REPORT
ON THE CO-ORDINATING GROUP MEETING
ON MENTAL HEALTH
Alexandria, 22 - 24 November 1978
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ANNEX I ADDRESS BY DR. A.H. TABA, DIRECTOR, WHO EASTERN MEDITERRANEAN REGION

ANNEX II AGENDA

ANNEX III LIST OF PARTICIPANTS

ANNEX IV BASIC DOCUMENTS AND BACKGROUND MATERIAL

1. Profile of Priority Programme in your country
2. Data Recording Sheets for Inpatient and Outpatient Census
The meeting was held in Alexandria at the WHO Regional Office from 22 to 24 November 1978.

Dr. A.H. Taba, Director of WHO Eastern Mediterranean Region, opened the meeting pointing to the success of previous Group Meetings on Mental Health in 1972 and 1976, which was evident from the keen interest in reviewing mental health legislation. But, despite many significant developments, available national resources were still inadequate to meet the rapidly growing needs for mental health care. Shortage of qualified mental health personnel, inadequacy of psychiatric training of general health workers and inappropriateness of models for the delivery of mental health care prevented wide population coverage.

Dr. Taba further indicated that the meeting was designed to examine current mental health problems, define future objectives and discuss difficulties encountered in national and regional programmes. The contributions of this meeting would be considered within the global context of the overall mental health programme, which is to be discussed during the Third Meeting for the Global Mental Health Programme of WHO, which will comprise all WHO Regional activities, and is scheduled to take place at EMRO in September 1979.

11 PURPOSE AND ORGANIZATION OF THE MEETING

The meeting of selected mental health specialists was called:
- to review progress in mental health care in the Region since the Group Meeting on Mental Health in 1976;
- to make relevant proposals for future work and to prepare EMRO for the Third Inter-regional Meeting of the Coordinating Group for the Global WHO Mental Health Programme scheduled to take place in EMRO in September 1979.

The meeting aimed at reviewing the scope and policy of mental health action, the regional perspective of mental health care programmes, several national mental health programmes, and such special topics as mental health training in schools of public health, post-graduate training in psychological medicine, drug dependence and mental health information.
Papers which had been prepared in advance were discussed, as were findings of various programmes and projects. To stimulate participants to produce a mental health care programme profile, a brief questionnaire was handed out and completed during the meeting.

III SCOPE AND POLICY OF MENTAL HEALTH ACTION

The history of WHO has showed an emphasis on mental health programmes during recent years, which reflects the increased interest of all countries in the world. The new trends in WHO mental health programmes include:

1. The wider scope of mental health action, encompassing psychosocial problems affecting mental health, promotion of health in general and a new role in the study and prevention of the dehumanization of medical care due to its technological advances, which have a negative influence on the doctor-patient relationship and on the interaction between the medical care system and the family of the patient.

2. A multisectorial approach to mental health care, i.e. collaboration of a multiplicity of disciplines such as education, social welfare, defence, labour and law.

3. A careful selection of priorities including the sequelae of neurological disorders, e.g. epilepsy.

Since modern health services covered only a minority of the population WHO attached priority to the development of primary health and sought ways of introducing mental health care with primary health care. An example of such action is WHO collaboration in six countries, where training in mental health care was given to general health personnel in geographically defined areas, where specific disease priorities had been identified.

Other action on a global level took place in the field of research, e.g. in a recent study on psychotropic drugs, assessing their need and effects in different countries and cultures.

The strategy for mental health action demanded establishment of "national coordinating groups for mental health" consisting of a few people drawn from various ministries and installed with a clear mandate for action. Such a group should plan and steer mental health activities within a country and coordinate with other countries.
in a Region and with WHO. At the Regional level, Regional Coordinating Groups should reflect inter-country concern and propose joint action helped by mutual input and experience.

At the global level a group consisting of Regional Advisers, WHO Central Office staff and selected experts should collaborate to make future programmes truly responsive to people's needs.

IV MENTAL HEALTH CARE IN REGIONAL PERSPECTIVE

The World Health Organization's Regional Office could be considered a mirror of the twenty-three countries in the Eastern Mediterranean Region. Not only is it a product providing as much clarity of vision as countries locally allow; it also reflects the images that are present and are desired.

