WORLD HEALTH ORGANIZATION
Regional Office for the
Eastern Mediterranean

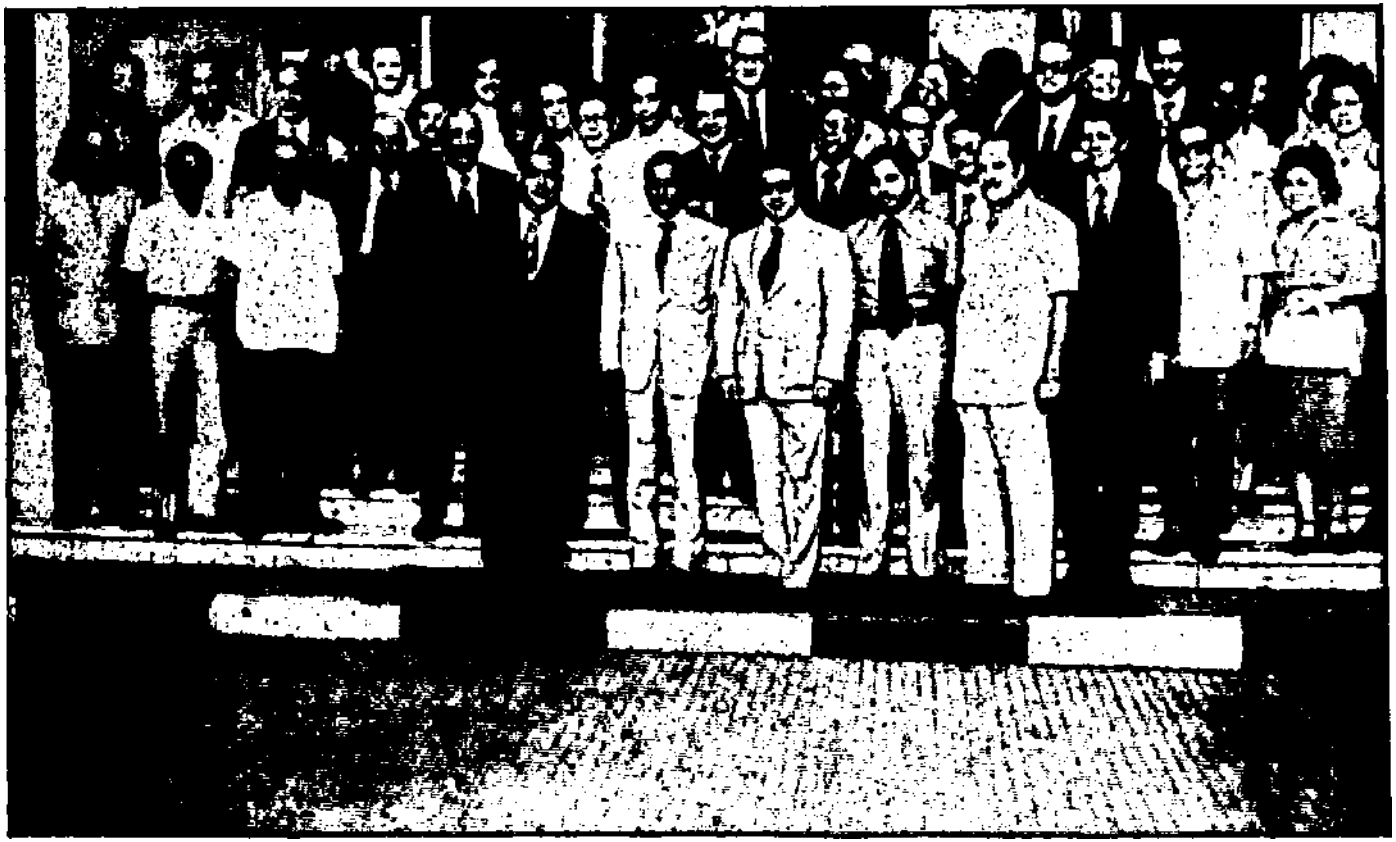
EM/MENT/82
EM/GR.MTG.MH.ML./12
EM/ICP/MNH/004/RB

September 1976

GROUP MEETING ON MENTAL HEALTH AND MENTAL LEGISLATION

Cairo, Egypt
12 - 17 June 1976

The views expressed in this report do not necessarily reflect the official policy of the World Health Organization.



Group of Participants who attended the Group Meeting on Mental Health and Mental Legislation, held in Cairo from 12 to 17 June 1976

TABLE OF CONTENTS

I INTRODUCTION

The meeting was held in Cairo, at the Nutrition Institute, from 12 to 17 June 1976.

In his opening address[1] His Excellency, Dr Fouad Mohyeldin the Minister of Public Health of Egypt, welcomed participants to Egypt, and stressed the importance of psychological factors in the overall concept of health. The rapid development of science and technology had given rise to social changes and to contradictions between old, strong traditions and newer standards and concepts. Mental health held a prominent place in health programmes and the development and training of a wide range of manpower for mental health services was of great importance, as was the need to examine existing mental health legislation. A principal objective of such legislation should be to preserve the rights of patients and to encourage humanitarian and effective treatment, while at the same time protecting society as a whole.

Dr A.H. Taba[2], Director of WHO Eastern Mediterranean Region stressed the recent socio-economic changes in the Region which influenced the health field. With continuing progress in the control of major communicable diseases, mental health was emerging more and more as a major public health problem. Recent resolutions of the World Health Assembly together with the lively discussion and resolution adopted at the Regional Committee Meeting in October 1975 in Teheran indicated increasing awareness and concern over mental health problems. Mental health services were being steadily built up in a number of countries but recurring difficulties were still encountered. A flexible approach was required to meet increasing needs and to extend coverage to rural and urban areas.

II THE PURPOSE AND ORGANIZATION OF THE MEETING

The Eastern Mediterranean Regional Office first held an Group Meeting on Mental Health in Alexandria in 1972 to bring together leading mental health professionals to review mental health needs, resources and programmes in the Region. The present meeting was intended to make an assessment of the impact of the earlier meeting and to review progress in the Region. Discussion focussed on topics of particular importance in the Region: the care of the mentally abnormal offender; problems of drug dependence; prevention and care in mental retardation and training of auxiliaries. The presence of leading mental health and legal experts gave an opportunity to review mental health legislation in detail, based on a recent international survey carried out by WHO. WHO Headquarters had been involved in preparations for the meeting and several temporary advisers with specific expertise in legislation had been invited to participate.

---

[1] See Annex I for full text of Address

[2] See Annex II for full text of Address

III MENTAL HEALTH SERVICES IN EASTERN MEDITERRANEAN COUNTRIES: THE NEEDS AND RESOURCES

1. General

The Eastern Mediterranean Region comprises twenty-four countries, with a total population of over 300 million, which present a wide variety of geographical and socio-economic conditions. It contains some of the least developed countries in the world and some with the highest per capita income. Rapid cultural and socio-economic change in the Region is significantly changing some of the oldest towns in the world and a population which contains 80 per cent of the nomads of the world.

Until recently, mental health activities were isolated and information was lacking. Such hospitals as existed were cut off from the main stream of health services and psychiatry was neglected. Data collected from twenty countries, show that there are 30 000 patients in mental hospitals and that many patients in the general health services show symptoms of major or minor psychiatric illness. Beds for the mentally ill are available in countries at ratios ranging from 1 ; 10 000 to 14 : 10 000. The large mental hospitals built in some countries during the last century, often badly staffed, continue to operate in isolation, outmoded and irrelevant to needs, having failed to establish any relationship with other health services.

With the reduction of communicable diseases in the Region, the extent of mental health problems has become more evident, particularly of mental retardation, drug dependence, mentally abnormal offenders, and psycho-social problems of migrant labourers and the elderly.

Many factors, including the paucity of accurate statistical data, have led to relative neglect by health administrators and the resources were not available to deal with mental health problems.

The situation has been affected by a shortage of manpower,always widespread and worsened by the "brain drain" of trained personnel to other countries. In addition, people are still inclined to attach a stigma to mental illness.

The demand for services varies from the one extreme of modern sophisticated psychiatric care to urban populations to the total dependence on traditional faith healers in the rural and poorer communities.

Health, social welfare, interior and other government departments deal with components of mental health problems, but overall co-ordination is lacking at departmental or ministerial levels.

Innovative methods of theoretical and practical training in countries could extend much needed services. In one country, from a baseline of thirteen psychiatrists for twelve million population,

a one-year training programme for general medical practitioners increased the number to forty psychiatrists, with twenty more expected shortly. In another country a local Diploma in Psychiatry has been introduced, which has already improved the local staffing position.

Since the Group Meeting in 1972, a number of specific activities have revealed the new thinking and urgent action in the Region. WHO and the governments of fifteen countries have discussed the development of national policies and plans for better mental health services. An Inter-regional WHO Seminar on the Organization of Mental Health Services in Developing Countries, held in Addis Ababa in December 1973[1], prepared the ground for the subsequent WHO expert Committee meeting[2] on this important topic.

A regional meeting, prepared jointly with WHO Headquarters, on the Application of Psychiatric Epidemiology, held in Khartoum in February 1975, resulted in similar meetings in several countries in the Region. A series of national seminars and meetings on a wide variety of mental health problems have been held in a number of countries.

Education and training of mental health personnel is given on an inter- and intra-country basis. Development of medical undergraduate and post-graduate teaching in psychiatry was assessed by WHO following the earlier activity in 1970[3].

It is recognized that traditional healers are still widely used in some countries and they are not to be denigrated. Instead the best possible use should be made of resources offered by traditional medicine.

Integration of mental health services with general health services is beginning and psychiatric units have been developed in general hospitals, and out-patient and consultative health services integrated at primary care level.

2. Specific topics for special study

Four sub-groups were formed, each of which studied a topic of prime importance as follows.

2.1 Care of Mentally Abnormal Offenders

The document[4] "Care of mentally abnormal offenders" deals with probably the first comprehensive survey of the problem of mentally

---

[1] EM/MENT/63, EMRO 5401, June 1974.

[2] Wld.Hlth.tech.rep.ser. 564, 1975.

[3] EM/MENT/43, EM/Ed.Tr./213, Seminar on the place of psychiatry in Medical Education, Alexandria, 8-15 July 1970.

