks to the introduction of new and potent drugs. Due to the shift of emphasis from asylum type of care to community-oriented and ambulatory care, there is now greater opportunity for an early detection and prevention. Nevertheless, in spite of these positive trends, I am sure you are aware of the immense task that remains to be done by the public health administrations of the developing countries particularly with respect to the establishment and development of an effective and realistic system of mental health care.

A glance at your provisional agenda inspires great expectations and hopes as to the outcome of your Seminar. You will discuss the concept of mental health and mental illness in different cultures. You will examine mental health care and traditional treatment in different societies. You will distinguish various responsibilities for mental health service, and you will establish principles for professional approach and administrative procedures in the delivery of mental health care. From your deliberations will emerge constructive recommendations which will serve as valuable guidelines to governments, communities, and professionals concerned with the delivery of mental health care. Hopefully, one of the tasks of this Seminar will be to formulate practical

recommendations which will enable Ministries of Health to develop an efficient realistic approach to mental health care as an integrated but recognized component of the health service system.

The Ministry of Public Health of the Imperial Ethiopian Government looks forward to receiving the conclusions and recommendations of this inter-regional Seminar on mental health, and I am sure that the Ministries of Health in the countries represented at this Seminar are awaiting your recommendations with similar eagerness and aspirations.

In conclusion, I should like, on behalf of the Imperial Ethiopian Government, to express sincere thanks to WHO for holding this Seminar in Addis Ababa and for organizing it on an inter-regional basis so that all Regions can benefit from it. I wish you all success in your deliberations."

Following this, messages sent by Dr Thomas A. Lambo, Deputy Director-General of WHO, and Dr A.H. Taba, WHO Regional Director for the Eastern Mediterranean, were read.

MESSAGE OF DR T.A. LAMBO, DEPUTY DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

" It is with mixed feelings that I am sending this statement to the opening session of the Inter-regional Seminar on Organization of Mental Health Services. On the one hand, I am most pleased to have the privilege of welcoming you to this Seminar, here in the Africa Hall, on behalf of the Director-General of WHO, Dr H. Mahler. However, on the other hand, I am most disappointed at not being able to be personally here with you. As much as I would have liked to be present, other WHO commitments have regretfully prevented me from doing so.

This Seminar is of considerable importance to WHO, as it deals with one of the Organization's most major areas of concern -- the planning and delivery of mental health services within developing countries. In this regard, I was particularly pleased to note the wide scope of topics that you will be considering during the coming days. Indeed, the full spectrum of problems and issues regarding the organization of services seems to have been well covered. It is certainly appropriate, for example, that consideration be given during the Seminar to the development of historical concepts regarding mental illness and mental health care, general principles of psychiatric care and methods of assessing population needs, utilization of basic statistical data, principles of planning and mental health legislation, training of various types of mental health personnel and methods of evaluating the impact of services.

I should like to point out some of the critical challenges this Seminar will be facing. To have effective mental health services, one must have a system which will provide total and comprehensive care, but which, at the same time, will be simple and economical to operate. The system must be stable and consistent but yet open to analysis and innovative activities, and thus continually undergo changes. Programmes must not only consider treatment services but must promote the development of preventive approaches as well.

For purposes of support by governmental and other public decision-making bodies, means must be found of rendering tangible and understandable many areas that often seem intangible and vague. We must propose a system that provides for regular communication between the community and the persons at all levels who are performing the services. The system must maintain the strength and attributes of the present cadre of mental health workers, but at the same time stimulate and explore new uses of old manpower and new sources of persons to provide needed services. One area to which WHO has recently been paying increased attention is the challenge of defining what constitutes basic mental health services. What kinds of personnel and how many are needed? What specific programmes are needed and what resources are required to provide basic services to a given geographical area?

These are formidable challenges and for which some sense of resolution must be reached in all service programmes. And, in this regard, I have the utmost confidence in the ability of the participants of this Seminar to produce meaningful and innovative recommendations regarding these challenges.

Before closing, I should like to take a couple of minutes to bring you up-to-date on the recent changes at WHO, Geneva. This past year has witnessed a variety of new developments within the headquarters mental health programmes.

In April 1973, the existing Unit of Drug Dependence and Alcoholism and the Unit of Mental Health were combined to form the Office of Mental Health. This new and elevated administrative structure will allow for an increased range of activities. The new Office of Mental Health will have several major programme areas -- including the delivery of mental health services, the development of mental health personnel, the epidemiological, diagnostic and statistical aspects of mental health; biological psychiatry (including psychopharmacology), as well as activities related to the problems of drug abuse and alcoholism. To these will be added two new programme areas : a programme covering the neurosciences and a new programme related to psychosocial problems. Additionally, consideration is currently being given to a possible WHO programme on child development and child mental health. Your thoughts and suggestions regarding any of these areas would be most welcome! Particularly appreciated would be the identification of specific mental health problems that are critical in developing countries and your suggestions for related research and/or programmes in which WHO could assist to demonstrate and evaluate possible solutions to these problems.

In closing, permit me to express my very best personal wishes for a most successful Seminar. "

MESSAGE OF DR A.H. TABA, DIRECTOR, WHO EASTERN MEDITERRANEAN REGION

" It is a great pleasure to me to send a message to this significant ceremony marking the Opening of this important Inter-regional Seminar on the Organization of Mental Health Services, and to thank you on behalf of the World Health Organization for your participation. Other duties, to my regret, prevent me from being with you.

This Seminar as you may probably know, is the first Inter-regional meeting on Mental Health to be held in the Eastern Mediterranean Region. It has therefore special significance, and I am pleased to see that it has such a wide representation. Furthermore, this Seminar is convened at a time when there is an increasing awareness of the growing mental health problems, and its various complications. Indeed the central theme of the Seminar, namely the organization of mental health services, is of great relevance to the expected development in psychiatric care in all the Regions.

Your agenda, as you will note, includes a variety of interesting topics, and I trust that there is enough stimulating material and adequate information, which will enable you to reach constructive conclusions and draw up useful recommendations, which I hope would be helpful to all the countries for improving the quality of psychiatric care, and bringing about significant development in mental health work.

Since its early inception WHO has shown great concern regarding mental health work and endeavoured to foster various activities in this respect. None-the-less the fact remains that psychiatric disturbances are now constituting one of the most challenging areas in the health field. It is true to say, while advances in public health work had contributed to the unravelling of the causes of the great majority of physical diseases, and through proper preventive measures, have reduced enormously the toll of human suffering, all medical efforts seem to have failed to uncover the underlying pathogenesis of the most disabling and gruesome mental maladies of mankind, notably the functional psychotic

disorders, which until now, generally form more than half the population of psychiatric hospitals. Moreover, recent studies have commonly pointed to the higher prevalence rate of mental illness than has been previously reported. Added to this is the fact that under present socio-economic developments and cultural changes, it is not only that there is a demonstrable increase in mental stress, but also that the threshold of community tolerance to mental patients has been found to be reduced. This naturally puts greater pressure and more responsibility on mental health workers, and calls for better organization and more efficient psychiatric care programmes.

On the other hand, one derives a great hope from recent progress in psychiatry over the last two decades.There are the present-day promising movements in comprehensive community care and the more effective therapeutic modalities. Most important, there is more and more recognition of the total approach in mental health work, which WHO as a public health organization has always been advocating. Like so many new developments in other medical disciplines, the recent movement in psychiatric care, such as social psychiatry, community mental health and so forth has generated interesting ideas and opened up new avenues. Nevertheless the road for the proper delivery of mental health services still seems long and full of obstacles. Beside the need for the development of functionally operative framework for the proper implementation of these concepts, new techniques have to be evolved, and new models have to be designed. Above all the question of manpower development has to be resolved. For experience shows that the acute shortage of qualified personnel and the effective utilization of available manpower resources are generally the most serious impediments in the proper development of mental health work.

On the whole, while there is a general agreement that mental health activities should be well-integrated with Public Health work, and that due emphasis should be placed on the training of general health workers, psychiatric teaching in the undergraduate medical education and in the basic training of nurses and other health workers is adversely lagging behind. I need not therefore stress here the importance of bringing the level of mental health training to such standards as to enable general health workers to cope efficiently with the complicated and multiple mental health problems.

Though it is assumed that the mental health needs vary from one country to another, it is essential that all-round and realistic programmes should be worked out. Several questions will obviously be raised in this connection and in the foremost of these is how to meet the overwhelming needs of many developing countries with such well-known limited resources. More particularly, what could best be done in the preventive field, specially with regard to child mental health, or what type of psychiatric programmes could be developed in such difficult areas as drug dependence, rehabilitation of the chronics, management of the mentally ill offenders and so forth. I am confident that in this distinguished meeting you will address yourselves competently to these questions and others, as well as to the various obstacles, which have long been standing in the face of mental health progress, and thereby attempt to find possible solutions for overcoming them.

May I conclude now by wishing you all the best for very successful discussions and fruitful deliberations."

The Seminar was attended by thirty-eight participants from thirty countries. [1]

Because of the full programme and the extensive discussions to be expected, it was decided to have a new Chairman every day. The Chairmen were as follows :

Tuesday 27 November	Dr Fikre Workineh, Ethiopia
Wednesday 28 November	Dr T. Asuni, Nigeria
Thursday 29 November	Dr F. Knight, Jamaica
Friday 30 November	Professor O. Shaheen, Egypt

(1) See Annex II, List of Participants.

Saturday 1 December	Dr S.M. Haq, Malaysia
Monday 3 December	Dr N. Chowdhury, Bangladesh
Tuesday 4 December	Dr T.I. Hamdi, Iraq

The Rapporteurs were : Dr R.L. Kapur, India
Dr F.C. Ottey, Jamaica

II INTRODUCTION

The objectives of the Seminar were as follows :

1. to discuss papers which had been prepared in advance on central issues in the planning and organization of mental health services;

2. to conduct case studies on the mental health problems of selected countries;

3. to formulate general guidelines for the development of mental health services;

4. to make recommendations, which could be brought to the notice of the governments of countries by WHO;

5. to suggest future activities to WHO for the follow-up of the above recommendations and of the Seminar.