In 1972, the group meeting in Alexandria reflected a picture in which the images were somewhat hazy:

1. Only four countries had mental health represented in their Ministry of Health.
2. Some six countries had, mostly outdated, mental health legislation. Another seven had scattered regulations.
3. Probably five countries were completely without any mental health facility for in-patients.
4. Four countries were altogether without psychiatrists.
5. Only two countries offered post-graduate training.

In 1978, after six years have passed, the picture reflected appeared much brighter. It still included twenty-three countries, although Ethiopia had left the Region but Djibouti had joined:

1. Eight countries had mental health representation in their Ministry of Health. Another nine had assigned advisers or consultants.
2. At least two countries had revised their mental health legislation, two more had drafted laws and in five countries the subject was under consideration.
3. None of the countries were presently without intra-mural services. More significantly, the emphasis had been on establishing psychiatric units in general hospitals in most countries.
4. Information about Somalia, Yemen and Djibouti was not readily available, but all other countries had psychiatrists.

5. The number of countries with post-graduate training in psychiatry had tripled, and in two more countries preliminary post-graduate training was available.

Apparently, mental health had gained the attention of governments in the Region and mental health specialists had moved sufficiently to the forefront for their voices to be heard by public health administrators.

Evidence of this was apparent in the recommendations adopted by the Regional Committee at its annual meeting in 1975, which dealt specifically with mental health services in EMR and emphasized a national mental health policy, community-oriented services, improvement of the organization and administration of services, their integration within the total health system and the development of a cadre of qualified mental health workers (see document EM/RC 25 A/3).

This imposed an extra burden on the mental health specialists who could not any longer stick to their psychiatric jargon, but who had to make sense to administrators and planners at various levels of authority. Fortunately, WHO had provided helpful language to organize the information which mental health professionals wanted to pass on to the administrators. It introduced the method of drawing up a so-called country programme profile, as explained in its Information Systems Programme Handbook, ISD/78/9.

The WHO Regional Office was itself in the process of making a Regional Programme Profile which should in fact be a composite picture of country programmes and main interests. In the following, the way in which such a profile could be drawn up is indicated.

A profile is a selection of information structured according to established needs.

A country profile contains:

1. General information about the country.
2. Health and health-related administration.
4. Health situation, including available resources and their utilization.
6. Technical cooperation with other countries.
7. Review and evaluation.
It would be obvious that the mental health specialist could only talk properly to administrators if he had his country's profile sharply in mind. The needs of his patients had to be considered against those of the total population and the resources available to the country as a whole. For example, there was no point in proposing psychiatric units in general hospitals, if priority had just been accorded to building community health centres instead of general hospitals.

Against the background of his country's profile the mental health specialist could start to write his country's mental health care programme profile which contained the following elements:

1. Policy basis.
2. Problem definition.
3. Objectives and targets.
4. Description of programme.
5. Monitoring and control.
6. Participants in the programme.
7. Essential reports, documents and publications.
8. Related programmes.

The mental health specialists from the various countries were the people who were specifically in a position to give meaning to each of the above elements in order to complete the image they wanted to be reflected by WHO.

V MENTAL HEALTH POLICY IN EMR

Not many countries in the Region have as yet formulated a MENTAL HEALTH POLICY, but awareness of the need for it is growing, and also that it should truly reflect the needs and demands of the population. The latter implies that countries cannot rely on copying mental health policies of other countries, which have preceded them in this respect. In addition, the needs and demands of the population should not be confused with those of mental health professionals themselves who also have their professional and personal standards and norms to adhere to, nor with those of the existing mental health services which, quite naturally, want to develop and renovate what they already have. Mental health policy should integrate those needs and demands.
While integration of MENTAL HEALTH POLICY with GENERAL HEALTH POLICY and SOCIAL WELFARE POLICY is essential, it requires involvement of mental health experts, not only including psychiatrists, but also psychologists, social workers, etc.

Preconditions for formulating a mental health policy are:

1. A mental health representative in the Ministry of Health.
2. Collaboration, for example in the form of a NATIONAL COORDINATING COMMITTEE FOR MENTAL HEALTH, of mental health professionals with representatives of various ministries with a clear mandate for action in the field of mental health, representatives of social agencies and of the community.