[4] EM/GR.MTG.MH.ML./5.

abnormal offenders ever conducted in the Region. Credit was due to the authors for having undertaken visits to practically all countries thus adding to the validity of the data. Except for a study in Iraq in 1975, no other relevant literature is available for the Region. The difficulties encountered by the study, included the fact that a number of authorities dealt with the mentally abnormal offender, namely the police, the prosecuter, the jurist, the prison officer and the psychiatrist. In some countries no special records of these patients were kept. The study indicated that socio-economic progress has, paradoxically, resulted in an increase in the number of mentally ill patients, especially vagrants, the homeless and the excited in penal institutions. Historically, of course, in most countries, the care of the mentally disturbed was initially provided within the prison system and still is undertaken either within the existing psychiatric services or within the penal system. The former seemed to be the more frequent in the Region.

Only one country in the Region (Egypt) has a special hospital for the mentally abnormal offender, but at least four countries provide these services within the psychiatric services as well as within the penal system. More than one-third of the countries has locked wards within psychiatric hospitals. Security measures in these wards also vary from single closed wards to open wards within locked, high-walled court yards.

Within the penal system, the custody of mentally abnormal offenders is carried out in separate units in prisons, detention centres, special institutions and asylums. Sudan is exceptional in having established during the last twenty-five years five separate, special institutions for forensic psychiatric care.

Reasons for admission range from vagrancy to management of a patient legally convicted but recommended for psychiatric care. One striking feature is that in no country is there an official body responsible for the care of the mentally abnormal offender. In a number of countries, this task is given to ad hoc committees, often comprised of psychiatric hospital physicians.

The deficiencies in the care of the mentally abnormal offender are generally reflected in the lack of qualified workers in this complex field. Forensic psychiatric teaching is rarely included in any undergraduate medical education programmes. On the whole, the treatment programmes are deficient and often lead to chronicity and personality deterioration.

At a professional level, the greatest deficiency seems to be the absence of any concept of diminished responsibility in the legal system of most countries. Fitness to plead or to stand trial is often ignored. The relative merits of the Anglo-Saxon and Napoleonic legal systems were considered. In the former, the psychiatric expert provides guidance to the jury and, under

the latter, the judge depends on expert advice solicited from judicial and medical experts. This led to consideration as to whether the whole question of the mentally abnormal offender was strictly a medico/judicial problem or one in which both were accountable to the public. This also involved questions concerning the authority most competent to order the release of a mentally abnormal offender.

Mention was also made of the Children's Act of 1935 in Sind (Pakistan), where a special Court decides on cases pending against offenders below the age of legal responsibility. Proceedings are held in camera without intermediation of the legal profession and are privileged. The convicted person is returned to the custody of the parents, if found suitable, or sent to a Remand Home or Borstal Jail depending on his age. Both are appropriately supervised by statutory visitors.

Concern was expressed that the problem of the mentally abnormal offender suffers not only from paucity of suitably qualified professional personnel but also from the lack of a philosophical approach to the problem. Is incarceration for reasons of the person's health, or public safety, or both?. If the safety of society is the main concern, then there was need to develop valid diagnostic criteria to detect offenders more prone to repeat criminal acts. These inevitably required better services, adequate legal provisions, enlightened community attitudes and an improved follow-up system. Concern was also expressed for the families of mentally abnormal offenders, who rarely receive any support or guidance, and constitute a "high risk group".

It was felt that while the problem of psychopathic personality was too complex in the present state of social development of the Region, nevertheless, the medical and judicial profession must address itself to differentiating between legal aspects and the urgent need to provide psychiatric care.

2.2 Problems of Drug Dependence

In view of the worldwide interest in the problem of drug dependence[1], it was felt that there was a need for carefully planned studies in the Region, to establish the size and extent of the problem with reasonable accuracy and to allow the correct determination of inter se priorities within the larger mental health programme.

[1] EM/GR.MTG.MH.ML./6

The Group recognized that in the recent past some visible changes have taken place in the pattern of drug abuse - viz more adolescents taking drugs, and their use has also extended to the female population in a Region hitherto relatively resistant to change in social behavioural patterns. There was also a noticeable shift to the use of synthetic drugs, which emphasized the need to prevent indiscriminate prescribing of dependence-producing medications by the medical profession. Hope was expressed that as a result of the Second Convention in September 1976, some drugs will be under increased surveillance.

Concern was expressed that repressive measures in some countries seemed to have intensified the problem, instead of reducing it. Maximum penalties and extreme measures appear to be nullified by the ingenuity of traffickers and pushers, as profits increase in direct proportion to the increased risks involved.

Greater attention needs to be paid to the identification of the causes of the increase in drug dependence - premorbid personality being an important determinant often disregarded. Contributory causes include the stresses of modern, complex urban life.

Drug dependence is linked to crime as a cause and as an effect. The problem was one that requires the attention of the whole community, including governments, leaders, educationalists, jurists, social workers, and the medical profession, with the technical advice and support of psychiatrists. Isolated severe legal measures or purely therapeutic approaches have, as was to be expected, fallen far short of expectations. The answer appears to lie in a holistic approach, with a judicious mix of urging, education, compassionate treatment, with group pressure and adequate follow-up. Legal measures should be realistic and based on well-established scientific evidence which will deal strictly with traffickers and pushers, but be lenient to growers and considerate to users.

Psychiatric treatment of drug dependence was discussed at length and the examples of good models of therapeutic processes were cited from Yaft Abad (Iran) and Ataba (Egypt). During the discussions, a note of warning was expressed about the counter-productive effects of widespread dissemination of information about drug usage - its problems and hazards.

A note of caution was expressed about over-enthusiasm for treatment programmes, even with hard drugs like opium, as in some countries of the Region, elderly persons were known to be stabilized on a steady dose and it was inadvisable to attempt to wean them off this.

2.3 Prevention and Care in Mental Retardation

The problem of mental retardation[1] is becoming increasingly evident because of decrease in communicable diseases, and increased life expectancy of brain-damaged infants. Social factors such as disintegration of the extended family, rapid urbanization and consequent need for learning more complex skills, all made previously covert retardation more obvious. Universal education is also an important element in uncovering mentally retarded individuals.

The complex and difficult task of classification and nomenclature may be approached on the more pragmatic lines of considering mental retardation as a failure of social adaptation and using the IQ as a secondary and less important quantitative indicator. This approach is important for the Region as estimates of IQ are dependent on adequate test instruments that are culturally unbiased and the availability of trained psychometrists, both of which are very scarce. However, there is no reason why a concerted effort should not be made to develop indigenous test instruments or adapt and standardize the more commonly used tests to the cultures and subcultures of the Region.

Studies in some countries, especially Pakistan, revealed that infection of the brain constitutes the largest single category of the causes of mental retardation, followed by other causes of brain damage resulting from maternal malnutrition and poor maternity and early infant care. This immediately determines the obvious priority of prophylactic measures during pregnancy to protect the mother and the unborn child. Nutrition and adequate antenatal care immediately present themselves as potential areas of concern. Improved midwifery and immediate post-natal care is another area which will be most rewarding as preventive measures.

Identification and case-finding should be accelerated in order to locate the retarded early enough to initiate training programmes.

Because of the widespread ramifications of the problem of mental retardation into fields of education, social welfare, legal and health activities, it should not become exclusively a medical problem. But it seemed inevitable that, at least at the present stage of development, a local hospital would appear to be the logical site for initial contact with the services. It is here that people tended to turn for advice and it would be easy to mobilize the services of all the disciplines required to make a proper assessment.

Factors affecting planning were also discussed and the Group felt that the type of services and facilities required will be influenced by the number of individuals in the various levels of retardation - mild, moderate, severe and profound - (classification adopted by WHO), and in age classifications such as children

[1] EM/GR.MTG.MH.ML./7

(pre-school and school age) and adults. Planning also needs to be related to other forms of community planning and to the social and economic trends,and services must be based on and utilize the available resources. Ingenuity and innovation in developing programmes now were essential, rather than hope that at some future date all the sophisticated elements required for a high grade programme will materialize.

In the view of the Group, governments should develop an inter-ministerial body involving the departments of Health, Social Work, Education and Justice, to ensure better co-ordination between the activities of agencies and between the government and voluntary agencies interested in mental retardation. The responsibility for care of the various groups of mentally retarded will have to be shared by the departments and ministries. Pre-school and school children will be the responsibility of the education department, which should include psychological services in its system. The moderate to the profound group, which requires occupational and day care programmes for the young, who will progress to rehabilitation when they reach adulthood, could be the responsibility of the labour and social welfare departments. Rehabilitation should be more realistic, training in agriculture, simple occupations, and low key workshops where the skills involved are more relevant to the prevalent social and economic situation being preferred. Emphasis was placed on developing programmes for multiple-handicapped persons, instead of solely for the mentally retarded. The group realized that in spite of the emphasis on the need to keep as many as possible of the retarded in the community, institutional custody of a small group of mentally retarded persons is still required, which would probably be the responsibility of the health department. On the other hand, many mildly retarded children might be educated with other children, although their educational progress would be slower and they would often have to repeat grades. This would contribute to a general policy of "normalization" of the life of disabled people.

Legal aspects of mental retardation require greater attention in the countries of the Region. There is little legislation in any of the countries relating to the rights and privileges of the mentally retarded, nor are there any statutory provisions making it mandatory for governments to provide the much needed services.

Finally, it was felt that much more publicity and public information campaigns are needed to inform and motivate the community on behalf of the mentally retarded. More literature, films, radio and television programmes and sponsorship at all levels of the community are needed to achieve this end.

2.4 Training of Auxiliaries[1]

Introduction

In the developing countries, most of the needs for mental health care remain unmet. For example in a typical rural community of 1 000 people, the following can be found on any single day:

1. Two people would have active functional psychoses which would benefit from immediate short-term treatment.

2. Ten people would be suffering from functional psychoses in recent months or years and would therefore be in need of follow-up care.

3. Depending on road traffic and infections, five to ten people will be disabled as a result of organic brain damage.

4. Five people would be suffering from grand mal epilepsy and should be on maintenance therapy.

5. Mental retardation to a degree impairing social functions would affect from twenty to thirty children of school age as well as a similar number of adults.

6. The largest group of mentally disordered would comprise those with minor psychiatric problems. Even if only those with at least three psychiatric symptoms for example sleeplessness, anxiety and depression are included at least 50 would be affected. These are normally self-limiting and the majority improve in two to three months. However, from the public health point of view people with such "minor" disorders overtax the existing health services by presenting themselves with somatic symptoms. Peripheral health workers are unable to detect their problems as psychiatric and, therefore, "medicalize" their condition.