The various papers [1] presented focussed on the following central themes : concepts of mental illness; needs of the population; delivery of mental health care; planning of mental health services; training of mental health workers; evaluation of mental health services; mental health legislation. These papers will be published by WHO in a separate booklet.

III THE SEMINAR

The WHO Regional Adviser on Mental Health, Dr T.A. Baasher welcomed the participants and outlined the Seminar programme. Apologies were expressed on behalf of Dr J.S. Neki and Dr K. Bhaskaran, who could not be present. He informed the group that three countries Ethiopia, Kuwait and Malaysia had been selected for "case study" discussions and the special problems of these countries would be introduced by Dr Fikre Workineh, Dr S.M. Saleh and Dr S.M. Haq respectively.

1. Evolution of concepts of Mental Illness and of Mental Health Care

The scientific session started with Dr Fuller Torrey as the first speaker. Introducing the topic "Evolution of concepts of mental illness and mental health care", he stressed two points :

(a) western psychiatry has been based largely on a medical model, but it seems that the model might not be suitable for many kinds of aberrant behaviour which psychiatrists, perhaps incorrectly, tend to define as "sick";

(b) just because they have been trained in the West, trainee psychiatrists and health officials from developing countries need not accept the western concepts as the "truth". They should decide whether these "truths" really fit the local context.

Rather than simply accepting the recommendations of professionals from developed countries on what one should do or not do for mental health services the doctor from a developing country should consider the following questions :

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(1) See Annex IV

(i) Who, among the people who behave strangely in the community, should be labelled mentally ill(i.e. having a brain disease)? Whose problems are more likely to be caused by lack of understanding about themselves? Whose problems are thought to be caused by supernatural forces? What other causes are contributing to strange behaviour ?

(ii) Depending on the answers to the first question what kind of help do these people need? Therapy? Education? Religious counselling? Exorcism?

(iii)What kind of institutions need to be set up to provide this help?

(iv) Which of these people should be deprived of the freedoms and civil liberties enjoyed by other members of the society?

(v) Who should help these people, how should they be trained, and how should their helping activities be accredited and monitored?

(vi) How should the system be financed?

2. Existing concepts of Mental Illness and of Mental Health Care in different cultures and traditional forms of Treatment

Dr T. Asuni followed by discussing the existing concepts of mental health care in different countries and the traditional forms of treatment. He complained that not enough effort had been made to make a critical examination of the concepts and methods used by traditional healers. He stressed that some "commonly held beliefs" can be dangerous and need not be accepted just because they are commonly held by the people. He wondered if it were possible for the psychiatrists to integrate with the traditional healers without putting some constraints on the latter and training them in some special way.

It is obvious that each system of traditional healing is geared to the fulfilment of the particular needs of a society, and that it cannot be transferred effectively to another society. The cults treat mostly psychoneurosis, and also aim at prevention of recurrence or exacerbation of symptoms. The most important question relates to the changing socio-cultural scene. To what extent is it possible or even wise to try to retain and integrate a practice of traditional healing into modern psychiatric practice when the socio-cultural basis from which it derives is changing? The argument in favour of integration is that even those who seem to have moved away from the traditional way of life often resort to traditional methods of treatment when in serious trouble. This seems a strong argument, but is the situation going to remain the same? Are there not those who do not resort to these traditional methods, and is the number of these increasing or decreasing?

In the discussion which followed, there were those who refused to contemplate collaboration with the traditional healers. There were others who advised that, since there were not enough psychiatrists and since the psychiatrists could not really solve all the mental health problems, the traditional healers might be allowed to carry on with their trade. One participant pointed out that the psychiatrists are forced into a medical model so as to be accepted by their medical colleagues in other specialities. Another suggested that the factors affecting the values and beliefs held by a group are many and varied. In this light, the medical planners should realize that their opinion, whether in favour of or against traditional healers, will have a modest role amongst the other kinds of information and philosophies to which the people are being exposed. Another participant presented some empirical data comparing the concepts of mental health held by traditional healers and non-medical educated members of a community, like school teachers. He found that the traditional healers held more "pragmatic views" compared to the other group.

3. The Spectrum of Mental Disorders : How much of this Spectrum should be the Responsibility of the Mental Health Service

Dr J.S. Neki's paper on "The spectrum of mental disorders" was presented by Dr Dube. According to Dr Neki, it is impossible to delineate the mental health responsibilities

of the mental health services, and to indicate the exact conditions with which they should deal. Much depends on the characteristics of the population, such as its affluence, its literacy, employment rate, etc.; also on the characteristics of the existing services and the available manpower. The above factors will determine who is going to deal with the psychoses, organic conditions, the psychoneuroses, psychopathy, addiction and mental retardation.

There is no universal prescription regarding the extent of clinical responsibility of the mental health services in any given community. In most developing countries mental health services are still rudimentary. In a way this is a happy situtation in so far as these countries have not yet been bound down into the strait jackets of already established institutions and service patterns many of which are of questionable utility. It is important, therefore, for the planners of mental health services in those countries to weigh the projected mental health needs of their communities against the manpower and other resources likely to be available and to predetermine what would be the spectrum of responsibilities of the mental health services in their own judgement. It would also be necessary to determine the relative responsibility of mental health services in areas where they face interaction with other services such as the educational, social welfare, public health, legal and administrative agencies.

The main themes of the subsequent discussion were :

(a) the place of teamwork in the delivery of mental health services;
(b) the role of the psychiatrist in this service;
(c) the role of other personnel and in particular mental health personnel.

(a) It was felt by most speakers that the concept of teamwork was extremely important; that we must start with this idea and then proceed to build up the team. One speaker felt that this was not an expensive endeavour, as suggested by Dr Neki in his paper. The importance of integration and co-ordination was stressed and it was suggested that the team should be extended to include not only psychologists and social workers, but also public health personnel, hospital assistants and educationalists. Advice and help should also be solicited from demographers, sociologists, etc., when indicated.

(b) The view was expressed that the psychiatrist should be the "propeller" in the delivery of mental health services. It was felt that the role of the psychiatrist in developing countries would continue to be much wider than in developed countries because of a lack of general medical manpower. Wherever possible, however, general practitioners should be encouraged to treat or continue to treat psychiatric patients, and psychiatrists should be careful to work within their area of competence.

(c) Most speakers shared the view that mental health personnel other than psychiatrists were of extreme importance in developing countries and that more use should be made of them and their area of competence extended. It was also felt that other personnel such as sociologists and educationalists should become more involved in the mental health services.

There was some discussion on the concepts of mental health and psychiatry. There appeared to be no general consensus as to whether the psychiatrist should be responsible for both fields. It might be a matter of personal motivation and training which would have priority.

4. General principles of Psychiatric Care

Opening the discussion on the principles of psychiatric care, Dr Baasher referred to a questionnaire study in WHO's Eastern Mediterranean Region, in which only one-third of the nineteen participating countries had any declared mental health policy.

Deploring the situation, he warned against having vague objectives such as "reduction in mental illness". He asked the planners to address themselves to specific questions, like :

- what is the aim of our service : removal of symptoms, or improvement in inter-personal relations?
- should psychiatry be institution-based or community-based?
- what other agencies besides the psychiatrists should be involved and what should be their responsibilities?
- how to achieve integration with other disciplines?
- how to ensure a continuity of care once the patient has had a spell of intensive therapy?
- what community attitudes are an obstacle to change, and how to deal with them?

He listed the following essential requirements for the planning and organization of mental health services :

(a) The setting-up of realistic objectives, and the formulation of a national policy with clearly delineated principles are considered of central importance for the proper development of psychiatric care.

(b) It is essential that the steps to be taken in programme development should be well defined, and attention be drawn to the possibility of obstacles to be met and attempts be made to overcome them in the appropriate time.

(c) Reliable information on psychiatric problems, the state of the services, and the current needs should be made available to monitor the progress of work, and help in future programme development.

(d) That psychiatric care should be based on accepted and acceptable philosophy. Because of the complexity of mental illness and the mounting needs, the search for new models and more effective techniques has to continue.

Due emphasis should be placed on the change of stress from hospital-based care to community-oriented services and the need to achieve population coverage.

(e) The need for integrating psychiatric care with public health work and social services has been underlined, and the major requirements to implement such a policy have been considered.

(f) The continuity of psychiatric care to provide early treatment, follow-up and sustained support, until a successful return to normal life takes place, is regarded as a fundamental principle.

Lack of extra-hospital facilities and failure of inter-professional communication are considered the two most common factors which lead to discontinuity of mental health care.

(g) The establishment of a range of facilities to cater for the needs of patients at the different stages of illness constitutes a basic principle in psychiatric care programmes.

The network of facilities should be flexible and the services should be harmoniously designed with the available resources, and well suited to the local conditions.

(h) Intensified efforts are still needed for the development of more effective preventive models, the care of the chronics, and the special groups, e.g. the mentally-deficient, mentally-ill offenders and drug-dependent persons.

(i) A central organizational set-up for efficient administration and development of all-round psychiatric care programme is always needed.

(j) Training of personnel must be given priority in psychiatric care programmes and a lot of innovative work is needed for local training in developing countries.

(k) Educational programmes and public orientation to mental health work are essential components of a psychiatric care programme; and a study of the cultural background is generally important to foster favourable community attitudes and enlist public support.

The main theme which developed during discussions was the relative importance of mental hospitals. While some still championed the cause of the mental hospital, the majority considered it to be a bad, humiliating place. Some went on to insist that no mental hospitals should be built where they do not already exist. It was suggested that the mental hospitals should be sub-divided into short-term and long-term units. One speaker considered the out-patient services to be the first priority in developing countries. Another suggested mobile units for the rural areas.

5. General Principles of Preventive Action in Mental Health

Next, Dr Ali Kamal introduced his paper on "General principles of preventive action in mental health". While admitting that a lot more needs to be known before preventive programmes can be properly organized, he was quite sure that prevention of mental disorders was in itself a philosophically worthwhile aim. He thought that the way of moving towards the fulfilment of this aim was to have better and comprehensive services, integration with other medical and non-medical disciplines, and evaluative research.