A mental health policy should clearly define and assign responsibilities for following up its objectives, taking into account the multisectorial approach which is essential to the promotion of mental health in a country. The psychiatrist still has an important role to play in mental health care, but its tremendous socio-economic implications require responsibility and action on the part of others.

VI MENTAL HEALTH COMPONENT IN THE GENERAL HEALTH INFORMATION SYSTEM

The evolving models of mental health care delivery in EMR require new models of information support to mental health programmes. The traditional model was custodial and included mental hospitals only. Therefore, having information on admission and discharge rates and on certain hospital functions (e.g. staff, equipment, finance) sufficed. The new models of mental health care delivery include:

- in- and out-patient treatment in the mental hospitals;
- in- and out-patient treatment in the psychiatric units in general hospitals;
- mental health care integrated within the general health services delivery system;
- mental health care components in primary health care;
- collaboration between health, social and other services in providing care for the mentally ill (including drug and alcohol dependents).

This leads to new models for the collection of information; i.e. data on the mental health care component in general health care, social and other delivery systems. Having identified such components, they in their turn should lead to the development of.
WMO is currently engaged in a global project including, in this Region, Kuwait, to assist countries to establish a basic recording system covering:

- patients with mental disorders, who are in contact with the existing health and social services, whether as in-, out-, or day-patients;
- health and other personnel available for patients with psychiatric problems;
- facilities available for the treatment of mental disorders.

This implies examination of the national system of health statistics and of its links with the demographic system to see which items of information are relevant to mental health care, and in addition, the mechanisms for speeding up data collection, processing, analysis and publication. Finally, the project aims at demonstrating ways in which mental health information can be used by those concerned with the provision, development and evaluation of mental health services.

To achieve its objectives the study includes the following steps:

1. Identification of a study area within a country or region, for which mental health data are to be collected.
2. Preparing a sociodemographic profile of the study area.
3. Listing all facilities within the study area, which persons with mental problems may contact.
4. Collection of data concerning the characteristics of the services, e.g. staff, finance, etc.
5. Establishing a project team for carrying out an in- and out-patient census in all (or suitable samples of) facilities. The census will be for in-patients on a given day and for out-patients during a two weeks' period.
6. Checking and tabulating findings.
7. Reducing the mass of data to meaningful indicators relevant for mental health planning and for monitoring the services in a digestible form.
8. Developing a mechanism to provide feedback to the staff in each individual reporting facility, describing uses made of statistics deriving from their reports, for more effective administration, for improvement of patient care, for studies in planning and evaluation, and for clinical, epidemiological and other types of research.
VII PROBLEMS OF MENTAL HEALTH CARE IN EMR

Although the number of countries in EMR with a mental health representative or a mental health unit in the Ministry of Health is increasing, in too many others their absence still constitutes a major obstacle to the development of Mental Health Care.

At present, mental health policy is largely a blend of what mental health professionals consider necessary and what is known about patients contacting the mental health professionals. Little is known yet about the specific needs and demands of large sections of the population, e.g. in the rural areas but also in the large conurbations which can just as well be found in the developing countries. The contributions of traditional healing practices to meeting the needs and demands of the mass of the population are largely unknown. How to reach these masses?

Through collaboration with traditional healers; by means of mental health activities incorporated in the work of primary health workers, and general health workers at other levels; by means of community mental health centres with an emphasis on out-patient care; through establishing psychiatric units in general hospitals, including out-patient clinics; or by means of out-patient services independent of or connected with community-oriented mental hospitals? This is a problem which each country has to solve in its own way, and in accordance with its own geographical and cultural conditions. Most probably, the problem of absence of mental health care for large sections of the population has to be solved by a combination of approaches, taking into account that one and the same country can have significant sections of its population in rural areas as well as in overcrowded urban areas. While in the first case primary health workers may be the only modern health workers available, the proximity of a mental hospital with community-oriented out-patient services may offer alternative solutions in a town.

However, with the exception of very few countries, a major obstacle to the development of mental health care is still the painful scarcity of mental health workers of all types: psychiatrists, psychologists, psychiatric nurses, nursing aids and other auxiliaries, social workers, etc.