What could an auxiliary health worker do in such a community?. For one thing, they offer the only hope of providing care. Neither psychiatrists, psychiatric nurses, general nurses nor the general duty doctor can have a direct impact to reach the people in rural areas and help them.

Health care at the community level will have to be taken up by the community if change is to occur by training people from the community as primary health workers. The first task of such a primary health worker will be immunization and environmental health, e.g. clean water and dealing with the most common killing diseases.

---

[1] EM/GR.MTG.MH.ML./8

Since the training of such health workers in many countries is only six months or less their mental health training will have to be limited and realistic, if they are to undertake any mental health work.

At the end of their training what tasks should they be able to perform? What are the educational objectives?

It will not be realistic to expect the primary health worker to be a skilled therapist or to use minor tranquilizers. The objective is not to "medicalize" the problems but to get in touch with the people in the village to solve the problem.

Among the tasks that these primary health workers could carry out are:

1. Dealing with acute psychiatric disturbances such as aggressive behaviour or social withdrawal with simple methods and understanding. For example simple examination and observation could identify most patients whose acute disturbance has an organic basis.

2. To be able to initiate treatment for patients with acute psychoses. Such people may be abused physically and may not be given food and drink. The death rate is usually high. Health workers reduce mortality by helping such patients to get food and drink, preventing physical abuse and using a tranquillizing drugs over a limited period.

3. Armed with a limited number of drugs, e.g. chlorpromazine and phenobarbitone, they can treat some cases in the acute and early phase or in life-threatening situations when there is no recourse to other help. In other circumstances patients can be referred to a health centre or general hospital for treatment.

4. Patients who have received treatment at a health centre or local hospital may be able to return to their families, provided they receive social support and maintenance drug therapy. Local health workers could provide the necessary support and ensure that patients are taking the necessary drugs. They could also mobilize help for patients within the community.

Another important group of auxiliaries are the attendants, aides, nurse assistants who work in mental hospitals. Their turnover is usually high, they are paid low salaries and their jobs carry with them the stigma of mental hospitals. These auxiliaries are more in touch with the patients. How can we increase their skills and therapeutic effectiveness? Can they be utilized also in the community, i.e. going to the patient or with the patient and even staying in his/her home to make re-entry into the community easier?

Their training, responsibilities given and the availability of supervision and services for referral all influence the effectiveness of auxiliaries' contribution.

Auxiliaries working in the community

Following discussion it was agreed that the following observations could provide the basis for future action:

1. Medical auxiliaries exist in all countries of the Region under various names, and they serve an important function.

2. There are various types of auxiliaries with varying degrees of training rendering various types of services in the health services. Generally speeking, these can be classified into (a) high level auxiliaries like the medical assistants and (b) low level auxiliaries which can be in (i) mental hospitals as attendants, aides and nursing auxiliaries, or (ii) working in the community as primary health or village health workers.

3. These auxiliaries with additional training in mental health other than their training in the other fields of medicine can help to ameliorate the shortage of manpower in the mental health field by using existing health manpower to incorporate mental health activities into their normal activities.

4. The level of education prior to coming to the training and the length of the training programmes to equip them to the task they are going to perform were left to be decided by the individual countries. However, it was suggested that these auxiliaries, should at least, read and write the local language.

5. The training should be task-oriented. Those involved in preparing the programme should first find out how mental diseases manifest in the particular region for which they are being trained.

6. Who should train them? Highly specialized persons like the psychiatrist are too far removed from these trainees to be primarily responsible for their teaching. In many cases psychiatric nurses would be in a better position to do the teaching. However, psychiatrists should have a say both in planning and supervising the programme. The need to include behavioural scientists in the planning of the programme was also stressed.

7. Training of auxiliaries should be related to the planned development of the overall future health services of a country.

8. There should be refresher courses to upgrade the auxiliaries in line with the changing situation within the region or country where they are working.

9. Auxiliaries can be used for case finding, advising individuals and families in matters related to health and mental health by helping them to find the solution within the community,(this calls for knowledge of the social and health resources). They could check that the patient gets the necessary medicine, and that the patient is taking it regularly and properly. With training, they can detect side effects of drugs. They could treat acute and life-threatening conditions, e.g. status epilepticus and acute psychosis, if they have a knowledge of a very limited but effective list of drugs,e.g.chlorpromazine and phenobarbitone.

10. If their use is to be effective, there is a need for regular supervision of the auxiliaries and the availability of services for referral.

Hospital based auxiliaries

Most of the points under community based auxiliaries apply also for hospital auxiliaries. Emphasis in the methodology of training should be more on small groups and seminars and it should be continuous. Lecture type teaching should be discouraged.

Hospital based auxiliaries should work also outside hospitals by going into the community, to the patients' homes upon discharge to help him, his family and the community to adjust to the new situation.

For both community and hospital based auxiliaries evaluation programmes are needed.

IV MENTAL HEALTH PROGRAMME STRATEGIES

Mental health needs and resources in the Eastern Mediterranean Region are similar to those in many other developing countries in Latin America, Africa and Asia. In most countries, there is a growing awareness of the extent of mental health problems, ranging from the need to care for the vast numbers of people mentally ill and with psychosomatic disorders to psycho-social factors influencing health care and general socio-economic development. The numerous resolutions adopted by the WHA[1] during its recent sessions are an expression of this increasingly felt need and request WHO to co-operate with countries in their dealing with mental health problems.

---

[1] WHA 26.52, WHA 28.57, WHA 28.80, WHA 28.81, WHA 29.21, Resolution EM/RC25A/R.14, October 1975 is also relevant.

Inadequate information for mental health programmes and a negative attitude to mental health problems due to shortage of manpower and facilities and a lack of adequate methodology taken in conjunction with the extent of the problems call for new strategies which have to be employed in the field of mental health.

Although new strategies will have to be adopted to specific situations, they will have some common characteristics. They must guarantee immediate action rather than prolonged investigation; they must be capable of producing visible and measurable results (e.g. reduction of individual and social complication of acute psychotic states); they must be cost-effective and appropriate to the resources available; they should utilize fully as yet unused resources (such as greater use of auxiliaries); they must be adapted to cultural and socio-economic characteristics of the country concerned and be based on a national commitment to a mental health policy.

1. National policies on mental health

Unless a clear statement of national decisions concerning mental health problems is formulated in a coherent national policy, it is unlikely that progress can be achieved. Policy decisions would concern priorities, objectives, legal and administrative provisions for mental health care, training and research; would consider the programme co-ordination and evaluation mechanisms, would make provision for review and updating of decisions; and would state responsibilities for implementation of programmes in unequivocal terms.

National mental health policies cannot be formulated by any single individual; co-ordination of views between and involvement of Ministries, governmental agencies, professional organizations and teaching institutions are essential; in most instances it is best to create a national co-ordinating committee which will formulate the policy and see to its implementation. Ad hoc multidisciplinary committees could be created to deal with problems where close co-ordination is particularly important, such as mental retardation and drug dependence.

These latter groups should include psychiatrists and other mental health professionals, those responsible for manpower development and drug policies, public health administrators, other relevant disciplines, representatives of other ministries, professional and voluntary organizations. Whenever possible, the national mental health policy should be an integral part of the national health plan.

The basic principles of a national policy could be summarized as follows:

(a) Selection of priorities

As resources are insufficient to cover all mental health needs, priorities should be based on criteria of prevalence, harmful consequences to the individual and the community, the availability of inexpensive and effective methods of management, and a realistic assessment of the country situation. Mental health professionals should avoid the danger of "overselling" themselves and arousing expectations which cannot be met. Whenever possible primary, secondary and tertiary preventive measures should be adopted. Similarly, in selecting research priorities, relevance to country needs should be the main criterion.

(b) Decentralization

This implies not only avoidance of large, custodial institutions but the extension of mental health care through provisions in general hospitals, health centres and in primary health care services, supported by an appropriate administrative framework for decentralized decision making.

(c) Integration with general health services

As the main mechanism of integration is training, increasing the amount and relevance of psychiatric teaching in medical undergraduate training would lead to more rational and informed response to mental health problems. Simple and circumscribed mental health care tasks could be assigned to peripheral health workers, provided that suitable methods of training are evolved. Again, such integration must be backed by appropriate administrative provisions.

(d) Community participation

There is far too little direct involvement of community resources in mental health care. The active involvement of teachers, police, community leaders and religious men should be secured. In some situations, contact with traditional healers may be useful and a study of the "role" and effectiveness of such healers should receive urgent consideration.

2. Mechanism of implementation

Programme implementation will involve:

(a) the acquisition and utilization of knowledge: well-designed studies and the collection and utilization of information as part of the national health information system.

(b) strengthening of resources: manpower development, establishment of units in general hospital, referral systems and drug supplies.

(c) programme evaluation: based on the health effect of interventions, their acceptability and their cost.

(d) co-ordination: with education services, welfare agencies, voluntary organizations, etc.

3. The role of WHO

Recognizing the variety of mental health needs and resources in the countries of the world and in consultation with them the new global mental health programme of WHO has been structured so that activities at national, regional and global levels complement each other and jointly present a cohesive response to country needs.

In this programme, the activities in the Eastern Mediterranean Region take a specially important place; there is a tremendous variety of socio-economic conditions, vast natural and human resources and, at the same time, trained manpower and facilities against the background of rapid industrial and technological development.

The programme includes five groups of activities.

The first group of activities consists of those designed to improve services for the mentally ill. The priority conditions which are the target of these activities fall into two groups: firstly, conditions which are prevalent and severely incapacitating all over the world. These include acute psychiatric emergencies, chronic psychotic states, widespread neurological disorders such as epilepsy, and conditions seen in groups of increased vulnerability, such as children and the old. The second group of priority conditions are of regional significance and include alcoholism, which takes its heaviest toll in Africa, the Americas and Europe; and drug dependence occurring in parts of Europe and in large parts of Asia and the Americas. The primary approaches to deal with these conditions are the integration of mental health components into the general health services; decentralization of mental health services where they exist and extension of their coverage, particularly to rural areas; identification and use of community resources including indigenous systems of care; development of mechanisms ensuring community participation and the development of improved technologies suitable for application, particularly in developing countries.

The second group of proposed mental health activities deals with the development of manpower resources. Here the focus is on: the addition of mental health skills to the repertory of the general practitioner, the primary health care provider, the decision maker and the public health planner (rather than the production of mental health specialists); the addition of public health skills and attitudes to the functions of mental health workers where they exist; and the development of research potential through research training contributing to country self reliance in research relevant to its needs.