The advantages of integrating psychiatric and general medical services are as follows : the removal of the stigma which is traditionally associated with mental illness; a better dissemination of knowledge about mental illness; the possibility of intervention at an early stage of the illness.

In the subsequent discussion, most speakers agreed that, since mental disorders had multiple causation, psychiatrists must work with others in the society to plan preventive programmes. One participant expressed his frustration with a psychiatrist's inability to alter the social conditions, but another did not take kindly to this attitude, stating that the profession could exert pressure if it "made enough noise". Another speaker pointed out that the profession was in fact already involved in the struggle for social change. He gave the example of the struggle for more humane mental health laws.

6. Assessing the Needs

Speaking on "Assessing the needs", Professor Giel pointed out that a "need" to seek help depended on many other factors besides morbidity. This being the case, surveys, expensive as they are, might not be the best method of determining need and planning services. To illustrate his point that the characteristics of services would themselves influence need, he re-examined some of the data presented by Professor Shaheen, and pointed out that the data raised interesting questions for further inquiry. In the discussion, several participants advanced possible explanations of the phenomena to which he has drawn attention. Other speakers, who addressed themselves to the main theme, pointed out the advantages of surveys -- for example, for basic research, providing aetiological explanations. Others, again, mentioned the political advantages of "figures".

The speaker agreed with these points and acknowledged the general advantages of epidemiological methods. He was only questioning the usefulness of surveys as measures of "need", he said.

7. Illustrative Presentation : Analysis of Cases seen at Out-patients

In his illustrative presentation, Professor Shaheen indicated the important place of the out-patient psychiatric department in the delivery of mental health services in developing countries. He pointed out how effective treatment in these clinics can be and how they can relieve the mental hospital of its heavy workload, but also mentioned the problems involved in delivering this service.

He stressed that the out-patient service will not substitute for the in-patient service completely. The key of the system of community mental health centres is the integration of these varied services including I.P., O.P., emergency centre, walk-in centre, and day and night hospitals. The essential quality is that these services be so organized as to form a co-ordinated system of care. Within that system the O.P. service can act as a complementary and preventive medium. It can be of great help in alleviating family anxiety, especially with regard to the stigmatizing reputation of hospitalization. Patients visiting the out-patient service live in their home settings where they continue to relate to family members and friends while engaged in intensive treatment. Such a programme offers effective treatment for patients suffering even from depressive and schizophrenic reactions, especially those whose personality traits or family relations promote co-operation with medical personnel.

Many questions concerning an out-patient service have arisen, such as :

(a) How often must patients be seen for evaluation and adjustment of medication?

(b) Would psychiatric hospital care be required frequently for such patients?

(c) What frequency of clinic appointments would be best for the patient and at the same time permit the clinic to handle an adequate volume of patients?

(d) Would an out-patient visit of ten to fifteen minutes' duration be sufficient to allow careful re-evaluation of the psychiatric status of each patient?

(e) What psychiatric medications would be most desirable for what patients?

(f) What type of procedure for the termination of these patients could be employed?

(g) What are the medico-legal problems in this type of programme and how can they be solved?

(h) Can this type of clinic be staffed with resident physicians working under the supervision of senior psychiatrists?

(i) Being attached to a university, can it be a field for research?

Some of these questions have been answered by experience and some will find the answer only through trial and error.

In the discussion which followed, various points made in the presentation were questioned and clarified. It was felt that it would have been interesting to have figures on how many patients had attended only once at the out-patient clinic, as experience indicated that this would be a high percentage. Also, the location and accessibility of the service influences the type of patient who comes for treatment, and it was felt that this may have accounted for the educational and socio-economic level of the patients seen.

8. Methodological problems of data collection and analysis

Miss Brooke than presented her paper dealing with the problems of data collection and analysis. She emphasized the importance of collecting data which is of relevance to the particular country and its mental health services. She stressed also the need for obtaining up-to-date data, processing it early, and making sure that proper use is made of the information obtained.

The basic problems of statistics in the field could be summed up very briefly as :

(i) what to count

(ii) how to count
(iii) what to do with the count

She stated that in considering these problems distinction be made 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. Data can be accurate (hard data), but subjective opinions may enter or they may be very hard to define in such a way that only one interpretation may be placed on them (soft data). The amount of data collected must be balanced against the resources which are available for processing it, and the amount of processed data must also be balanced against the number of trained people available to interpret it.

It was important to remember that data should be up-to-date. What happened three years ago might have a historical interest but what is happening now would 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. Once the data answering a question have been obtained, there is no need to go on collecting 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.

In the discussion which followed it was felt that, although it would be helpful for psychiatrists to have some knowledge of statistics, it may well be useful to train statistical technicians to work in developing countries, and that psychiatrists should work closely with statisticians when they are available. The problem of relevant data collection was also discussed and the importance of international uniformity in data collection stressed.

9. Illustrative Presentation : Analysis of national statistics of mental health services[1]

Dr Baasher next gave an illustrative presentation of an analysis of National Statistics of Mental Health Services in nineteen countries in the Eastern Mediterranean Region. He stressed the need to obtain statistics in order to plan effectively, but indicated the problems involved in collection of data, particularly in such a Region, where there are great geographic, economic and social differences.

In the subsequent discussion, it became apparent that the designations of mental health workers -- such as "social workers" -- were differently interpreted in different countries, and that there were also diagnostic differences in various regions. It was felt that, although this confusion was to some extent inevitable, it could be lessened by making accompanying clarifying statements and defining the terms used. Care should also be taken to collect data from all areas of a particular country.

10. Illustrative Presentation of a population survey of mental disorders

Dr Kapur, in an illustrative presentation, used a population survey in South India to compare the prevalence of psychiatric disorders in three different caste groups. He mentioned the problem of cross-cultural studies, why he thought an intra-national comparison would be useful, and how he developed a structured interview schedule combining the clinical and questionnaire approaches. The schedule measured symptoms; in addition, he tried to relate symptoms to demand, as measured by consultation, and also to subjective feeling of dysfunction.

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(1) For full information see also report on Group Meeting on Mental Health, EM/MENT/49, EM/GR.MT.MH./17, Alexandria).

An objective social functioning questionnaire had also been prepared. His results had so far indicated that change in residence patterns was associated with a high symptom rate, as was recent parent death, increasing age (up to age of forty years), matrilineal caste, among other factors. He found that consultation rate increased with increasing numbers of symptoms and particularly with somatic symptoms (of which females had more than males). Objective measures of dysfunction had little or no relation to symptom rate dissatisfaction, or consultation rate, and he felt that the three factors of symptoms, dissatisfaction, and consultation had to be taken together if one wanted a good indicator of psychopathology. He mentioned the findings of psychotics (seven) only among one caste group -- the Brahmins -- but felt that this would require further study.

In the discussion that followed it was agreed that, in view of the finding that consultation rates increased with increasing numbers of symptoms, and particularly somatic symptoms, general practitioners, who were likely to be the first doctors to meet such symptoms, should have a good basic psychiatric training. It was noted that other evidence had indicated that consultation was also influenced by other factors such as neuroticism and personality traits, particularly the number of "complainers" in the population, and that one should also be concerned with the number of non-consultors. Dr Kapur replied that people do not consult because they are not disturbed enough; he stressed again that increased dissatisfaction and increased symptoms were shown to have led to increased consultation.

Some of the findings of the study and its practical applications including possible conclusions that could be drawn as regards taking preventive action, were questioned. Most participants expressed great interest in any future findings to emerge from further analysis of the data.

11. Principles of Planning : Administration and Organization

Dr K. Bhaskaran's paper on the administrative and organizational aspects of planning was presented by Dr A. Zarrabi. He stressed that before proper planning of mental health services for any region can take place, certain essential data such as number of personnel, facilities for treatment, degree of integration of mental health services with the other health services, must be obtained. He mentioned the present trend toward organizing community services in many countries and noted that the model of community psychiatry that will fit a particular community will depend on the factors previously mentioned. He defined the goals in mental health planning as follows :

(a) Providing the optimal and effective direct and indirect services to the community that resources in terms of funds and professional personnel would permit, and this in a way that would least interfere with the familial, social and occupational life of the patients.

(b) Evolving the most satisfactory and at the same time economical delivery system to dispense mental health services to the poorly served rural population.

(c) Training adequate numbers of professional personnel.

(d) Imparting the needed psychiatric orientation to members of other help-giving professions, like general practitioners, school teachers, social workers, public health nurses, health visitors, village level workers, etc., whose active collaboration is very necessary for operating community-based programmes satisfactorily.

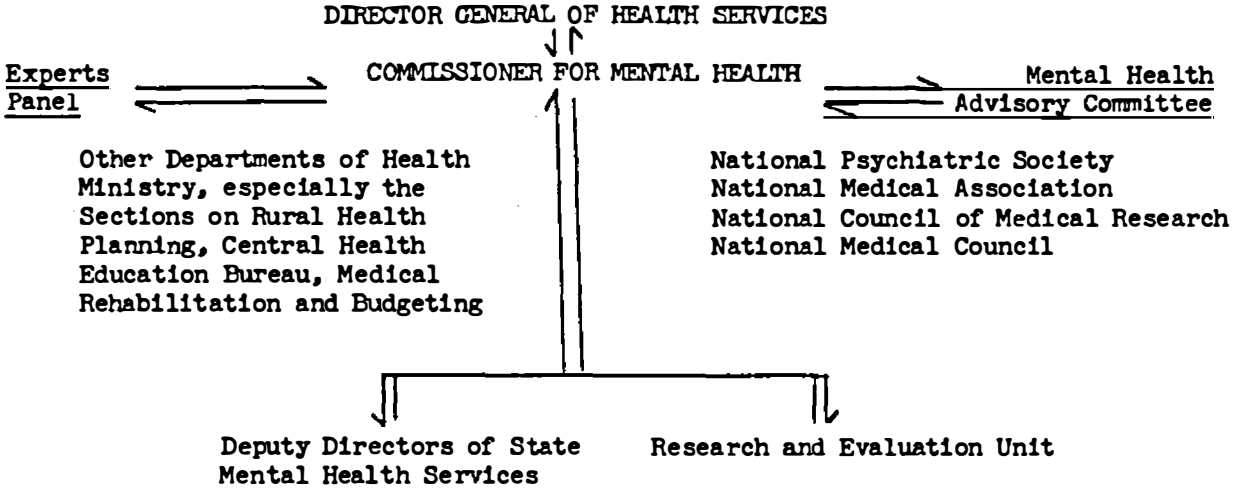
(e) Preparing the community for active participation in community mental health programmes.