While the lack of mental health services and mental health manpower affects the population as a whole, more circumscribed categories of people are particularly under-
served either because they have hitherto received little or no attention, or because of their specific needs. These comprise:

- the population aged up to 15 years, which in most countries in EMR makes up almost half of the total population;
- mentally-disturbed offenders, who are often kept under inhuman conditions;
- drug dependents, who are increasing in numbers, and are subject to changes in the pattern of dependency because of the introduction and spread of manufactured drugs;
- mentally retarded people, who nowadays constitute a greater burden on their families because of socio-economic changes affecting the latter, and of society's increased demands for education.

With regard to the existing services, two important problems could be identified. Firstly, the large proportion, up to two thirds, of long-stay patients in mental hospitals receiving no treatment of any kind, and without hope of further improvement. Secondly, the absence of mental health legislation or the presence of outdated legislation. Mental health legislation should determine the right of all people to mental health care and the norms for what constitutes proper psychiatric care; it should also protect the civil rights of psychiatric patients.

Concerning proper mental health care, a constant shortcoming is either the absence of psychotropic drugs or their availability in a bewildering variety of combinations which are expensive and have not proven their value.

VIII OBJECTIVES AND APPROACHES IN MENTAL HEALTH CARE

1. Prevention

Not very many measures to prevent mental illness have as yet been identified and applied. Mental health education as part of mother and child care and family health programmes, in public health courses, in schools etc., would promote mental health in general.

In some Muslim countries in EMR, suicides, attempts at suicide and alcoholism appear to be very rare. This suggests a strong influence of Islam or of religion in general in the prevention of mental health problems. In Saudi Arabia, religion and prayer also play an important role in the treatment of mental illness.
With regard to dependence on opium, the example of Iran shows that changing regulations restricting *papaver* cultivation and distribution can either diminish or magnify the problem of opium dependence.

2. **Extension of mental health care to the majority of the population**

Two approaches complement each other with regard to reaching a larger proportion of the population:

1. The existing mental health services have to be improved, strengthened and decentralized: this involves units in general hospitals and out-patient services.

2. Mental health care has to be integrated with general health care, also at the primary health care level.

This combined approach implies training courses in mental health care of various kinds. Refresher courses for mental hospital staff to improve their standards, to make them more community-oriented, to engage them in supervising and supporting health workers at other levels of service and also to make their own work more attractive.

Courses in mental health care must be established for general health workers already in the services and for people administering these services. There must be special courses in limited mental health care activities for primary health workers.

3. **Improvement of existing mental health services**

Specialized mental health services are the backbone of the total mental health care system, whether this is integrated with the general health care system or not. Mental health professionals (e.g. psychiatrists, psychiatric nurses, social workers, etc) are still too scarce in most countries to provide proper mental health care. With regard to psychiatrists, the disadvantages associated with relying on the developed countries for training are obvious. More and more countries are organizing their own basic post-graduate courses in psychiatry. This prevents brain drain and unnecessary frustration in the practice of psychiatry. Such basic training can always be complemented with training abroad for the acquisition of special skills and techniques.

The mental hospitals are often still too large and overburdened with long-stay patients. Several countries in EMR have already adopted programmes for rehabilitation of long-stay patients which include training rehabilitation workers and establishing.
sheltered workshops and homes or villages for chronically handicapped people. Another approach would be that of screening all in-patients with a length of stay of, for example, five years or more and investigating their residual social abilities and social background including family circumstances. Following this, contact with the family can be re-established and their return home attempted. Essential components of such a programme would be:

(a) a pilot study to examine the feasibility of this approach under the prevailing circumstances;
(b) a training programme for people involved in screening and later supporting chronic patients, based on the findings of the pilot study, and
(c) organizing a supportive network for families receiving and maintaining patients at home.

In addition to creating community-oriented out-patient services, dealing more adequately with acute admissions, programmes for activating and reducing the long-stay population would considerably improve the standards of mental hospital care, which in turn would render them more attractive to be employed in, and to serve for training.

4. Clinical psychologists in mental health care

In various countries in EMR clinical psychologists are increasingly playing a role in the mental health services, in the assessment of patients, in their treatment and rehabilitation and also in prevention. They participate in mental health promotion programmes and also in mental health research.

As in the case of psychiatrists, under- and post-graduate training in psychology and clinical psychology in a country or in the Region is necessary to fulfill the growing demand for this type of mental health professional.