The third group of activities concerns the psychosocial aspects of the environment. Here the priority will be the development of skills and identification of resources that can assist communities exposed to increased psychosocial stress, such as those undergoing rapid urbanization and the uprooted. In addition, an activity will deal with the development and application of techniques minimizing mental health risks in the working environment. The primary approach in this area will be the development of methodologies and co-ordination of international efforts.

The fourth group of activities deals with research. A central theme of these activities is the need to increase relevance of research to country needs, while retaining technical soundness and scientific quality. The activities could be divided into three sub-groups: firstly, those that will generate knowledge necessary to implement other activities and achieve the overall goal of the programme (e.g., development of epidemiological methods for service evaluation and for assisting countries in the assessment of the mental health needs; or the development of improved treatment technology); secondly, research necessary to shift the emphasis of the programme from mental illness to mental health (e.g., on the definition of factors protecting or improving the healthy mental functioning of individuals and families, and explaining low consultation and hospitalization rates in certain individuals and groups); and, thirdly, activities necessary for the co-ordination of effort in mental health research (e.g., the development of methods of collaboration in biological and psychopharmacological research).

The fifth group of activities is concerned with programme support. Improving co-ordination between the different services and agencies that are involved with mental health problems is a central theme in this work and involves close collaboration with the United Nations and its other specialized agencies. This approach is particularly important in dealing with drug dependence and alcohol related problems, mental retardation and juvenile delinquency. Emphasis is also placed on developing a common language which will facilitate communication between mental health professionals and other health and social service personnel. This in turn contributes towards WHO's efforts to provide users with timely, relevant and reliable information concerning mental health needs and services which will be used in planning and evaluation of national mental health programmes.

The basic principles of country programmes outlined above have been applied to the WHO mental health programme. Co-ordination between Regions and with other WHO programmes is achieved through a Co-ordinating Group for the mental health programme which includes members of the secretariat from countries, Regional Offices and Headquarters as well as leading mental health professionals, public health administrators and representatives of non-governmental organizations. Co-ordinating activities throughout the world involves not only overcoming unnecessary duplication of work but producing

mutual reinforcement by rapid exchange of information, joint activities and sharing of methods of work and training. The pattern of activities which results is not uniform but a mosaic with individual, differentiated projects combining to provide a co-ordinated whole. In this way the WHO mental health programme contributes to the primary objectives of the Organization: co-operation with countries, so as to increase self-reliance and information transfer designed to avoid inappropriate adoption of technology and methods from other countries and to allow countries to develop relevant and realistic responses to mental health problems.

V MENTAL HEALTH LEGISLATION

Mental health laws vary widely in the world, from emphasis on protection of the property of the mentally ill, social control of the mentally ill, and regulations for admission to and discharge from hospitals, to regulating control and administration of mental health services and the actual control and administration of mental hospitals. In 1954, WHO carried out the first international review of mental health legislation and the Expert Committee[1] on mental health made a series of recommendations. This became a point of reference for many countries for over a decade. As it became apparent that the legislation surveyed in that report is no longer relevant or appropriate to the prevailing situation, it was decided that an attempt should be made to produce a model legislation, for the benefit especially of the developing countries. It was, later, considered that a wide survey of mental health legislation would be preferable, on the basis of which countries could assess their existing laws in relation to their socio-cultural situation and, when necessary, enact relevant, realistic laws designed to promote extension of effective mental health care.

The document entitled "Harmonizing Mental Health Legislation and Programme Objectives: an international survey" was the first step in preparing a publication based on the legal survey, which would include recommendations and suggestions for assessment and improvement of mental health legislation. The present Group Meeting was an integral part of further work needed to finalize the document and its comments and suggestions would provide guidance for the final stages of work. A questionnaire was sent to the WHO Expert Advisory Panel on Mental Health to all countries in this Region and to selected countries in other Regions, followed by a more detailed in-depth analysis and documentary validation of the information received from some selected countries. This review included not only the statutory provisions but also the operation of the law in the countries

[1] Wld.Hlth.Org. techn. rep. ser., 98, 1975

under review. The first realization was that mental health legislation, to be effective, should be realistic in terms of the facilities and related provisions for its proper implementation.

The survey indicated the main considerations that must be taken into account in deciding if it is imperative to have formal legislation at all, or to make changes in existing legislation. Following this, the survey proceeds to discuss the evaluation of the concepts governing legislation: concepts of mental illness, attitudestowards treatment, therapeutic progress, the changing attitudes towards and concern for the preservation of human rights. In this area, the role of the patient in the community, his rights for practical reasons, and the protection of the community, form an involved and complex process.

The survey revealed that interest in changing a law was not directly related to its "age" but more to the development and direction of social changes. The review also showed that the voluntary care system had become the major point of concern and interest in recent years. This was particularly true of the developed countries which obviously had a longer history of custodial care. Developing countries tend to have a higher percentage of a voluntary care system, as revealed in the responses to the questionnaire; perhaps because legal processes are less cumbersome in these countries, the definition is less precise and the judicial processes are applied more loosely.

The operation of the procedure involved in protection of the civil rights of the individual appeared to be a limiting factor in the movement from custodial care to newer approaches, which included voluntary admission, care in the community, preventive care, crisis intervention, etc. A major finding of the review was that there are many alternatives for mental health legislation and that individual countries should exercise careful selection and be prepared to adopt innovative legal approaches.

When the scope of legislation and its implications in making distinctions within the overall category of mental disorders are reviewed, it appears that the same wide variation appears from country to country. In the majority of countries, there is a basic general system including all forms of mental disorders; some combine mental illness and retardation but have separate legislation for other categories of mental health disorders; and some have separate legislation for mental illness and retardation, as well as separate legislation for all, or nearly all, other categories.

Some of the laws in these countries recognize different categories of disorders in their definitions, but nearly all make no distinction in the operation of the legal procedures. An exception is the Mental Health Act of 1959 in England and Wales,

where the general definition of "mental disorder" covers mental illness, sub-normality, and psychopathy, but the law makes some distinction in the process of admissions and discharges for the different sub-classifications. At the other extreme, the Indiana law in the United States, legislation uses the term "mental illness" to cover all categories, specifically including, "mental retardation, epilepsy, alcoholism, or addiction to narcotic or dangerous drugs".

All this implies that, as in medicine where progress is producing sub-specialities, in mental health legislation the laws are also changing to special categories. From a compendium type legislation, fears of stigma are forcing legislators to carve out special sub-legislations. It is here that definitions of "dangerousness" begin to assume major proportions.

The concept of community mental health care, which is really an outreach of the hospital system, first crystalized in a French enactment in 1944. The movement soon spread to many other, mostly developed, countries. Very few of the countries surveyed were found to have provided in their mental health legislation for locally operated mental health centres.

The hospitalization procedures in this survey, as in the 1955 WHO survey, show the same variation and complexity of legislative systems. There is however, a definite trend towards a voluntary access to treatment. Three different voluntary admission systems are seen to be operating in the countries surveyed: (1) countries wherethere are clear legal provisions authorizing voluntary or informal admission; (2) countries where there are legal provisions only for involuntary commitment, but where voluntary patients are administratively admitted; and (3) countries where there is no law for any hospitalization, but where voluntary patients are informally admitted. The first two of these systems have, by implication, encouraged the development of psychiatric units in the general hospital.

Involuntary hospitalization procedures also reflect a healthy trend in that there is an increasing tendency towards compulsory hospitalization on medical certification alone without prior judicial or administrative tribunal review. This process reduces the stigma involved in the judicial process. Involuntary admission, however, remains the most heavily used procedure for prolonged hospitalization in most countries.

Observational hospitalization appears to be on the decline and is used in order to determine the condition of the patient and the severity of disturbance.

Emergency hospitalization, where the key factor is time, is also being increasingly used. This facilitates crises intervention and management of short-lived episodes or suicide attempts.

Protective measures for patients have become important issues recently, springing as they do from the increased concern for the right of the individual and the deprivation of liberty, which is also a personal trauma and a social political and legal stigma of great severity. This issue covers not only the right of freedom from improper confinement, but also the right to treatment and further the right to proper and adequate treatment of the individual as opposed to stereotyped global treatment prevalent in the asylum system. In effect, all this indicates a dynamic relationship that is emerging between the law and the rights of the individual.

In the discussion which followed the presentation, it was clear that mental health legislation where it exists in the Region was part of a colonial heritage. Emphasis was placed repeatedly, on the need to review such legislations in the light of relevance to the needs. It was stressed that lessons should be taken from the mistakes of other countries who have a longer history of mental health legislations. Doubts were expressed about the desirability of having legislation where none previously existed, but this was counterbalanced by the experience of some such countries, who were compelled to draft legislations because in their absence the onus on psychiatrists became too much and unfair. In this situation they were the sole arbitors in making difficult decisions. It was also suggested that, ideally, observational hospitalization should be in a general hospital.

The document"Mental Health Legislation in Developing Countries of the Eastern Mediterranean Region"[1] was introduced by Dr W.J. Curran. In the Eastern Mediterranean Region, thirteen out of the twenty-four countries responded, six were found to have legislation on mental health, and three more were considering the adoption of a law. Five countries with no legislation have been referred to as having "informal systems".

Egypt has a long tradition of medicine and also of mental hospitals. Mental health legislation was introduced in 1944 and contained a provision for voluntary access to treatment. In 1952, extra-mural and out-patient services were created, along with a policy of decentralization and extension of mental health services outside Cairo.

In Sudan, modern psychiatry has a short history and legislation is adequate. It was drafted by psychiatrists in conjunction with the legal department.

In Syria, the two hospitals are critically understaffed and overcrowded, legislation does not contain any provision for voluntary access to care and there seems to be a great deal of discretion in the hands of the hospital director. The length of time of detention and appeal procedures are not specified.

---

[1] EM/GR.MTG.MH.ML./10

Reference was made to the merit of sections 29 and 30 of the Mental Health Act 1959 of England and Wales, whereby seventy-two hours observation is possible simply on certification by one medical officer. Scotland has extended this period of observation to one week believing that seventy-two hours is too short.

The problems posed by the conflicting need to protect the individual from himself, and the society from him, and the deprivation of his liberty, were discussed. While no easy solution to this dilemma is possible, it was apparent that any legislation will have to reflect the country's state of social development and must be a dynamic progress. Reference was made to simple legislation which identified needs, took resources into account and was then given the legal guard. In the more simple situation family pressures may be more effective than legal pressures. Traditional values and practices should be utilized and benefit derived from long established cultures.