(f) Making legislation concerned with admission of patients in mental hospitals, their discharge and their rights more humane and more in tune with the current psychiatric thinking and practice.

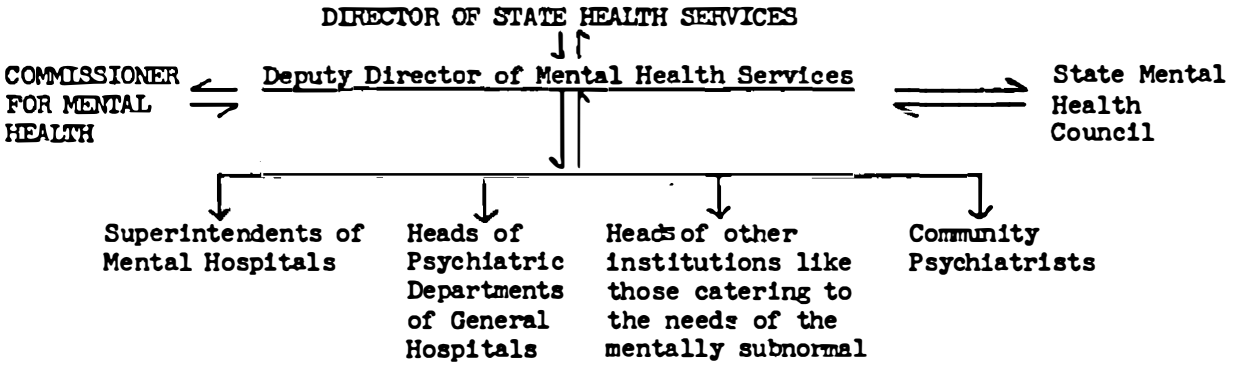
(g) Evaluation of the efficacy and adequacy of the different kinds of services.

A model scheme for the setting up of mental health services in a country such as India was then presented :

ORGANIZATION OF MENTAL HEALTH DEPARTMENT AT THE CENTRAL GOVERNMENT LEVEL



ORGANIZATION OF MENTAL HEALTH DEPARTMENT AT THE STATE GOVERNMENT LEVEL



There were two main themes of discussion :

(a) It was agreed that community psychiatry programmes should be tailored to the communities which they served. The cost of such programmes should be carefully considered, as should the capacity of the community to accept and cope with such programmes. Programmes should not be introduced which the community cannot accept at present, and there should not be too much optimism about community psychiatric programmes being the final solution to mental health problems.

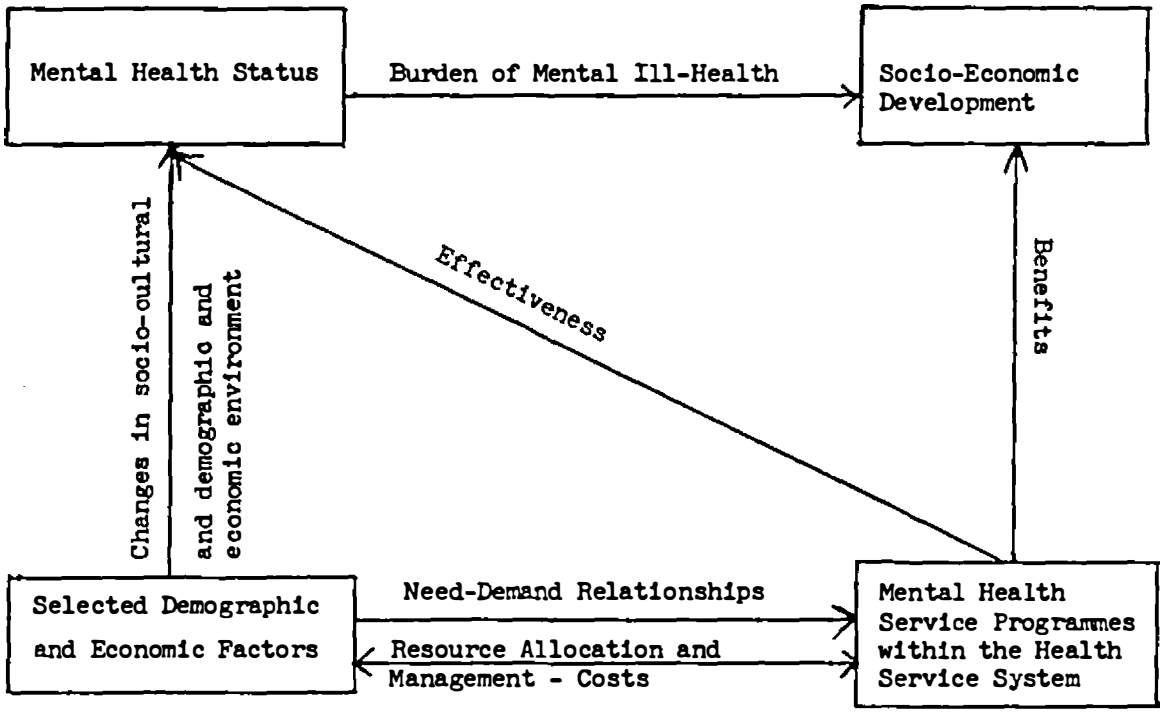
(b) The problem of obtaining good planning and managerial personnel was discussed. It was felt that mental health administrators should be culturally prepared for the areas in which they would work, and that possibly, psychiatrists should have courses in management and planning. There should also be an attempt at more integration between psychiatrists and administrators.

There was also mention of the fact that public health officers and general practitioners must be involved if psychiatric programmes are to be taken into the community. The whole concept of community psychiatry was also questioned and a call made for clarification of the different models.

12. Principles of Planning : Demographic and economic aspects of Mental Health Care in developing countries

In presenting his paper, on "Demographic and economic aspects of mental health care", Dr A.Benyoussef highlighted the importance of defining in non-medical terms some of the issues related to planning and development of mental health services. Although other factors are also important, he felt that some stress should be put on demographic and economic factors and that one of the key factors was the assessment of the various options available based on the particular priority setting and the impact which would be produced :

FRAME FOR ASSESSING OPTIONS FOR THE DEVELOPMENT OF MENTAL HEALTH SERVICES



Leading Issue : Which Options for Development of Mental Health Service Programmes?

He stressed that the search for options will be different in each socio-economic context, but that in the developing countries they will be motivated by a desire to make rapid progress toward the following general goals for mental health services and health services in general :

(a) Peripheral primary mental health services which will be accessible to the total population.

(b) A referral system with efficient forward and backward channels for those persons with special mental health service needs.

(c) An allocation of mental health service resources which is based upon overall national and social priorities.

(d) A mental health service programme which is designed and administered in a way that is consistent with national values and acceptable to the population and responsive to its expectations.

(e) A management system for mental health service resource use and utilization which is able to promote efficiency.

(f) A standard national mental health service technology that is simple and appropriate for the priority mental health service problems.

(g) An improvement in mental health status (including also development and disability) not only through health service action but also through induced change in other sectors.

(h) The ability of the mental health services to adapt flexibly to changes in needs, demands and other resources.

In the discussion of this paper, the general feeling was expressed that it was extremely important for psychiatrists and other mental health workers to concentrate on influencing health ministries and other important planning agencies. It was also noted that sometimes concentrating on such things as better education, diet, schools, etc., may be the best way to help the development of mental health services on a long-term basis.

13. Principles of Planning : Staffing Requirements

Dr M.R. Chaudhry spoke on "Principles of planning (staffing requirements)". He began by citing staff requirements of a thirty-bed unit in a general hospital and a 250-bed psychiatric hospital. He thought that the continuity of care required a psychiatric team. He went on to discuss the special problems of Pakistan, the lack of any formal training in psychiatric nursing, the concentration of specialists in cities, and the out-dated mental health laws. He thought that auxiliaries would have to take up more responsible roles in rural areas. He recommended that there should be short courses in psychiatric nursing, and urged that WHO should follow-up its recommendations, in order to help countries make good their deficiencies in trained personnel.

He pointed out that the psychiatric services in the West have evolved out of a particular socio-economic and cultural set-up. The developing nations do not have the peripheral support the developed countries derive from well-organized medical, social and voluntary services. The teaching and training of personnel in developing countries will have to be somewhat different from that practised in the developed countries. The Western training and grafting will not serve the purpose even in the most modern community psychiatric services model.

The staff should be trained locally so as to equip them to deal with problems peculiar to developing countries. Mental hospitals and clinics in the developing countries themselves should be used for the in-service training of nurses and other personnel.

The shortage of professional staff in developing countries can be solved by developing a concept of multi-purpose paramedical staff. It may thus be possible for one worker to take several roles, and such shortcuts may give rise to interesting experiments.

In the discussion which followed, some speakers questioned the "rigid" concept of the psychiatric team as consisting of a psychiatrist, a clinical psychologist, a social worker and a nurse; in USSR, a team composed only of a psychiatrist and a nurse has been shown to be sufficient. In some situations, psychiatric aides might be the only other members of the psychiatrist's team. Other participants opposed the reduction of the four-man team. Some argued that the staffing should be flexible, and in relation to the workload; and some others pointed out that the family of the patient could share the workload.

A West Indian participant, talking about the concentration of psychiatrists in the cities, stated that in Jamaica the psychiatrist trainees are required to work in villages for six months, during the final stage of their training.

A psychologist member of the group complained that the clinical psychologist is usually assigned a peripheral role as a tester. He thought that the psychologist could take an active role in therapy programmes.

Dr Baasher, taking up the issue of WHO following up its recommendations, agreed to the suggestions, but thought that the real pressure on governments could only be brought by the national groups.