5. Mental health legislation

The approach of EMRO has been to survey mental health legislation (see "Report on the Group Meeting on Mental Health", 1972, EM/MENT/49); to discuss the subject during visits of the Regional Mental Health Adviser to individual EMR countries; and to organize a "Group Meeting on Mental Health and Mental Health Legislation" in Cairo (EM/MENT/82, June 1976). The subject will not be discussed any further in this report. More detailed information can also be found in "The Law and Mental Health: Harmonizing Objectives" by W.J. Curran and T.W. Harding (WHO, Geneva, 1978).
The above approach has been quite effective in stimulating countries in EMR to drafting or revising mental health legislation.

6. **Psychotropic drugs**

Psychotropic drugs are an essential element in mental health care. Unfortunately, their availability is either lacking or too abundant and too costly. This is mainly the result of the absence at the central administrative level of a mechanism for selecting a limited range of effective psychotropic drugs, for buying these drugs in bulk and at as low a cost as possible or for promoting the manufacture locally, for stockage and for their distribution and proper use.

It would be helpful if WHO could issue annually a list of essential psychotropic drugs, with available sources of competitive prices.

**IX  CONSTRAINTS IN MENTAL HEALTH CARE IN EMR**

There are many factors constraining the development and execution of mental health care programmes. Although often low priority is accorded to mental health care this is often the result of scarcity of financial resources combined with other overriding priorities. Yet, lack of information about the burden of mental health problems on the community contributes to this low priority. This is only partly caused by lack of knowledge about mortality in mental disorders. Long-term disability of psychiatric patients, absenteeism from work because of mental health problems, and frequency of attendance at general health services of patients with psychological complaints. Another important reason is that planners and public health administrators have not yet sufficiently been made aware of existing facts about these various aspects of mental illness.

Lack of trained manpower in mental health action is perhaps the second most pressing constraint. Again, this is only partly due to a lack of financial resources, although this counts heavily. Often the status of mental health workers is considered so low and their circumstances of employment in large mental hospitals so unattractive that few people want to join the mental health services. At the same time in various countries of EMR, it has been shown that this can be overcome by improving the existing services and developing stimulating mental health care training programmes, increasing a sense of responsibility in mental health workers of all types.
The stigma attached to mental illness is not infrequently the result of the bad conditions prevailing in the traditional mental hospitals which in turn has led to a stigma attached to various jobs in mental health care.

Another constraint sometimes is the lack of proper models for psychiatric care in the countries of EMR, which have very different cultural and socio-economic conditions: from extremely rich to very poor, with differing religious denominations, or in various stages of technical development. Relying heavily on models for mental health care imported from western society may sometimes hamper its development locally.

Finally, although traditional communities often have their own secure way of dealing with mentally disturbed people, involvement of society in general in mental health care is sometimes difficult to achieve, which might explain why mental health policy is still absent in already formulated national health policies.

X CONCLUSIONS AND RECOMMENDATIONS

Since the Group Meeting on Mental Health, Alexandria, 4-7 September 1972, the following significant developments have taken place in the countries of the Eastern Mediterranean Region:

- more countries have mental health representatives in their ministries of health;
- several countries have by now drafted or revised mental health legislation; some others are studying this important subject concerning the rights of mental patients;
- no countries in the Region are today without in-patient facilities, while most countries, in developing their mental health services, have put emphasis on psychiatric units in general hospitals;
- hardly any country is today without one or more mental health specialists; the number of countries with some form of post-graduate training in psychiatry is increasing rapidly.

These are promising developments, yet they have to be seen against the increasing awareness that mental disorders are amongst the most serious health problems in all countries of the world. There is sufficient evidence that the burden of mental illness tends to increase with rapid social change, as is occurring in the countries of EMR,
while the more severe mental disorders lead to serious social disability. In
addition, patients repeatedly attending clinics in general hospitals frequently have
problems of a psychological nature, and therefore, constitute a considerable burden
on the general health services.