Saudi Arabia is drafting a new legislation which has the merit of simplicity of approach and operation.

A note of caution was voiced against hasty attempts to extend mental health legislation into side-issues like sexual offences and drug dependence.

Civil rights

A series of declarations adopted by the United Nations General Assembly provide a clear basis for the protection of the rights of the mentally disabled (the Universal Declaration of Human Rights; the Declaration of Rights of the Child; the Declaration of Rights of the Mentally Retarded and the Declaration of Rights of Disabled Persons). Nevertheless, in many parts of the world the mentally disordered remain an underprivileged minority, discriminated against and deprived unnecessarily of a wide range of civil rights. The origin of this situation lies in the feelings of apprehension and fear generated by mental illness and the projection of a stereotyped image of dangerousness, unpredictability and loss of reason for all mentally ill people. In some countries, this image is reinforced by the existence of large mental hospitals with custodial functions linked in the minds of the public to the prison system. The lack of effective mental health care has contributed to the stigma. Public pressure on mental health professionals to extend therapeutic action to unjustified measures of social control was often intense.

The meeting heard of a number of courageous attempts to counteract such pressure and re-establish the rights of the mentally ill, mainly by adopting an open doors policy and extending the coverage of mental health care. In many societies, it was felt that traditional values, such as religion and the influence and responsibility of the family, provided a powerful means for preserving and strengthening civil rights and supporting the mentally ill. Dissemination

of information about mental illness was also thought to be an effective way of counteracting stigma, provided that it was accompanied by provision of services.

It was clear that in some situationsthe mentally ill would lose some of their civil rights, but this should be guided by the principles that there should not be an automatic loss of all civil rights and they should only be withdrawn when a compelling reason existed; rights should be withdrawn explicitly for only a limited period; periodic review is essential.

Judicial aspects

The courts can be seen as the protector of both society and the individual. Courts can only take action when a case is brought before them, but it is likely that they would always retain the right to restrict the liberty and rights of the mentally ill. In situations where the family has lost control and feels unable to care for a mentally ill person, they may seek the help of the court. In such a situation, the possibility that the family wishes to get rid of a difficult member for unjustified reasons must be considered. The court, therefore, needs clear information on the psychiatric status of the patient and on the real life situation in his environment. Courts would be more helpful if psychiatrists were able to classify and describe patients with greater precision. If alternative sources of help were available, patients and their families could seek treatment before the situation reached a crisis.

Mental health law and planning services

As far as possible, mental health services should be considered within the general health care provision. One possible approach is to integrate legal provisions for the mentally ill into the general public health law (as had been recently achieved in Sudan). In all situations the following principles apply:

- legislation should in no way hinder access to treatment;
- compulsory legal powers should be used only as a last resort;
- legislation should not lead to the separation of mental health services from general health services;
- the concept of "treatability" (used in a wide sense to include social support and protective care) should be a criterion for the use of mental health laws.

In the service situation, it is useful to distinguish between two types of problem which might require legal intervention: first, acute emergencies, which could often be dealt with entirely by medical authority, provided that some mechanism of appeal was available to patients and their relatives; and second, long-term problems, where

more subtantial legal checks were required, together with a social assessment of each patient. It was important that mental health law should be realistic in relation to the pattern and level of services provided, otherwise there was a danger that laws would "oversell" mental health care and lead to a backlash of public disenchantment.

VI SOCIAL, PUBLIC HEALTH AND FORENSIC VIEWPOINT

1. Social viewpoint

The role of the social scientist in the mental health field is a major one, not often given its proper recognition. The lack of special resources for the young and the poor often prevent them from benefiting from the mental health services which are available, and here, as in many other instances, a social scientist could play an effective role.

There is a clear separation between the problems affecting children and those affecting adults and between those found in rural and urban situations. From the social scientist's point of view, some of the adverse effects of crime, delinquency and related social problems may be aggravated by legislation, if those differences are not taken into account. Legislation must be applicable to particular situations, easily understandable and operable, if it is to be beneficial.

2. Public health viewpoint

From the public health viewpoint in mental health care, there is deep concern at the lack of preventive measures in the mental health care programmes especially in developing countries. Preventive services are inexpensive and have a far-reaching impact on reducing the prevalence of disease. The discussions, the documents, even the major document "Harmonizing Mental Health Legislations and Programme Objectives", showed a tendency to base objectives on achieving a determined ratio of professionals to population. The figures which form the basis of this kind of calculation do not reflect the uneven scatter, with the heavy urban bias, in either the professionals or the services. The end result is that the resources are least where the need is greatest and people at the periphery either have to do without services or seek the help of the traditional healer.

Mental health workers should plan their objectives based on the following basic principles:

(a) A programme that will reach the most peripheral population in the health care system.

(b) An attempt to decrease the number and frequency of hospitalizations.

(c) To expedite access to treatment for patients living in remote, rural areas.

Objectives such as these would justify support to mental health programmes by the health administrator, which appears to be lacking in many countries of the Region. In view of the financial constraints, manpower shortage and social stigma, mental health care must also seek to integrate itself with the general health services and utilize the existing structure and manpower. In order to be able to achieve this, the psychiatrist needs to delegate some of his skills to less qualified members of the team, without endangering the patient's life. This would also allow the psychiatrist to devote more time to cases requiring his skill, to plan and train members of his team and to be able to supervise as a team leader. The most peripheral member of the team must be a member of the community itself, either the traditional healer or his alternate, where appropriate, commonly called the village health worker.

The village health worker is a member of the community, preferably chosen by them as a means of their participation, who is trained to identify mentally disordered persons early and refer some of them to senior members of the team. This early referral results in less overt symptomatology and therefore a better chance of managing the patient in the health centre or the general hospital. This process also makes it easier for relatives to visit and discuss with the doctor the problems connected with the patient's return and care at home. It should also be possible to provide health education to the relatives of patients and to give them social help when necessary. Rehabilitation and other aspects of prevention should also be easy.

Prevention of physical disorders by immunization, and internal disorders associated with mental disease, especially those requiring a nation-wide programme, would also be helped, and more easily achieved, by adopting this strategy. The close relationship between mental health and ecology has been established.

The approach is obviously multidisciplinary, involving many governmental agencies. Physical trauma resulting in mental disorders also require the collaboration of other specialities and other government agencies, especially those concerned with transport, traffic regulations and administration of justice. The psychiatrist can collaborate with the obstetrician and offer joint counselling services to reduce the incidence of disorders which have been established as being genetically determined.

There seems to be a lack of school psychological services in many countries of the Region. They are essential for the early recognition of the problem child and the mentally retarded child.

Health education is another important area that needs strengthning in the countries of the Region. Advances in therapy now make it possible for the patient to return to the community much earlier than before, thus reducing the stigma associated with the mental hospital. Therefore there should be an increasing tendency to base psychiatric services in general hospitals.

The mental hospital itself in many countries of the Region needs improvement, not only in the therapy given, but also in rehabilitation and after-care. The psychiatrist must look beyond the mental wards and plan programmes that have a wider impact. He can only do this if he works closely with social and preventive medicine personnel, even if he has to take a short course of study for this purpose.

3. Forensic viewpoint

The task of the forensic psychiatrist is complex. He is often required to function as an adviser to a judge, to whom he can provide a balanced view. In a therapeutic position in the prison, he has to be partial to his patient in order to develop a therapeutic rapport. His problem arises when the patient refuses treatment, which is his right in a prison as it is outside. Another situation that a forensic psychiatrist may find himself in, is when he has to give evidence as an expert witness on the question of diminished responsibility. Needless to say, all these areas often overlap.

One category of patients that has caused much discussion and concern both to the professionals and to the public is the psychopath. It has never been finally settled in any country whether he should be sent to a prison or a mental hospital. This is a matter of public opinion, awareness, legal statutes and professional bias.

The professional relationship between the prisoner and the doctor was discussed. The contract implied in this relationship was more in theory than in practice.

The laws relating to mental illness must be relevant, simple, provide ready access to treatment and have a voluntary form of treatment as a major component. Before a country decides to have new legislation in the mental health field or review legislation to improve or update it, it would be well advised to appoint a review body on the lines of one or more of the following:

(a) A statutory commission, the best example of which is provided by the Royal Commissions appointed in the United Kingdom.

(b) A committee appointed by the relevant ministry, usually the ministry of health. They would necessarily involve psychiatrists, but greater variety in contributing persons will increase the acceptability of the legislation drafted.

(c) A professional group, such as psychiatrists may perform the same function. They, however, tend to view from a narrow base and their own interests may predominate in their recommentations.

(d) Lay associations, like those for mental health and mental retardation, may participate in this activity - and this is happening more often - depending on their relative strength and voice in public affairs.

(e) Universities or academic departments of psychiatry may wish to undertake a review of legislation as part of their academic activity.

(f) Courts or tribunals can also adopt mechanisms which would eventually influence legislation. The prerequisite for this is that cases must appear in court for them to be able to act.

The review mechanisms, whatever basis they may have, will be effective only if they have official status, enjoy prestige, and also have access to the planning process of the country, so that they can view the problem in its wider perspective. They must have time to sit and discuss problems if possible with lay representation, and should be able to contract out research on selected areas needing deeper inquiry. They must also have international links to keep them informed of general trends. WHO can set up a process by which it can provide a clearing-house for information on mental health legislation, but this would have to be a two-way process, with countries providing their own information in exchange for information they receive. It was emphasized that mental health laws have to satisfy two conflicting needs, be stable and yet to have the flexibility to change. The best way in which this could be achieved is for laws to remain simple; if a law fails, then the cause lies in itself. Any deficiency in legislation is soon reflected in the failure of its proper application. Simple laws work on trust; where trust is lacking, the law has inevitably to be complex.

The point was also made that psychiatrists often seemed not to be very helpful in a legal situation. One reason advanced was that they tended to rely too much on technicalities, instead of using simple behavioural terms which would help the legal profession and the public to understand the implications of psychiatric problems as they affect the client in a court of law.

VII CONCLUSIONS AND RECOMMENDATIONS

1. Co-ordination

1.1 Co-ordination is a crucial requirement of all mental health programmes. At a national level, the planning and delivery of mental health care, the training of personnel, the evolution of

relevant research strategies, the collection and use of information and the contribution of mental health expertise to the solution of social problems all require close and continuing collaboration between and active involvement of many disciplines, government departments and service agencies. For this reason, national co-ordinating committees, including mental health professionals as well as social workers, public health administrators and representatives of various ministries, could serve a vital function in promoting rational and relevant mental health activities.