14. Psychiatry in basic medical education

Professor G.M. Carstairs spoke on "Psychiatry in basic medical education". He said that, in spite of a number of reports and recommendations, psychiatry has still not achieved its rightful place in the medical curriculum. In some centres, more progress has been made than in others, and this was often due to individual personalities. The greatest stumbling block was medical colleagues in other disciplines. It would help if it were realized that most of them were "sincere" in their resistance to psychiatry. Psychiatric morbidity surveys, reporting psychiatry seminars and recommendations in medical journals and showing representation on Medical Councils would go a long way in breaking the resistance.

Medical students who follow role models can also be allies. Professor Carstairs insisted that the head of the department of psychiatry should be "visible" to the students. Morbidity surveys in the student population and having the students' help in carrying out morbidity estimates in other wards could be of great help.

Politicians should also be engaged and informed, not only by the present office holders in the psychiatric society but by future office holders also.

He repeated the necessary prerequisites for the improvement of psychiatric teaching which have been stressed again and again at the seminars by WHO or by WFMH :

(a) Creation of an independent Department of Psychiatry in each Medical School, under the direction of a Professor, with supporting staff.

(b) Provision of in-patient and out-patient psychiatric services as integral parts of the main general teaching hospital.

(c) A separate examination in psychiatry, which must be passed before the student can graduate; or inclusion of a significant amount of questions on psychiatry in the medical finals.

(d) Satisfactory performance of a clinical clerkship in psychiatry during the undergraduate course, or as part of a rotating internship should be a prerequisite before awarding the M.B. degree.

In the discussion which followed, the importance of giving psychiatric education in the mother tongue was stressed. A warning was sounded against insularity in an attempt to get established. Some thought that psychiatry would become acceptable if its importance were demonstrated. Professor Carstairs did not agree with this, giving examples of the poor progress of psychiatry in the Sixties, in spite of new psychotropic drugs. He also cited the rapid progress of psychoanalysis in the Fifties, notwithstanding a lack of any evidence of its usefulness.

An example was given to show that students are more progressive than their teachers, and that advantage could be taken of their idealism.

15. Training of Psychiatrists

Professor N.N. Wig spoke on the "Training of psychiatrists". Considering the acute shortage of psychiatrists in developing countries, he thought it irrelevant to discuss "how many" psychiatrists needed to be trained. He believed that the training should preferably be carried out in home countries. If training were given abroad, the person should have some experience at home before going.

The ideal would be to have training both in a general hospital unit and a mental hospital unit, but if there had to be a choice he preferred a general hospital training since the spectrum of illness was much wider there. He advocated the setting up of national centres of training and gave examples of Indian national centres. Commenting on the type of training, he considered it desirable to train a general psychiatrist. He warned against too much leaning on neurology, and thought that much more stress should be put on social sciences. Training in research should also be an essential part of the programme.

He listed the following subjects to be taught in the training programme :

(a) Clinical training should be central to the training programme.

(b) Psychotherapy including individual and group therapy should be an essential part of the training not only for their value in treatment, but also for their important role in understanding psychodynamics and psychopathology.

(c) Research orientation should be an integral part of post-graduate training. Students should be encouraged to take up independent research projects under supervision.

(d) Neurology teaching is important for a psychiatrist but relationship of psychiatry to other branches of general medicine and surgery is equally important.

(e) Adequate number of lecturers covering basic sciences and social sciences should be provided. He had been regularly using services of neighbouring university departments of psychology, sociology, anthropology for lectures to students.

(f) Though there should be exposure to sub-specialities like child psychiatry, forensic psychiatry, geriatric psychiatry, the main aim of the training should be to turn out competent general psychiatrists.

WHO could help new training centres in developing countries by sending "senior" teachers, financial help, and by providing a good library service.

In the discussion which followed, the importance was stressed of a period of training in general medicine before taking up psychiatry. There was prolonged but inconclusive discussion on the problem of "brain drain". It was pointed out that research should be of the applied variety and that training should suit cultural setting. There was discussion on the importance of mental hospitals in psychiatric training, and the importance of administrative psychiatry was mentioned. The feasibility of a shorter training programme for doctors who work in mental hospitals was questioned.

16. Training of Nurses

Mr M. Kozma talked about the training of nurses. He conveyed that a short psychiatric experience by itself is not enough to enable a nurse to act as a member of a mental health team. A specially designed training programme, including a period of experience in mental health centres, is needed.

From his own experience, he said, nurses do not respond well towards psychiatric training. He described his programme in which a psychiatric nurse was given a three year diploma. There were shorter programmes for an assistant nurse, and a general nurse.

However, in any planned basic psychiatric nursing programme the following areas must be included :

(a)
- History of nursing - nursing procedures and ward management.
- Human development. The behavioural pattern within the family and society.
- The roles of social and cultural factors in illness.
- Human behaviour in health and in sickness.
- Introduction to human biology in association with nutrition and first-aid.
- Dynamics of group behaviour.
- Introduction to psychiatric treatment.
- Nursing care and management of psychiatric patients and of patients undergoing psychiatric treatment.
- Introduction to physical disturbances and nursing care of physical illness.
- Therapeutic procedures.

The training period should not be less than three years. The standard as to the theoretical instruction and examination can vary considerably between one country and the other; such standard will be raised as the general educational standard of the candidates rises and the availability of student candidates increases.

Practical training should be carefully and thoroughly applied. "It is essential that the theoretical preparation of the psychiatric nurse must throughout be closely related to the practical therapeutic aspect of the work of a mental hospital and the mental health need of the community".

As it was found necessary by the Group Meeting to include teaching and experience in psychiatric nursing in the teaching programme of general nurses, I believe it is as important and essential to include teaching and experience in general nursing care in the teaching programme of psychiatric nurses.

"Although the emphasis is strictly on the role of the nurse in the psychiatric team, the need for a proper understanding of the physical functions of the body and physical care must not be overlooked".

(b) An assistant nurses programme must be implemented specially where the ratio of all kinds of trained nurses is very low. Such a programme must be designed to give the candidate sufficient experience and knowledge so that she can participate to the fullest possible extent in all fields of nursing of psychiatric patients.

It should include theoretical training which can be correlated with practical experience whether in the hospital, clinic, outpatient hospital or the patient's home.

Such a programme may be of one or two years' duration, according to the points previously mentioned, and must cover the following areas :

- The function of the nurse.
- The function of the hospital, clinic, etc.
- Nursing ethics, historical survey, nursing procedures.
- The patient as an individual.
- Special care, physical and psychological.
- Community care, including rehabilitation.

(c) A six-month programme is a necessity. It must be similar in principle to the assistant nurse programme. Its aim is to train all the existing "nursing" personnel in mental institutions, whatever their educational standard or how old they may be.

Every person employed in the nursing service must benefit from this type of training Instruction may be given by trained instructors or by qualified nursing staff, and the duration must be not more than six months.

An assessment is then made and promising candidates may be encouraged to undergo further training as assistant nurses.

(d) The last programme that may be recommended is a post-graduate course of one year's duration for the generally trained nurse who wishes to take up psychiatric nursing as a career.

The course must cover the areas not fully covered during her general nursing training. This post-graduate course must be encouraged and made attractive so that candidates may be tempted to take the challenge and enter the psychiatric nursing field.

In the discussion which followed, attention was drawn to shortage, not only of psychiatric nurses but also of general nurses. It was suggested that we should concentrate on training psychiatric nursing tutors who could then teach other nurses in their own centres. Some thought that a nurse should be taught in the local language, and the importance of cultural factors in training was also suggested.

17. Types and roles of Auxiliaries

Dr C.R. Swift presented his paper on the types and roles of auxiliaries, and stated from the beginning that this would vary from country to country, particularly depending on the ratio of doctors and psychiatrists to population, and the rural versus urban doctor ratio. He said that, although in some situations auxiliaries were forced to function independently, he preferred to define an auxiliary as a person who assisted a professional and was supervised by the professional. He then raised various questions regarding the role of the auxiliary, and kind of auxiliaries who should be trained, who should train them and where, and what training they should have. He tended to be in favour of auxiliaries having a general as opposed to a purely psychiatric training and felt that this would be best done in the place in which they would be working. Although there were many questions concerning auxiliaries that remained unanswered, he felt that there was little doubt about their function in the preventive aspects of health care.

He gave a sample outline of a course for medical auxiliaries. This course would normally take place during the final year of two or three years of training for the general duty medical auxiliary. Student intake would be after ten or twelve years of general education. This course outline was intentionally general; it should be adapted to fit the needs of the particular country. The purpose of the course was to prepare the auxiliary for general medical duties especially in outpatient clinics, dispensaries and health centres. The emphasis of the course should properly be on prevention and health education.

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

INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRY

A. Student attitudes toward psychiatric illnesses

An initial opportunity for free student expression.
Exploring belief in witchcraft, the stigma and fears.
Acceptance of various views by teacher.
Emphasis made that students don't need to choose between traditional beliefs and the content of this course.

B. Behaviour

Determinants of behaviour : Genetic factors
Environmental factors

C. Anxiety

Normal vs. abnormal anxiety.
Origins of anxiety.
- Fear of abandonment.
- Fear of injury (death).
- Fear of failure.
- Fear of consequences of one's own anger.

D. Stress

Examples of stress in everyday life.
Each stress experience results in :
- Mastery (adequate coping) or,
- Failure (inadequate coping).

How does a person cope with stress?
Healthy ways.
- Continuing usual life routines as much as possible.
- Obtaining encouragement from own past experiences.
- Obtaining encouragement from friends and people important to the individual, (including health personnel).
- By the use of identification, with parents and others.
- Talking about it with special friends.
- Reducing the stress.

Less healthy ways.
- Withdrawal, avoidance of stress.
- Regression.
- Blaming others.

E. How does an auxiliary strengthen mental health?

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

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

Throughout, the preventive potential of an auxiliary is emphasized.

F. Personality Development

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

Points of special emphasis :
- Development from dependence (at birth) to independence (at maturity).
- Negative behaviour. Fears. Aggressive behaviour.
- Growth of sexual feelings in childhood and adolescence.
- Social growth, especially during adolescence.
- The process of identification.
- Young adulthood. Middle age. Old age.