In the light of the above, the Group has looked into ways of implementing the
available knowledge regarding methods of prevention, treatment and rehabilitation in
mental health care, after having defined some of the more pressing mental health
problems:

- limited or even completely absent access to mental health care for large sections
  of the population, e.g. in rural areas as well as in large conurbations, or
  for specific age groups such as children;
- the presence of large numbers (up to two thirds of mental hospital in-patient
  populations) of long-stay patients crowding wards while not receiving any
  treatment;
- the special plight of mentally disturbed offenders, often without treatment and
  retained under inhuman conditions;
- a growing number of people dependent on drugs, as well as rapid changes in the
  patterns of dependence from natural to manufactured drugs;
- the burden of mentally retarded patients on their families, which is aggravated
  by their increasing rates of survival, socio-economic changes and by society’s
  demands for education of its children;
- the absence or deficiencies of mental health legislation establishing the right
  of all people to mental health care, determining the norms for proper psychiatric
  care, and protecting the civil rights of psychiatric patients;
- either the lack of psychotropic drugs or their availability in a bewildering
  variety of combinations which are expensive and have not proven their value.

1. Mental Health in National Health Policy

Since most countries nowadays act with regard to health on the basis of a national
HEALTH POLICY, the Group recommends that such a policy should be formulated with the
inclusion of a MENTAL HEALTH POLICY.

WHO should encourage the involvement of mental health professionals, whenever
possible, in health programming at country level.
2. National Coordinating Committee for Mental Health

As the promotion of mental health will only be successful with the combined effort of many disciplines, government departments and social agencies, this implies on the level of individual countries the institution of a NATIONAL COORDINATING COMMITTEE FOR MENTAL HEALTH including mental health professionals, public health administrators, representatives of various ministries with a clear mandate for action, and representatives of various community agencies. This national coordinating committee should be involved in formulating, evaluating and updating a national mental health policy under the chairmanship of a mental health professional.

3. Information concerning Mental Health Care

Mental health policy should be based on and evaluated against the background of relevant information concerning the needs and demands of the population. While establishing those needs and demands should be of continuous concern to Governments, the Group realizes the difficulty of obtaining relevant and reliable information of such nature. However, it considers that the minimum of information should include basic statistics on the operation of health services dealing with mentally disturbed patients such as types and numbers of staff, admissions and discharges, bed-occupancy, and out-patient contacts per institution or facility, as well as information on the patients themselves (e.g. provisional diagnosis, place of residence, etc.)

Necessary elements of a programme for developing general health data recording and reporting systems should be: definition and incorporation of a mental health component in the general health information system, training of staff in mental health statistics, establishing mechanisms for a continuous dialogue between producers and consumers of information and sensitizing the services to the need for collecting such information.

4. Priorities within Mental Health Care

In addition to the necessity of integrating mental health within general health programmes particularly those for primary health care, there is a need for establishing priorities within mental health care itself, because of the many competing claims upon its limited resources. Priority should be given to problems which, while being serious enough, stand a good chance of being solved because a solution is available and acceptable and people are concerned about them. Although the Group recognized
the importance of specific problems such as drug dependence in the Region, it felt that single-purpose projects should not be implemented at the expense of other mental health requirements. Activities in the field of drug dependence should be facilitated but within the context of the total mental health programme.

5. Training of Manpower

While significant increases in the numbers of various types of mental health personnel in the countries of EMR can be observed, the Group considers it necessary to re-emphasize the recommendations of the two previous Group Meetings regarding the priority of developing and conducting training programmes in Mental Health Care for:

(a) general health personnel at all levels, including primary health workers, to extend mental health care through its integration with general health care;
(b) physicians and general nurses already in the services, to involve them in mental health care;
(c) mental health professionals, doctors as well as nurses, to enable them to provide the necessary supportive mental health care network, to train others in the delivery of circumscribed tasks in mental health care, and to administer the mental health services.

6. Training of Mental Health Specialists

Recognizing the disadvantages associated with relying on the developed countries for the training of mental health specialists, the Group recommends that basic training of Mental Health Specialists should take place in their own countries, or failing this, in their own region and culture area.

7. Clinical Psychologists

The role of clinical psychologists in the mental health service, regarding assessment, treatment, rehabilitation and prevention, has been growing tremendously in various parts of the world over the last thirty years (c.f. WHO Chronicle, March 1972). The Group noticed that their availability was lacking in a number of countries in the Eastern Mediterranean Region. The Group recommends that Governments make adequate resources available for the development of training programmes in clinical psychology.
8. **Psychotropic Drugs**

Since treatment with psychotropic drugs is an essential element in mental health care and because of the emphasis on decentralization of mental health care and its integration with general health care, the Group recommends that steps be taken to select a limited range of psychotropic drugs, to look into ways to reduce their cost, and to facilitate their stockage, proper distribution and use at all levels of health services. For this purpose it is recommended that WHO issue annually a list of essential psychotropic drugs, with available sources of competitive prices.