1.2 At a regional level, the Group Meetings organized by WHO play a similar co-ordinating role and these meetings should be continued. The meeting endorsed the recommendations made at the previous Group Meeting in 1972. The approach adopted in the present meeting, in which a general review of the mental health situation in the Region had been combined with a detailed and comprehensive consideration of one important, specific topic, viz mental health legislation, had been highly successful. Group Meetings should be continued, and the same approach used. Active participation of the group in dealing with mental health problems of regional and global importance should continue between its meetings. This participation should be concerned with follow-up of the Meeting's recommendations and evaluation of their impact within countries.

1.3 Active involvement of WHO Headquarters in the Group Meeting had significantly increased its value. Close co-ordination between the regional mental health programme and activities in WHO Headquarters and other Regions will be strengthened so that the Region could contribute to, and benefit from, a co-ordinated global WHO mental health programme. Exchange of experience with other Regions concerning common problems would be valuable for future work in the Eastern Mediterranean Region.

2. Training

2.1 In seeking to extend mental health care through integration into general health services more and better training in mental health should be provided for health workers and those in related fields.

2.2 Training of physicians and general nurses needs to be strengthened considerably, both during their basic training and through refresher courses.

2.3 The training of mental health professionals should not be based on the curricula and objectives of the industrialized countries. Psychiatrists in developing countries need more skills for supervision, training and administration. Throughout their training a public health approach should be adopted. The Group supported the efforts in several countries of the Region to develop post-graduate training and called for continuing intra-regional co-operation to make such programmes fully responsive and relevant to the Region's needs.

2.4 Increase in the numbers of auxiliary personnel offers an important opportunity to extend the coverage of mental health care. Careful supervision of such auxiliaries will be essential and their training should be directed towards the defined and circumscribed tasks necessary to deal with the priority mental health problems of the community.

3. Provision of services

3.1 The Group fully endorsed the recommendations of the Seminar on the Organization of Mental Health Services held in Addis Ababa in December 1973.

3.2 It was recommended that the trend to provide mental health care within general hospitals (both in-patient and out-patient services) should be encouraged and intensive efforts made to introduce such care directed at priority problems into more peripheral parts of health services, such as health centres and primary health care. Large, centralized institutions should not be established for any kind of mental disorders.

3.3 National health insurance schemes and other health insurances should include provision for mental health care on the same basis as for other categories of illness and services under such schemes should be available in the whole range of general health facilities (general hospitals, health clinics and the private medical sector).

3.4 Innovative and alternative approaches should be sought, including the involvement of the community and all its resources, such as traditional and religious leaders, police, teachers and others, in the care and support of the mentally disordered.

3.5 In most countries severe economic constraints make it unrealistic to expect massive budgetary allocations for mental health programmes. Nevertheless, in many countries the extent of mental health problems has been underestimated and some additional resources would be justified. Planning within the overall national health plan should be based on a policy developed by a mental health unit within each country's health ministry. Integration, the concentration on priority conditions and the use of a limited range of drugs would increase the cost effectiveness of mental health services.

3.6 In view of the importance of public attitudes towards mental disorders and various programmes of care and treatment for the mentally ill, and since stigmatizing attitudes are not uncommon, it was urged that special emphasis be given to carefully developed programmes to educate the public about mental health, using all available mass media.

4. Social problems

4.1 Rapid social change in many parts of the Region has inevitably led to many stressful situations, particularly problems for youth and migrant labour. Mental health expertise should be used more in dealing with these problems. It is recommended that the advice of mental health professionals be sought in the planning and implementation of all major social actions such as re-settlement and industrialization.

4.2 Road accidents are becoming common in nearly all countries of the Region. The Group drew attention to the role of alcohol and other drugs in the cause of such accidents. More services for alcohol and drug problems are needed as well as measures to limit consumption. Head injuries resulting from road accidents are now an important and preventable cause of mental disability.

5. Research

5.1 Research on mental health problems wihin the Region should be stimulated. Centres for research and training should be established, based on existing institutions or departments. The main emphasis of such research should be application-oriented, the main aim of which should be to solve significant mental health problems.

5.2 Traditional and indigenous methods of care should be explored with an open mind. Carefully designed studies should be carried out to assess the skills and techniques involved in such care as well as its limitations. The aim of the studies would be to enlighten the public and to allow health planners to decide whether such methods can contribute to mental health care.

5.3 See also the recommendation under "Drug dependence", section 8.1.

6. Mental retardation

6.1 Socio-economic change and the increasing availability of education has accentuated the problem of mental retardation.

6.2 Further information on the prevalence and consequences of mental retardation is needed.

6.3 Close co-ordination between medical, social, educational and vocational services is needed to provide comprehensive help for mentally retarded individuals. Additional resources are also needed.

6.4 Early detection in infant welfare clinics together with straightforward advice and counselling for parents are required. As far as possible family care of mentally retarded children should be encouraged, and necessary support and advice made available for families.

6.5 There may be scope for including mildly and moderately retarded children in normal schools, by adopting a flexible approach and providing some limited additional special education. Training of more severely retarded children must be included in the range of educational and other services. It was emphasized that all retarded people, however severe their impairment, could benefit from appropriate training.

6.6 As far as possible, a normal life style and pattern of relationships should be sought for the retarded.

6.7 Prevention should be actively pursued through ante-natal and maternity services, infant welfare and adequate nutrition.

7. The mentally abnormal offender

7.1 Services for the mentally abnormal offender are characterized in the Region by inadequate physical conditions and manpower shortage. Additional resources are required but efforts should also be made to reduce the numbers of people drawn into the system. A clear distinction should be made between giving expert advice to the courts and providing therapy. Better co-ordination between psychiatrists, the courts and ministries of the interior is needed, and other disciplines, such as psychologists and social workers, should be involved in management.

7.2 There should be special provision and services for mentally retarded offenders.

7.3 Steps should be taken to prevent inappropriate referrals to mental hospitals for long observational periods of persons under criminal charges. The use of community mental health resources by the courts and correctional system should be encouraged. The operation of separate institutions for abnormal offenders is a questionable use of mental health resources and should be discouraged whenever it is practicable to do so.

7.4 Studies are needed to evaluate different approaches to the care of mentally abnormal offenders and to establish workable and valid criteria of dangerousness. The definition of mental illness should be a matter for the medical profession rather than the courts.

7.5 Mental health services for clients in correctional settings, in prisons, should be strengthened or, if not yet present, established. Mental health training for prison personnel, including warders, should be provided by mental health professionals attached to the prisons.

8. Drug dependence

8.1 Studies should continue to establish the true nature, extent and consequence of drug use in the Region. In these studies, care should be taken to differentiate between different types of drugs, the age of users and the social setting of drug use.

8.2 Existing models for the treatment of drug dependence in the Region should be evaluated in terms of effectiveness and cost. Further models should be developed. It is unlikely that methods used in different socio-cultural and economic conditions can be readily transferred to countries of the Region and adopted in programmes for the treatment and control of drug dependence. Management should include not only short-term detoxification but psychological, vocational, and related counselling, long-term follow-up, social support and the provision of employment opportunities, whenever possible.

8.3 Legal provisions are necessary in conjunction with the other preventive measures. However, some legal measures based on an inadequate understanding of the total problem of drug dependence can be counterproductive to an effective drug control and treatment programme.

9. Mental health legislation

9.1 The Group considered that the information and suggestions in the draft document on mental health legislation provided a valuable means whereby countries could assess their mental health laws and, where necessary, enact new Laws. All countries of the Region were urged to carry out such an assessment.

9.2 It was agreed that mental health laws should be simple and relevant to the socio-cultural setting in which they are to operate. In certain situations it was recognized that no formal law may be necessary, at the present time.

9.3 Law should not provide any obstacle to ready access to treatment. Compulsory provision should be used as little as possible. Emergency admission on medical authority is appropriate in most countries and an adequate period of initial assessment and treatment should be provided for. Longer term confinement should involve more stringent legal checks, social assessment and a periodic review system.

9.4 Training is needed for health workers, lawyers, social workers, police and others in the proper use of mental health laws and could be provided in multidisciplinary groups.

9.5 Laws should not be formulated or operated so as to reinforce the stigma of mental illness by unduly emphasizing dangerousness or custodial treatment. The public should be made aware of the success and ready availability of informal treatment.

9.6 The operation of mental health laws should be continuously monitored so that future need for modification or more radical changes can be identified. In each country, the objectives of mental health legislation should therefore be defined, for example in terms of increasing the availability and use of voluntary care, protection of civil rights and changing public attitudes. Information

should then be collected so that an evaluation of whether these objectives are being achieved can be made. This evaluation can best be carried out by an inter-ministerial body with access to the planning process, with representatives of professional groups, lay organizations and universities.

ANNEX I

ADDRESS BY
H.E. Dr FOUAD MOHYELDIN
MINISTER OF HEALTH

Ir is a great pleasure for me to inaugurate this meeting, prepared by WHO, to discuss the problems of mental health and mental legislation.

May I first welcome the Director of the WHO Eastern Mediterranean Region, The Arab League representative, professors coming from the countries of the Region to participate in this meeting, representatives of UNDP, the World Federation for Mental Health and World Psychiatric Association. I hope that our guests from the Arab countries and friendly nations will enjoy a happy stay in our country.

The concept of health has been changed by passage of time. These days health is defined as the integral feeling of bodily, mental and social happiness. Now it is focussing on the importance of mental health, as the ability to face psychological crises, the positive feeling of personal happiness and satisfaction, in addition to the ability to make other people happy are considered to be the objective of psychological activities, Mental health became a wide field including many subjects, such as nervous and psychic disturbances, forensic-psychological medicine, behaviour diviations in children, addiction (drug-dependence, narcotics, alchohol), mental retardation, and many other phenomena. I am pleased to know that this group meeting will discuss a number of the more important of these subjects.

Nowadays, we see rapid development in science and technology. It is natural that such rapid change leads to social changes, and consequent contradictions between the old strong traditions and recently developed standards and new concepts. There is a struggle between the individual's ambitions and his sufferings from incapability and other limitations. Such conflicts disturb the psychological status of individuals and badly affect their stability. These contradictions have opened the door to many psychological and mental disturbances which affect the contemporary person and make him anxious about the expected results of scientific and technical development and suspicious of many contemporary human values. This puts an important duty (a heavy burden) on those responsible for health in our country, that is the management of these problems and the efforts to reach a form of compromise between scientific development and mental insurance. We must concurrently make use of the new methods of civilization and keep our confidence in the ethnic belief and traditions which secure our path and protect us from many risks.