G. Abnormal Psychology (Psychopathology)

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

These will be discussed under disorders of : Motor Activity - Mood (affect) - Speech - Perception - Thinking - Memory - Awareness - Intelligence.

H. The causes of the psychiatric illnesses

Brief presentation of genetic, physical and psycho-social factors.

I. The prevalence of psychiatric illness

Reference here to prevalence studies carried out in Africa and Asia. Purpose : to give the student an idea of the frequency.

J. Introduction to interviewing techniques

Can often be done best in connection with actual interviews with patients. Few points to be emphasized :

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

K. Clinical Psychiatry

A brief introduction to the common disorders found in one's country. Where possible to be illustrated by patient 's presentation. The following disorders will be discussed :

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

L. Management of patients

- Introduction to treatment.
- Importance of liaison with family. If patient is hospitalized, planning for his discharge begins when he is first admitted.
- Education of family regarding the patient's illness.
- Importance of continuity of care.
- Emphasize again and again, the preventive role of the auxiliary.

M. Traditional beliefs and psychiatric illnesses

- A return to the subject of student beliefs and attitudes.
- Traditional beliefs able to be integrated with main features of this course.

N. Mental health and psychiatric programme in the country

An outline of present programme and future plans, emphasizing the important place the auxiliary has in this programme.

O. Closing session(s)

Unsigned questions from students to be discussed by teacher.

Student evaluation of the course by completing evaluation questionnaire.

Next, follows a sample outline for a course for the nursing auxiliary working with psychiatric patients in a hospital setting. The suggested course content is appropriate for the auxiliary who has little or no training, certainly none in the field of psychiatric illness or mental health. These sessions are intended to be in-service in nature, held during the working day of the auxiliary, probably for one hour weekly for ten to fifteen weeks. It is suggested that the time be about equally divided between lectures and discussions. In the following outline only main topics are suggested. The local situation, the educational and work background of the nursing auxiliary, the interests and skill of the teachers will determine more specific course content.

INTRODUCTION TO MENTAL HEALTH AND PSYCHIATRY

A. Sessions led by Medical Officer, Psychiatrist, or Experienced Medical Auxiliary

(a) Discussion of causes of the mental illnesses

Traditional beliefs as suggested by students.
Genetic, physical and psychosocial causes.
Some integration of traditional and "scientific" approaches.

(b) Introduction to concepts of stress and anxiety

(c) Types of patients (to be presented in symptomatic rather than diagnostic groupings)

Withdrawn - overactive - paranoid - confused - depressed - anxious - epileptic - alcoholic.

(A simple explanation of symptoms can be undertaken : visual hallucinations usually associated with extreme fear; grandiose delusions often follow feelings of insignificance, etc.)

(d) Treatment considerations including prevention

B. Sessions led by Social Worker

(a) Social background as related to the mental illnesses

(b) Importance of family

- As a source of information about the patient.
- As possibly a contributing stress to the patient.
- As important in follow-up planning and responsible for patient returning for outpatient visits.

(c) Importance of co-operation between ward staff and social worker

Means of facilitating planning for patient's future.

C. Sessions led by Nursing Staff

(a) Purposes of Hospitalization : Patient's reaction upon entering hospital.

(b) Nursing management of various types of Patients

Withdrawn - Overactive - Paranoid - Epileptic - Alcoholic - Confused - Depressed - Anxious.

(c) Introduction to nursing, psychiatric and other procedures

- Admission routine.
- Physical therapies.
- Occupational and recreational therapy.
- Physical therapies (E.C.T.)
- Concept of Milieu Therapy - Importance of nursing auxiliary's role.
- Drug treatment - Purposes - Side reactions and dangers.
- Other treatments - Psychotherapy
- Discharge routine.

(d) Nursing Auxiliary as a member of the treatment team

- Importance as observer and source of information to nurse and doctor.
- Importance as helper of patients. Auxiliary determines the atmosphere of the ward.
- Key role of auxiliary in treatment of patient.

In the discussion there was much support for the points made by Dr Swift. It was felt that there was a definite place for auxiliaries, that they could function in a complementary fashion and even be cultural interpreters for the doctor. Although it was felt that more auxiliaries should be trained, there were those who felt that they should be selected carefully and supervised carefully, and who were anxious lest they take on responsibilities with which they were not competent to cope. Some speakers felt that there was little danger of this, however, and in fact wanted the whole concept of the auxiliary expanded to include patients' relatives. They noted that the presence of relatives was usually a good prognostic sign; it ensured that the patient would be looked after, and the relative was usually willing and able to carry out a professional's instructions.

18. Essential requirements of Mental Health Legislation

Professor A.S. Manugian added his own comments to the summary he gave of Doctor K. Bhaskaran's paper on "Mental health legislation". He stressed that most legal terminology is concerned with checks and restraints, while its real function should be protection of the dignity and rights of the individual and the provision of services. He found very little substance in the "Introductory guidelines to mental health legislation" draft and thought that they were couched in vague sweeping terms.

He resented the fact that in some mental health laws a person was expected to be "cured" before discharge. This he thought unjust to people suffering from incurable conditions but who were well enough to be rehabilitated in society. He proposed that one might consider legislation to govern the doctors' right to experimentation. Laws relating to the mentally-ill and their care should be humane and reflect the current psychiatric thinking and practice. The framing of the laws, including their review from time to time should be entrusted to the authority charged with the responsibility for planning and organizing mental health services for the country. Improvement of the status and functioning of mental hospitals, the organization of a net-work of community based services with adequately trained staff to operate them, orientation courses for medical practitioners and law-enforcing officers, and education of the community in matters of mental health and disease are all necessary requirements for a satisfactory implementation of the laws.

In the discussion which followed, some participants described the legislation in their respective countries. There was some discussion about the age of responsibility. There were comments that often it was difficult to apply the law and that in the process of certification different people might act with different motives. The need was stressed to monitor that the legislation be used as intended.

19. Evaluation of services

Dr F.R. Hassler spoke on "Evaluation of services". He stressed the need for clear objectives, planned action programme feedback, and quantifiable measures to test whether objectives have been achieved. He gave examples of the programmes which it might be useful to evaluate. The role and function of traditional healers, and auxiliary workers, comparison of treatment in general hospital and mental hospital; prevention programmes, and mobile teams were some of the examples he gave.

According to Dr Hassler the types of evaluation can be listed as follows :

(a) Before and after measurement.
(b) Operation or action research.
(c) Longitudinal study.
(d) Programme audit.

Evaluation must be seen as a process involving a number of steps :

(a) Analysis of the problem(s) with which the programme must cope.
(b) Identification of the goals to be sought.
(c) Determination and description of the various activities within the programme.
(d) Selection of criteria to measure the degree of change that will take place (or not, as the case may be).
(e) Selection of methods to determine whether any change observed is the result of the programme, or due to some other cause.
(f) Determination of the durability of the effects.

It might also be useful to consider a checklist of questions that programme directors and their staff could review in the process of developing mental health programme evaluative activities. The checklist would have to include the following questions :

- Has an evaluator (or team) been clearly designated as responsible for this purpose and the required administrative arrangements for staff time and other needed resources?
- Have members of the community been involved in determining the priority and general nature of the programme or activity?
- Have both service delivery and evaluation personnel participated in the study of goals and selection of target groups and in the overall planning and development of the activity?
- Have programme goals been stated in such a way that they can be objectively assessed by evaluation instruments or other indices?
- Have the various operational components of the activity been defined so that the essential characteristics of the service or programme can be clearly identified and communicated to others?
- Has there been a field testing period of "pilot" phase of the project and the evaluative procedure to be utilized?

In the discussion some participants wondered if, in the condition of scarcity of resources, it was more important to carry out programmes or to evaluate them. The general consensus was that evaluation was important, though it need not always be carried out through tight, sophisticated, experimental design.

IV CASE STUDIES

During the afternoons of 28 and 29 November, members of the Seminar met in three small groups, each with a Chairman, Rapporteur and Resource Person, as follows :

	Group A	Group B	Group C
Chairman	Dr Labban	Dr Swift	Dr Manugian
Rapporteur	Mrs Moser	Dr Shafique	Dr Howarth
Resource person	Dr Fikre Workineh (Ethiopia)	Dr Saleh (Kuwait)	Dr Haq (Malaysia)

In each group the Resource Person briefly outlined the geography, socio-economic structure and health services of his country and described the existing mental health services, together with the numbers of personnel of various levels of training currently available, and the level of financial support accorded to these services.

The groups then addressed themselves, with the help of the Resource Person, to answering the following questions :

1. Does this society exhibit any traditional attitudes, customs or social institutions which are considered to be : (a) helpful, or (b) harmful to mental patients?

2. Can any of these cultural factors be controlled, or utilized, in the development of mental health services?

3. During the next five years, what should be the priorities in :

(a) creation of treatment facilities,
(b) involving non-psychiatric personnel in mental health care,
(c) training of psychiatrists, of other doctors, of nurses and other medical personnel in basic psychiatry?

4. What are the principal difficulties to be overcome in developing better mental health services in this country?

In addition, each group was asked to give its attention to two particular questions, as follows :

Group A : (i) What steps should be taken to involve patients' relatives in their treatment and after-care, in Ethiopia?
(ii) Do Ethiopian patients comply with the re uirement to take psychotropic drugs regularly for extended periods? If not, how can this obstacle be surmounted?

Group B : (i) Can (or should) psychiatrists practise in a culture other than their own -- whether in the United Kingdom, in North America, or in Kuwait?
(ii) Is the group satisfied with the level of instruction in psychiatry given to (a) nurses, (b) medical students in Kuwait? If not, how can this be improved?

Group C : (i) Most psychiatrists live in towns, most patients live in villages. How can mental health care realistically be made available to villagers in Malaysia?
(ii) Is there a brain drain of medical personnel from Malaysia? If so, how can this be combatted?

After spirited discussion of these questions during the two afternoon sessions, the Chairman and Rapporteur of each group in turn reported their group's answers to these questions at the plenary session of the Seminar on the afternoon of 30 November. As will be reported in the evaluation of the Seminar, many participants

thought that these case studies conducted in small groups were a particularly helpful experience.