9. **Other roles for mental health professionals**

Awareness is increasing of the dehumanizing effect of recent technical advances in general medical care, on its application to individual patients and on its interaction with the families of patients. In some cases modern medical care could gain from the study, in this respect, of traditional medicine. The Group feels that mental health professionals, because of their reliance on the analysis and management of relationships, should play a role in the re-humanization of medical care and in protecting the psychological needs of patients and their families.

10. **Mental Health Research**

Research is an important tool in the training of mental health professionals as well as in the evaluation of services and their improvement. Service delivery, drug efficacy, training methods, and the outcome of care are some examples of priorities in research. The Group recommends the promotion of national and regional research programmes and the establishment of centres to facilitate such research.

11. **Intercountry Coordination of Mental Health Programmes**

Although the Group fully acknowledges national responsibility for mental health policy and action, it is also aware that many mental health problems (e.g. drug dependence) ignore national frontiers and therefore demand coordinated programmes. WHO has, as one of its main tasks, global and regional coordination of mental health programmes for which it has its global and regional coordinating committee meetings.

**NATIONAL COORDINATING COMMITTEES FOR MENTAL HEALTH** would constitute a logical extension of this network.
ANNEX I

ADDRESS BY DR A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION
at the opening session of the
COORDINATION GROUP MEETING ON MENTAL HEALTH
Alexandria, 22-24 November 1978

I have the pleasure, on behalf of WHO, to welcome you all to this Regional Office and to thank you for your cordial collaboration and participation at this important mental health meeting.

Some of you may recall that in recent years we have organized two previous group meetings similar to this one. The first was in 1972 and the second in 1976. In this connection, you will be pleased to learn that the ideas and recommendations emanating from these meetings have been generally helpful in providing valuable guidelines for the better development of mental health activities. Following the last meeting many countries, for example, expressed keen interest to review their mental health legislations and amend them along the proposed lines and in harmony with universally accepted practices.

Over the years, it is also clear that several countries in this Region have made serious attempts in order to develop mental health care. Nonetheless, the needs are increasingly growing and available national resources are generally inadequate to meet these needs. Indeed, in the wake of rapid socio-economic developments and the changing medical scene, mental health is now emerging into the forefront of public health problems. Yet, despite the significant developments which have been generally achieved in therapeutic modalities, there are still many questions regarding the nature and extent of mental illness which continue to be unanswered. Furthermore, due to shortage of qualified mental health personnel, inadequacy of psychiatric training of general health workers and inappropriateness of psychiatric models, it has not been possible to utilize modern mental health technology for wide population coverage.

Because of this, your meeting has been designed with a view to examining the current mental health problems, defining future objectives and strategy, discussing
the difficulties encountered in national and regional programmes and drawing up suggestions for future planning and programming. Apart from these general issues you will note that your agenda includes specific activities in a variety of areas which some of you have mutually and collaboratively developed with WHO. I am confident that your distinguished group will competently discuss these specific topics dealing with training, extension of mental health care, mental health information and drug dependence.

Some of you have already participated in the WHO Inter-Regional Workshop on Drug Dependence which was held last month in this Office and I feel happy on this occasion to reiterate what I had previously stated regarding the success of the Workshop. Your further contribution in this meeting to this topic should be usefully complementary to the previous one.

I sincerely believe that, with your knowledge and experience and based on the exchanged views and available information, you will be able during this meeting to formulate appropriate proposals and draw up relevant recommendations which should form a practical framework for a viable and dynamic mental health programme.

I am sure you will be interested to learn that the Third Meeting for the Global Mental Health Programme, which comprises all WHO Regional activities, is scheduled to take place in this Office in September next year and hence the importance of your contribution in this meeting which will be given due consideration within the global context of the overall mental health programme.

With these ideas in mind, I wish you fruitful deliberations and successful discussions. I look forward, with interest and keenness, to the recommendations emanating from your distinguished Group.