I hope that through the discussions and studies of your meeting, some illuminating guidance may appear to help us in achieving this aim.

Ladies and Gentlemen,

Mental health occupies nowadays a prominent place in the health services; maybe this was the motive that led the WHO Director-General to put in front of the General Assemblt,during its meeting last month, a detailed report calling for the support of international activities in the field of mental health, its relations to the different health, social and economic aspects, and in the study of problems related to the individual's behaviour. It is quite clear that the field of mental health is inter-related with many other fields, an important one of which is law and legislation. There is a great need now to study the extent of responsibility of the mentally or psychologically handicapped in front of law and the measures that must be taken to protect them, and at the same time to protect the community against danger from these handicaps.

Also, it is very important to formulate suitable legislations capable of limiting the spread of narcotics and dangerous drugs, getting rid of the problem of addiction, and resisting the aberrations related to psychological and mental instability.

The time when a mental handicap was considered a touch of the devil has gone forever. Then the mentally handicapped was taken as a criminal or rejected and his treatment was isolation.

To-day when we study mental health legislation a priority in our aims is the preservation of the rights of patients, kind humanitarian treatment and at the same time, protection of society and conservation of its rights.

Undoubtedly,the importance of the topic of mental health legislation is the reason your meeting is paying special attention to it.

I think that I do not need to examine the programme of this meeting which is very rich in topics to be discussed, but I would like to mention with appreciation your interest in development and training of manpower working in the field of psychiatric and mental health. I would like to mention also that this training is not only for physicians and specialists in psychiatry, but has became a necessity for physicians from all specializations, for nursing staff, and for auxiliary personnel, in addition to psychologists and sociologists. It is necessary for all who work in the field of health care to pay attention to the psychological aspects.

Ladies and Gentlemen,

Once more, I welcome our distinguished guests. I thank WHO and its Regional Office for preparing this important meeting. I thank all who worked to prepare for this meeting and those participating in it. I hope for this group meeting all possible success.

Thank you.

ANNEX II

ADDRESS BY
Dr A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION

Your Excellencies, Dear Colleagues,

It is a great pleasure for me to address this distinguished group and welcome you all, on behalf of the World Health Organization, to this important mental health meeting, which we are very happy to hold in this great and historical city of Cairo. In this connexion, I would like to avail myself of the opportunity to thank the Government of Egypt, the Ministry of Public Health, and particularly His Excellency Dr Fouad Mohyeldin, the Minister of Health, for hosting this meeting and for their excellent collaboration not only in the organization of this meeting, but in all other areas of our collaboration in the health field.

This meeting, as you will note from the Agenda, consists of two parts. The first is a follow-up of the last WHO Group Meeting on Mental Health which was held in Alexandria Regional Office in September 1972 and the second deals primarily with mental health legislation. Since the Alexandria meeting, and during the last four years, the countries of this Region, similar to other parts of the world, witnessed great socio-economic changes, which have naturally influenced the health field, including mental health. And health, of course,is inseparable from the community and indeed follows it very closely, for better or worse. It is important to indicate that with socio-economic developments and the continuous progress in the control of the various well-known communicable and many non-communicable diseases, mental health is more and more emerging as a major public health problem.

Being fully conscious of these developments, WHO's ever-growing interest in promoting mental health work is clearly demonstrated by its various activities and is reflected in the series of resolutions taken by the Health Assembly,especially in recent years, which I need not repeat here. More relevant to this Region, the lively discussions and the resolution adopted by the Regional Committee during its meeting last October in Teheran indicate the increasing efforts to deal more effectively with intricate mental health problems.

At the national level, I am pleased to note the genuine attempts made by many countries to implement the recommendations made at the last Group Meeting, as well as at other WHO scientific activities. Significantly, more and more countries are building up their mental health services, though many difficulties still beset the development of adequate mental health care. In many countries of this

Region, to quote only one example, there are still large-size mental hospitals which are draining all the available resources. Consequently, the pertinent issue which these countries have to resolve is: how to move out of such a situation and develop a more flexible and better means in order to meet the rising needs and provide an adequate coverage for urban as well as rural population? This, of course, calls for a simpler and more dynamic system of approach, with a searching look to make full use of available resources for appropriate application of health technology and for proper community involvement. While at present there is no one ideal model, I am quite confident that the potentialities and the possibilities in the majority of the countries of this Region are so many that it will not be so long before excellent mental health programmes are developed. Needless to say, to achieve this cherished hope, the right concepts and the sound techniques have to be developed and indeed realistically implemented in the complex field of mental health. Hence, the importance of this meeting, in which I am happy to participate in its opening session today.

Apart from dealing with mental health issues in general, it is important that you focus on specific topics, namely the management of mentally-abnormal offenders, the prevention and care of the mentally-retarded, drug dependence and training of auxiliary personnel. Of course, there are other equally important topics, such as the case of the chronic mentally-ill patients, but these will be dealt with in other meetings.

On the other hand, defective and out-dated mental health legislation has been a long-standing impediment in the way of appropriate development of mental health care.

It is timely that this meeting, with its wide and multidisciplinary representations and on the basis of the valuable material collected and collated from various countries, is singularly competent to discuss and come out with up-dated recommendations for mental health legislation, in harmony with modern concepts and the current progress in the mental health movement.

Furthermore, an important feature of this meeting is that, though it is basically regional, I am pleased to point out that the joint participation of WHO Headquarters, together with the contribution of leading personnel and eminent jurists from Africa, Europe and the United States of America, will no doubt enrich the sharing of experiences and the exchange of views.

Distinguished Colleagues, I wish your meeting fruitful deliberations and successful discussions, and I hopefully look forward to the ideas emanating from your expert group, as well as recommendations which, I trust, will be helpful in the further development of mental health work.

Thank you.

ANNEX III

AGENDA

I Opening Session

II Election of Meeting Officers

III Adoption of Agenda

IV Impact and Follow-up of Development since the Group Meeting on Mental Health in 1972

1. Mental Health Services in EMR
2. Specific topics for special study
   - care of mentally abnormal offenders;
   - problems of drug dependence;
   - prevention and care in mental retardation;
   - training of auxiliaries.

V Mental Health Legislation

International review and formulation of guidelines

VI Field Visits

VII Summary Report and Recommendations

VIII Closing Session

ANNEX IV

PROGRAMME

Saturday, 12 June 1976

9.00 a.m. - 10.00 a.m.	- Registration of participants
10.00 a.m. - 10.30 a.m.	- Inaugural Address by H.E. Fouad Mohyeldin, Minister of Public Health, Egypt.
	- Address by Dr A.H. Taba, WHO Director, Eastern Mediterranean Region.
10.30 a.m. - 11.00 a.m.	- Recess.
11.00 a.m. - 1.00 p.m.	- Election of Officers Chairman, Vice-Chairman, Rapporteur (MH), Co-Rapporteur (MHL).
	- Adoption of Agenda.
	- Introduction to programme of work by Dr T.A. Baasher.
	- Mental Health Services in EMR by Dr T.A. Baasher Doct./4
	- WHO Mental Health Programme - an overview by Dr N. Sartorious and Dr T.A. Baasher
5.00 p.m. - 7.00 p.m.	- Above continued.
	- Discussion.

Sunday, 13 June

9.00 a.m.* - 1.00 p.m.	- SPECIFIC TOPICS FOR SPECIAL STUDY BY GROUPS:
	A. Care of mentally abnormal offenders by Dr A. Wagdi and Dr T.A. Baasher Doct./5

*Recess 10.30 - 11.00

B. Problems of drug dependence
by Dr M.A. Shamie Doct./6

C. Prevention and care in mental retardation
by Dr Zaki Hasan Doct./7

D. Training of auxiliaries
by Dr T.W. Harding Doct./8

Sunday, 13 June (cont'd)

5.00 p.m. - 7.00 p.m.

- Report of the Groups (Plenary)
- Discussion.

Monday, 14 June

9.00 a.m.* - 1.00 p.m.

- Field visits** (except for sub-committees' members)
- Sub-committee for technical consideration of Draft Review and material and alternative approaches to the formulation of mental health legislation.

Tuesday, 15 June

Moderator: Vice-Chairman

9.00 a.m.* - 1.00 p.m.

- MENTAL HEALTH LEGISLATION
  - Introduction
    by Dr T.W. Harding
  - Harmonizing Mental Health Legislation and Programme Objectives: An International Survey
    by Professor W.J. Curran Doct./9

    Discussion.

---

*Recess 10.30 - 11.00

**Participants will be requested to choose among the following: Psychiatric Department, Cairo University; Psychiatric Department, Ein Shams University; Abbassia Mental Hospital; Khanka Mental Hospital; O.P. Psychiatric Clinic, Ahmed Maher General Hospital; Rehabilitation Centre for Mentally Retarded, Mataria; Rehabilitation Centre for Drug Addicts; Museum for Health and Pharmacy History.

Tuesday, 15 June (Cont'd)

5.00 p.m. - 7.00 p.m.

- Mental Health Legislation in Developing Countries of the Eastern Mediterranean Region by Professor W.J. Curran Doct./10
- Remarks by participants at national level.

Wednesday, 16 June

Moderator:

9.00 a.m. - 1.00 p.m.

- MENTAL HEALTH LEGISLATION(Cont'd)
  - Mental Health Legislation in Developing Countries of the Eastern Mediterranean Region by Professor W.J. Curran Doct./10 (cont'd)
  - Remarks by participants at national level (cont'd)
  - Ongoing mechanism of review by Dr T.W. Harding Doct./11
  - Discussion.

Afternoon free, except for the Sub-committee on Mental Health Legislation.

Thursday, 17 June

Moderator:

9.00 a.m.* - 12.45 p.m.

- Summary report and recommendations
- Discussion and approval of the above

12.45 p.m. - 1.00 p.m.

- Closing session.