V EVALUATION

To evaluate the content and the proceedings of the Seminar, the participants were asked to answer the following questions :

1. What do you consider were good features?

2. What features do you consider were not so good?

3. What suggestions do you have which would improve similar group activities for another time?

4. How do you propose to make the results of the Seminar known to your country, and also to follow them up?

5. Which features would be more immediately applicable in your own situation?

Of the forty-eight participants, thirty-five (73 per cent) completed the questionnaire, and of the 175 possible responses ten (6 per cent) were lacking. Five of the latter pertained to question 5.

Question 1

The ample opportunity for an exchange of ideas and experiences between professionals from different countries was mentioned most frequently (about two-thirds). Next came the good quality of the papers (one-third), and the fact that they were not presented in full detail at the time of the sessions but were just briefly high-lighted or commented upon. The case studies and the comprehensiveness of the Seminar were also appreciated, while some participants were much in favour of the emphasis on community mental health services

Question 2

About one-third of the participants felt that there was insufficient time for discussion. Some mentioned that this was due to too many papers being introduced in one session, or to the time taken by some discussants who seemed to prefer the sound of their own voice.

There appeared to be rather mixed feelings about the case studies. On the one hand some people thought they were too few and wished that more time had been allotted to them; on the other hand, there were some participants who found them ill-prepared and, because of this, rather futile.

Some participants regretted the relative absence in the Seminar of professionals other than psychiatrists. Others were disappointed at the emphasis on auxiliaries, and missed a discussion on the role of the social worker.

Question 3

Suggestions for improvements were numerous and of a varying nature : e.g. better seating arrangements would have been more conducive to open discussion and exchange of viewpoints.

The participants suggested more case studies in smaller groups, particularly if they were better prepared than the present ones. It was suggested that there should be more time for presentation and discussion of personal experiences in the respective countries. This seemed to some extent in contradiction with other statements indicating

that the discussion should have been much more directed towards specific questions, circulated in advance, or put by formally appointed discussants. In a way, the latter suggestion was in keeping with a general call for more authoritative and directive chairmanship.

The following suggestions were more specific :

1. Government officials and administrators should be invited to meetings like the present one. More junior psychiatrists should be asked to attend seminars and similar meetings.

2. More regional or local seminars should be held, particularly consequent upon a visit by a senior consultant, who could present a report on the local situation for a thorough discussion.

3. The follow-up of a meeting should be discussed more extensively; and the participants should be given homework to take with them, such as collecting basic statistics to implement and to be reminded of what they had experienced during the meeting.

4. More and better information about each individual participant would prevent misunderstanding and improve the discussions.

Question 4

Most participants agreed to make the results of the Seminar known through personal contacts with officials and colleagues, a personal report in the country's language backed up by the WHO report and by publications in medical journals or newsletters. The two following statements were more specific and of particular interest:

1. One participant stated that it would be helpful to invite someone in high office to co-author a paper on the Seminar and its recommendations, highlighting points of special interest for the country.

2. Another participant thought that his attempts to follow-up the Seminar would carry more weight if he were formally recognized as a WHO expert.

In summary, the follow-up would be more effective if the WHO report were sent to as wide a variety of government departments as possible; and if the participants had a sufficient supply to hand to interested people.

Question 5

On the whole, the participants were much less outspoken and specific in their responses regarding the more immediate application of what they had taken from the Seminar. However, the following summary of observations can be made:

1. It was thought possible either to strengthen or to introduce the teaching of psychiatry and mental health care in the training programmes of all health workers.

2. Some considered it possible to promote the training of auxiliaries.

3. Others saw a chance for planning on the national level and for the introduction of a central administrative body for mental health care.

4. For some, the mental health system in another country proved an eye-opener with regard to their own set-up.

5. A number of participants found the change in role of the psychiatrist, becoming less of a therapist and more of a teacher, and superviser, immediately applicable.

6. Several people mentioned that they could involve the community and its representatives more than they had hitherto done, learning from them as well as relying upon their voluntary support and assistance.

In summary, the evaluation of the Seminar provided a rich variety of comments, with some central themes such as the usefulness of well-prepared case studies, a more focussed discussion, even less time to be spent on formal presentation of papers, and the participation of professionals other than psychiatrists only.

VI RECOMMENDATIONS

1. Every country should formulate a National Policy on Mental Health, in which the contributions of health, education and welfare services would be co-ordinated. Senior psychiatrists, with the assistance of other mental health experts, should take part in deciding the National Policy on Mental Health. The planning and administration of services required for the implementation of that policy should be the responsibility of a separate Mental Health Division within each country's national or provincial health administration.

2. Countries should review their mental health legislation and enact new legislation where necessary; but it is equally important to study the effectiveness and the consequences of new legislation in this field once it has come into effect.

3. Mental Health Services should be integrated with general health services by including mental health units in all general health facilities. The isolation of some traditional mental hospitals should be overcome.

4. In order to bring a measure of mental health care within reach of the rural population, increased use should be made (under medical supervision) of general medical auxiliaries who have been given practical instruction on the prevention, recognition and management of certain psychiatric conditions.

5. There is an urgent need to increase the number of psychiatrists. Basic training in this specialty should be provided in the doctor's own country; or, if this is not possible, in a Regional Training Centre in the same cultural region.

6. In view of the pressing need for more psychiatrically trained nurses and assistant nurses, priority should be given to the training of psychiatric nurse tutors, in one or more Centres in each WHO Region.

7. Clinical teaching for both psychiatrists and nurses should be given in the language and in the typical work-setting of the country.

8. Efforts should be made to subject therapy by traditional healers to scientific evaluation.

9. Operational research should be carried out to determine the effectiveness of new and existing services. Basic statistics should be collected on the distribution and availability of personnel and utilization of facilities, in order to contribute to such research.

10. In view of the shortage of statistical personnel, WHO should introduce Regional Training Courses for medical statistical technicians.

11. Since there is general agreement that psychiatric morbidity exists in all populations, we should not wait for field surveys before establishing mental health services. Field surveys, however, are useful in discovering aetiological relationships, in completing the clinical picture of particular syndromes, in assessing community attitudes, etc. In addition to more comprehensive studies, much can be gained from surveys of psychiatric morbidity in general health facilities; such surveys can help to persuade medical colleagues that psychiatry can contribute to better patient care.

12. The present strong emphasis on community-based mental health services, with a changing role for traditional mental hospitals, should not be allowed to result in neglect of the chronic patients. Alternative provisions for their accommodation, treatment and rehabilitation should be provided.

13. Participants in WHO Seminars, Expert Committees and similar meetings should communicate the findings of these meetings to their national colleagues, for example through their Medical or Psychiatric Associations, and through reports in the Journals of these Associations.

14. Psychiatric professional groups in each country should formally draw WHO recommendations to the attention of their national health and other appropriate administrators, and urge the implementation of such recommendations.

15. In view of the important role to be played by auxiliaries over the next few years, WHO is advised to organize a seminar on the teaching of mental health care, as part of the training of general health auxiliaries. At this seminar national participants would be asked to provide examples of curricula for such training, as practised (or planned) in their respective countries, and data on evaluative studies of the work of such auxiliaries.

16. To assess progress in the improvement of teaching of behavioural and social sciences and psychiatry in the curricula of medical schools in the developing countries, a survey of such teaching should be carried out, and its findings discussed at another WHO seminar on this topic.

17. In view of the many problems and major difficulties encountered in creating adequate mental health programmes in the developing countries, it is recommended that there should be a Regional Adviser on Mental Health in every WHO Region.

ANNEX I

AGENDA

I Opening of the Meeting.

II Election of Chairman, Vice-Chairman and Rapporteur.

III MENTAL HEALTH CONCEPTS

- 3.1 Evolution of concepts of mental illness and mental health care.
- 3.2 Existing concepts of mental illness in different cultures and traditional forms of treatment.

IV THE SPECTRUM OF MENTAL DISORDERS

V PRINCIPLES OF MENTAL HEALTH CARE

- 5.1 General principles of psychiatric care.
- 5.2 General principles of preventive action in mental health.

VI METHODOLOGICAL PROBLEMS OF DATA COLLECTION AND ANALYSIS

VII PRINCIPLES OF MENTAL HEALTH PLANNING

- 7.1 Administration and Organization.
- 7.2 Economics of mental illness and mental health care.
- 7.3 Staff requirements.

VIII TRAINING OF PERSONNEL

- 8.1 Psychiatry in Basic Medical Education.
- 8.2 Training of Psychiatrists.
- 8.3 Training of Nurses.
- 8.4 Types and roles of Auxiliaries.

IX MENTAL HEALTH LEGISLATION

X EVALUATION OF MENTAL HEALTH SERVICES

XI RECOMMENDATIONS

ANNEX II

LIST OF PARTICIPANTS

AFGHANISTAN	Dr Mohamed Sadiq Asefi Psychiatrist Kabul
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WHO SECRETARIAT

Dr T.A. Baasher	Secretary of the Seminar	Regional Adviser on Mental Health WHO Regional Office for the Eastern Mediterranean
Dr F.R. Hassler	Senior Medical Officer	Office of Mental Health WHO Headquarters, Geneva
Mrs J.M. Moser	Scientist	Office of Mental Health WHO Headquarters, Geneva
Dr A. Benyoussef	Scientist	Division of Strengthening of Health Services/Resource Groups, WHO Headquarters, Geneva
Prof. G.M. Carstairs	Consultant	Professor of Psychiatry, Department of Psychological Medicine, University of Edinburgh
Prof. R. Giel	Consultant	Professor of Social Psychiatry Groningen, Netherlands
Miss C. Cartoudis	Conference Officer	WHO Regional Office for the Eastern Mediterranean
Miss J. Bell	Secretary	WHO Regional Office for the Eastern Mediterranean

ANNEX III

PROGRAMME

TUESDAY, 27 November 1973	- AFRICA HALL - PLENARY HALL
8.30 a.m. - 9.00 a.m.	- Registration of Participants
9.00 a.m. - 9.30 a.m.	- Opening Addresses : Message of H.E. Ato Ketema Abebe, Minister of Public Health. Message of Dr T.A. Lambo, Deputy Director-General, WHO Headquarters Message of Dr A.H. Taba, WHO Regional Director, Eastern Mediterranean Region
9.30 a.m. - 10.00 a.m.	- Recess
10.00 a.m. - 10.30 a.m.	- Election of Officers
	- Adoption of the Agenda
	- Evolution of concepts of mental illness and of mental health care, by Dr F. Torrey Doct./4
10.30 a.m. - 11.00 a.m.	- Discussion
11.00 a.m. - 11.30 a.m.	- Existing concepts of mental illness in different cultures, and traditional forms of treatment, by Dr T. Asuni Doct./5
11.30 a.m. - 12.30 p.m.	- Discussion
	- Lunch break
14.30 p.m. - 15.00 p.m.	- The spectrum of mental disorders : How much of this spectrum should be the responsibility of mental health service, by Dr J.S. Neki Doct./6 (Presented by Dr K.C. Dube)
15.00 p.m. - 16.00 p.m.	- Discussion
16.00 p.m. - 16.30 p.m.	- Recess
16.30 p.m. - 17.15 p.m.	- (Reading of papers for next day)

WEDNESDAY, 28 November

9.00 a.m. - 9.30 a.m.	-	General principles of psychiatric care, by Dr T.A. Baasher Doct./7
9.30 a.m. - 10.30 a.m.	-	Discussion
10.30 a.m. - 11.00 a.m.	-	Recess
11.00 a.m. - 11.30 a.m.	-	General principles of preventive action in Mental Health, by Dr A. Kamal Doct./8
11.30 a.m. - 12.30 p.m.	-	Discussion
	-	Lunch break
14.30 p.m. - 16.00 p.m.	-	Case studies in groups
16.00 p.m. - 16.30 p.m.	-	Recess
16.30 p.m. - 17.15 p.m.	-	(Reading of papers for next day)

THURSDAY, 29 November

9.00 a.m. - 9.30 a.m.	-	Assessing the needs (At clinical levels through national statistics by population survey), by Dr R. Giel Doct./9
9.30 a.m. - 10.00 a.m.	-	ILLUSTRATIVE PRESENTATION : Analysis of cases seen at out-patients, by Dr O. Shaheen Doct./10
10.00 a.m. - 10.30 a.m.	-	Discussion
10.30 a.m. - 11.00 a.m.	-	Recess
11.00 a.m. - 11.30 a.m.	-	Methodological problems of data collection and analysis, by Miss E. Brooke Doct./11
11.30 a.m. - 12.00 noon	-	ILLUSTRATIVE PRESENTATION : Analysis of National Statistics of Mental Health Services, by Dr T.A. Baasher Doct./12
12.00 noon - 12.30 p.m.	-	Discussion
	-	Lunch break

THURSDAY, 29 November (Cont'd)

14.30 p.m. - 16.00 p.m.	-	Case studies in groups
16.00 p.m. - 16.30 p.m.	-	Recess
16.30 p.m. - 17.15 p.m.	-	(Reading of papers for next day)

FRIDAY, 30 November

9.00 a.m. - 9.30 a.m.	-	ILLUSTRATIVE PRESENTATION : of a population survey of mental disorders, by Dr R.L. Kapur Doct./13
9.30 a.m. - 10.30 a.m.	-	Discussion
10.30 a.m. - 11.00 a.m.	-	Recess
11.00 a.m. - 11.30 a.m.	-	Principles of planning I (Administration and Organization), by Dr K. Bhaskaran Doct./14 (Presented by Professor A. Mamugian)
11.30 a.m. - 12.30 p.m.	-	Discussion
	-	Lunch break
14.30 p.m. - 16.00 p.m.	-	Reporting of case studies
16.00 p.m. - 16.30 p.m.	-	Recess
16.30 p.m. - 17.15 p.m.	-	Reporting back (Continuing)

SATURDAY, 1 December

9.00 a.m. - 9.30 a.m.	-	Principles of planning II (Demographic and economic aspects of Mental Health Care in Developing Countries), by Dr A. Benyoussef Doct./15
9.30 a.m. - 10.30 a.m.	-	Discussion
10.30 a.m. - 11.00 a.m.	-	Recess
11.00 a.m. - 11.30 a.m.	-	Principles of planning III (Staffing requirements), by Dr M.R. Chaudhry Doct./16
11.30 a.m. - 12.30 p.m.	-	Discussion
	-	Afternoon free
SUNDAY, 2 December	-	Free day

MONDAY, 3 December	-	TRAINING OF PERSONNEL
9.00 a.m. - 9.30 a.m.	-	Psychiatry in Basic Medical Education, by Dr G.M. Carstairs Doct./17
9.30 a.m. - 10.00 a.m.	-	Discussion
10.00 a.m. - 10.30 a.m.	-	Training of Psychiatrists, by Dr N.N. Wig Doct./18
10.30 a.m. - 11.00 a.m.	-	Recess
11.00 a.m. - 11.30 a.m.	-	Discussion
11.30 a.m. - 12.00 noon	-	Training of Nurses, by Mr M. Kozma Doct./19
12.00 noon - 12.30 p.m.	-	Discussion
	-	Lunch break
14.30 p.m. - 15.00 p.m.	-	Types and roles of Auxiliaries, by Dr C. Swift Doct./20
15.00 p.m. - 16.00 p.m.	-	Exercise in Groups. (Each group asked to define the content of instruction to be given to one specific type of Auxiliary : e.g. Nursing Assistant in a rural health centre).
16.00 p.m. - 16.30 p.m.	-	Recess
16.30 p.m. - 17.15 p.m.	-	Reporting back by groups.
TUESDAY, 4 December		
9.00 a.m. - 10.00 a.m.	-	Completing the Questionnaire on Evaluation of the Seminar
10.00 a.m. - 10.30 a.m.	-	Essential requirements of Mental Health Legislation, by Dr K. Bhaskaran Doct./21 (Presented by Professor A. Manugian)
10.30 a.m. - 11.00 a.m.	-	Recess
11.00 a.m. - 11.30 a.m.	-	Discussion
11.30 a.m. - 12.30 p.m.	-	Evaluation of services, by Dr F.R. Hassler Doct./22
	-	Discussion
	-	Lunch break

TUESDAY, 4 December (Cont'd)

14.30 p.m. - 16.00 p.m.	Chairman : Dr Fikre Workineh Recommendations. Discussion of Seminar and its follow-up. Report on Questionnaire.
16.00 p.m.	SEMINAR ENDS

ANNEX IV

LIST OF BASIC DOCUMENTS

PROVISIONAL AGENDA	EM/SEM.ORG.MH.SERV./1
PROGRAMME OF THE SEMINAR	EM/SEM.ORG.MH.SERV./2
LIST OF PARTICIPANTS AND OBSERVERS	EM/SEM.ORG.MH.SERV./3
EVOLUTION OF CONCEPTS OF MENTAL ILLNESS AND OF MENTAL HEALTH CARE Dr F. Torrey, Special Assistant to the Director, National Institute of Mental Health, Rockville, USA	EM/SEM.ORG.MH.SERV./4
EXISTING CONCEPTS OF MENTAL ILLNESS IN DIFFERENT CULTURES AND TRADITIONAL FORMS OF TREATMENT by Dr T. Asuni, Medical Superintendent, Neuro-Psychiatric Hospital, Aro Hospital, Abeokuta, Nigeria	EM/SEM.ORG.MH.SERV./5
THE SPECTRUM OF MENTAL DISORDERS : HOW MUCH OF THIS SPECTRUM SHOULD BE THE RESPONSIBILITY OF THE MENTAL HEALTH SERVICE by Dr J.S. Neki, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India	EM/SEM.ORG.MH.SERV./6
GENERAL PRINCIPLES OF PSYCHIATRIC CARE by Dr T.A. Baasher, Regional Adviser on Mental Health, Eastern Mediterranean	EM/SEM.ORG.MH.SERV./7
GENERAL PRINCIPLES OF PREVENTIVE ACTION IN MENTAL HEALTH by Dr Ali Kamal, Director, Department of Mental Health, Ministry of Public Health, Baghdad, Iraq	EM/SEM.ORG.MH.SERV./8
ASSESSING THE NEEDS (AT CLINICAL LEVELS THROUGH NATIONAL STATISTICS, BY POPULATION SURVEY) by Dr R. Giel, Professor of Social Psychiatry, University Hospital, Groningen, the Netherlands	EM/SEM.ORG.MH.SERV./9
ILLUSTRATIVE PRESENTATION : ANALYSIS OF CASES SEEN AT OUT-PATIENTS by Dr O. Shaheen, Head, Psychiatry Department, Cairo University, Cairo, Egypt	EM/SEM.ORG.MH.SERV./10
METHODOLOGICAL PROBLEMS OF DATA COLLECTION AND ANALYSIS. by Miss Eileen Brooke, Head Department of Medical Statistics, Research Institute of Social and Preventive Medicine, University of Lausanne, Lausanne, Switzerland	EM/SEM.ORG.MH.SERV./11
ILLUSTRATIVE PRESENTATION : ANALYSIS OF NATIONAL STATISTICS OF MENTAL HEALTH SERVICES by Dr T.A. Baasher, Regional Adviser on Mental Health, Eastern Mediterranean	EM/SEM.ORG.MH.SERV./12

ANNEX V

LIST OF BACKGROUND MATERIAL

WHO Expert Committee on Mental Health (1962) Eleventh Report. The Role of Public Health Officers and General Practitioners in Mental Health Care. (Wld Hlth Org. Techn. Rep. Ser., No.235.)

WHO Expert Committee on Mental Health (1967) Fourteenth Report. Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs. (Wld Hlth Org. Techn. Rep. Ser., No.363.)

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Mental Health programme of the World Health Organization, 1949 - 1972. (1972) (WHO/MH/72.4).

Stanley & Tsy Yi Lin - The Scope of epidemiology in Psychiatry - PHP 16

WHO South East Asia Regional Office (1971) Report on a Seminar on the Organization and future needs of Mental Health Services (SEA - 71/2816)

WHO European Regional Office (1973) - The Methodology of Psychiatric out-patient data collection - Report on a Pilot Study - EURO 5404 II by Miss E.M. Brooke.

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