*Recess 10.30 - 11.00

ANNEX V

LIST OF PARTICIPANTS

BAHRAIN	Dr Jan Ahmed Al Safar* Consultant Psychiatrist Hospital for Psychiatry and Nervous Diseases Ministry of Health Manama
CYPRUS	Dr Petros Matsas Medical Superintendent Psychiatric Institutions Athalassa
DEMOCRATIC YEMEN	Dr Abdel Gadir El Kaf Chief Consultant Psychiatrist Ministry of Health Aden
EGYPT	Dr Mohamed Saad Eddin Fouad Under-Secretary Health Affairs Ministry of Public Health Cairo
	Dr Ahmed Saad El-Din El-Hakim Director Mental Health Services Ministry of Public Health Cairo
ETHIOPIA	Dr Fikre Workneh Assistant Professor of Psychiatry Faculty of Medicine Addis Ababa University Addis Ababa
IRAN	Dr Aslan Zarrabi Chief Mental Health Department Ministry of Health and Social Welfare Teheran

*Did not attend

IRAN(Cont'd)	Dr M.A. Shamie Director Yaft-Abad Treatment and Rehabilitation Centre Ministry of Health and Social Welfare. Teheran
IRAQ	Dr Mahdi Hussain Taan Consultant Psychiatrist Shamayieyah Psychiatric Hospital Baghdad
JORDAN	Dr Jamil Ibrahim Qandah Psychiatrist Amman
KUWAIT	Dr Mohamed Talaat Reda Director Kuwait Psychiatric Hospital Kuwait
LEBANON	Dr A.S. Manugian* Physician Superintendent The Lebanon Hospital for Mental and Nervous Disorders Beirut
LIBYA	Dr Malak Girgis Chief Mental Health Division Ministry of Public Health Tripoli
PAKISTAN	Dr K. Zaki Hasan Professor Department of Neuropsychiatry Jinnah Post-graduate Medical Centre Karachi
	Dr Malik Hussain Mubbashar Head,Department of Psychological Medicine Central Government Hospital Shahrah-e- Pahlevi Rawalpindi

*Did not attend

QATAR	Dr M. Fakhr El Islam Consultant Psychiatrist Ministry of Public Health Doha
SAUDI ARABIA	Dr Osama M. El Radi Director Psychiatric Hospital Taif
SUDAN	Dr Hasab El Rasoul Suliman Director-General Chief Consultant Psychiatrist Mental Health Services Ministry of Health Khartoum North
SYRIA	Dr Gamal El Attasi* Professor of Psychiatry Faculty of Medicine Damascus University Damascus

OBSERVERS

Dr Omar Shaheen
Professor of Psychiatry
Kasr-El-Eini Faculty of Medicine
Cairo University
Cairo

Dr Yehia Taher
Vice-Dean
Faculty of Medicine
Cairo University
Cairo

Dr Omar El Garem
Professor of Psychiatry
Faculty of Medicine
Alexandria University
Alexandria

Dr Abdel Aziz Askar
Former Professor of Psychiatry
Cairo University
Cairo

*Did not attend

Dr Mohamed Shalan
Assistant Professor of Psychiatry
Faculty of Medicine
Al Azhar University
Cairo

Dr Mustapha Kamel
Assistant Professor of Psychiatry
Abbassia Faculty of Medicine
University of Ein Shams
Cairo

Brigadier Dr Adnan El Beih
Chief
Department of Psychiatry
Armed Forces Hospital
Maadi
Cairo

Dr Mahmood Moustafa
Professor of Neurology
Abbassia Faculty of Medicine
University of Ein Shams
Cairo

Dr Helmi Ghali Abdel Messih
Director
Mental Health Hospital
Khanka
Cairo

Dr Ahmed Nayer Kotri
Assistant Director
Mental Health Administration
Ministry of Public Health
Cairo

Brigadier-General Dr Atef Hassanein
Director
Manshiet-El-Bakri Military
Psychiatric Hospital
Cairo

Dr Kamal Abdel Mohsen El Fawal
Director
Mental Health Hospital
Maamoura
Alexandria

OBSERVERS (Cont'd)

Dr Awatif Gebril
Chief
Department of Neurology and
Psychiatry at the Specialized
Medical Councils
Cairo

Dr Anam Wahby
Director-General
Training General Administration
Ministry of Public Health
Cairo

Dr Mustapha Ismail Swaif
Professor of Clinical Psychology
Faculty of Arts
Cairo University
Cairo

Dr Mohamed Abdel Wahab El Khalafawy
Director-General of Special
Education
Ministry of Education
Cairo

Dr Osama Elwan
Professor of Neurology
Faculty of Medicine
Cairo University
Cairo

Mrs Mervat El Geneidy
Lecturer, Mental Health
High Institute of Nursing
Alexandria

Mr Wagdi Abd-El Sammad
Counsellor
Ministry of Justice
Cairo

Dr Hind Abd-El-Aal
Lecturer, Mental Health
High Institute of Nursing
Cairo University
Cairo

Miss Safia Magdi
Clinical Psychologist
Faculty of Arts
Cairo University
Cairo

UNITED NATIONS REPRESENTATIVE

Mr S. Linner
Resident Representative
United Nations Development Programme
Cairo

OTHER ORGANIZATIONS

WORLD FEDERATION FOR MENTAL HEALTH	Dr Adly Fahmy Abdou Chief, Psychiatric Unit Ahmed Maher Hospital Cairo
WORLD PSYCHIATRIC ASSOCIATION	Dr Ahmed Okasha Professor of Psychiatry Abbassia Faculty of Medicine University of Ein Shams Cairo
EGYPTIAN ASSOCIATION FOR MENTAL HEALTH	Dr Gamal Madi Abul Azayem Director Mental Health Hospital Abbassia Cairo
EGYPTIAN PSYCHIATRIC ASSOCIATION	Dr Mahmoud Sami Abdel Gawad Assistant Professor of Psychiatry Kasr-el-Eini Faculty of Medicine Cairo University Cairo
LEAGUE OF ARAB STATES	Dr Ahmed Safwat Health Department League of Arab States Cairo

WHO SECRETARIAT

Dr A.H. Taba	WHO Director	Regional Office for the Eastern Mediterranean
Dr M.O. Shoib	Director Health Services	Regional Office for the Eastern Mediterranean
Dr T.A. Baasher	Regional Adviser on Mental Health, and Secretary of the Group Meeting	Regional Office for the Eastern Mediterranean
Dr N. Sartorius	Chief, Office Mental Health	WHO Headquarters, Geneva
Dr T.W. Harding	Medical Officer, Office Mental Health	WHO Headquarters, Geneva
Dr J. Bernheim	WHO Temporary Adviser	Professor of Legal Medicine, University of Geneva, Switzerland
Dr W.J. Curran	WHO Temporary Adviser	Professor of Legal Medicine, Harvard School of Public Health Boston, USA
Dr Z.M. Dlamini	WHO Temporary Adviser	Senior Medical Officer, Ministry of Health Mbabane, Swaziland
Dr J.H. Henderson	WHO Temporary Adviser	Scottish Home and Health Department, Edinburgh, United Kingdom
Mr Hon. Justice O. Kolawole	WHO Temporary Adviser	Judge's Chambers, High Court of Justice Ijebu Ode, Western State, Nigeria
Mr S.K. Mukherjee	WHO Temporary Adviser	United Nations Social Defence Research Institute, Via Giulia 52, Rome, Italy

WHO SECRETARIAT (Cont'd)

Dr S.A. Shah	WHO Temporary Adviser	Chief, Centre for Studies of Crime and Delinquency, National Institute of Mental Health, Rockville,USA
Dr A. Wagdi	WHO Temporary Adviser	Mental Health Adviser, Ministry of Public Health, Cairo, Egypt
Miss C. Cartoudis	Conference Officer	Regional Office for the Eastern Mediterranean
Mrs A. Economakis	Secretary	Regional Office for the Eastern Mediterranean.

ANNEX VI

BASIC DOCUMENTS AND BACKGROUND MATERIAL

BASIC DOCUMENTS

PROVISIONAL AGENDA	EM/GR.MTG.MH.ML./1 Rev.1
PROVISIONAL PROGRAMME	EM/GR.MTG.MH.ML./2 Rev.2
PROVISIONAL LIST OF PARTICIPANTS	EM/GR.MTG.MH.ML./3 Rev.1
MENTAL HEALTH SERVICES IN EMR by Dr T.A. Baasher, Regional Adviser on Mental Health, Eastern Mediterranean Region, Alexandria	EM/GR.MTG.MH.ML./4
CARE OF MENTALLY ABNORMAL OFFENDERS by Dr A. Wagdi, Mental Health Adviser, Ministry of Public Health, Cairo, and Dr T.A. Baasher, Regional Adviser on Mental Health, Eastern Mediterranean Region, Alexandria	EM/GR.MTG.MH.ML./5
PROBLEMS OF DRUG DEPENDENCE by Dr M.A. Shamie, Director, Yaft-Abad Treatment and Rehabilitation Centre, Teheran	EM/GR.MTG.MH.ML./6
PREVENTION AND CARE IN MENTAL RETARDATION by Dr Zaki Hasan, Professor, Department of Neuropsychiatry, Jinnah Post-graduate Medical Centre, Karachi	EM/GR.MTG.MH.ML./7
TRAINING OF AUXILIARIES by Dr T.W. Harding, Medical Officer, Office Mental Health, WHO Headquarters, Geneva	EM/GR.MTG.MH.ML./8
HARMONIZING MENTAL HEALTH LEGISLATION AND PROGRAMME OBJECTIVES:AN INTERNATIONAL SURVEY by Dr W.J. Curran, Professor of Legal Medicine, Harvard School of Public Health, Boston	EM/GR.MTG.MH.ML./9
MENTAL HEALTH LEGISLATION IN DEVELOPING COUNTRIES OF THE EASTERN MEDITERRANEAN REGION by Dr W.J. Curran, Professor of Legal Medicine, Harvard School of Public Health, Boston	EM/GR.MTG.MH.ML./10

WHO EMRO

ONGOING MECHANISM OF REVIEW
by Dr T.W. Harding, Medical
Officer, Office Mental Health,
WHO Headquarters, Geneva

EM/GR.MTG.MH.ML./11

BACKGROUND MATERIAL

OMH/73.4, Introductory Guidelines on Mental Health Legislation, (Draft).

Report of the Meeting of the Co-ordinating Group for the Mental Health Programme, WHO Geneva, 17 - 23 February 1976.

WHO Offset Publication No.22, "Mental Health Services in Developing Countries".

Wld Hlth Org. tech. rep. ser. 564, 1975, Organization of Mental Health Services in Developing Countries - Report of the Expert Committee on Mental Healch.

EM/MENT/71, Report of the Seminar on the Application of Psychiatric Epidemiology, Khartoum, 17 - 21 February 1975.