Thank you.
ANNEX II

AGENDA

1 OPENING SESSION
2 ELECTION OF MEETING OFFICERS
3 ADOPTION OF AGENDA
IV SCOPE AND POLICY OF MENTAL HEALTH ACTION
V REGIONAL PERSPECTIVES OF MENTAL HEALTH PROBLEMS AND POSSIBILITY FOR ACTION
VI NATIONAL MENTAL HEALTH PROGRAMMES
   6.1 Review of problems
   - General
   - Specific (including psycho-social problems and drug dependence)
   6.2 Mechanisms and co-ordination of the programme
   6.3 Strategies for delivery of mental health care
   6.4 Legislation
   6.5 Training programmes
   6.6 Research
VII TECHNICAL CO-OPERATION IN:
   7.1 Training
   7.2 Research: Extension of Mental Health Care
   7.3 Drug Dependence
   7.4 Mental Health Information
VIII CONCLUSIONS AND RECOMMENDATIONS
IX CLOSING SESSION
### ANNEX III

**LIST OF PARTICIPANTS**

### CYPRUS

Dr Petros Matsas  
Medical Superintendent  
Psychiatric Institutions (for Cyprus)  
Athalassa

### DEMOCRATIC YEMEN

Dr Abdul Cadir El Kafi*  
Psychiatric Consultant  
Ministry of Health  
Aden

### EGYPT

Dr Ahmad Saad El-Din El Hakim  
Head  
Mental Health Services  
Ministry of Health  
Cairo

Dr Moustapha Soueif  
Professor and Chairman  
Psychology Department  
Faculty of Arts  
Cairo University  
Cairo

Dr A.F. El-Sherbini  
Professor of Family Health  
Head, Family Health Department  
High Institute of Public Health  
Alexandria

### IRAN

Dr Irajd Siassi  
Deputy Minister of Health and Welfare  
for Mental Health and Rehabilitation  
National Iranian Society for Rehabilitation  
of the Disabled  
Teheran

### IRAQ

Dr Jabiah Jodeh Ahmed Al-Shatahchi  
Specialist in Mental Health and Psychiatry  
Shamaiya Psychiatric hospital  
Director, Rushd Hospital  
Baghdad

*Did not attend
KUWAIT

Dr Abdullah Al Rifai
Secretary General
Faculty of Medicine
Kuwait University
Kuwait

LEBANON

Professor A.S. Manugian O.B.E.
Medical Director
The Lebanon Hospital for Nervous and Mental Disorders
P.O. Box 110092
Beirut

PAKISTAN

Dr Mohammed Zaheer Khan
Associate Professor
Dow Medical College
Department of Psychiatry
Civil Hospital
Karachi

Dr Malik Husain Nabbashar
Head
Psychological Medicine Department
Central Government Hospital
Karalpindi

SAUDI ARABIA

Dr Osama Al Khado
Director-General
Psychiatric Hospital
Taif

SUDAN

Dr Hasab El Rasoul Soliman*
Director
Mental Health Services
Khartoum

REPRESENTATIVES FROM OTHER UNITED NATIONS BODIES

Fu Fawzi El Ghifry
Programme Officer
United Nations Development Programme
Cairo

OBSERVER

Dr Sawsan Fahmi
Professor of School Health
Department of Family Health
High Institute of Public Health
Alexandria

* Did not attend
WHO SECRETARIAT

Dr I.A. Jaasner
Regional Advisor on Mental Health - Secretary of the Meeting
WHO Regional Office for the Eastern Mediterranean, Alexandria

Dr G. Rikka
Director strengthening of Health Services
WHO Regional Office for the Eastern Mediterranean, Alexandria

Dr H. Sartorius
Director Mental Health Division
WHO Regional Office for the Eastern Mediterranean, Alexandria

Mr W. Gulkinat
Statistician Mental Health Division
WHO Central Office, Geneva, SWITZERLAND

Professor Robert Giel
WHO Consultant
WHO Regional Office, Geneva, SWITZERLAND

Conference Services

Mrs C. Cartoudis-Demetrio
Conference Officer
WHO Regional Office for the Eastern Mediterranean, Alexandria

Mrs A. Economakis
Secretary
WHO Regional Office for the Eastern Mediterranean, Alexandria
ANNEX IV

BASIC DOCUMENTS AND BACKGROUND MATERIAL

1. PROFILE OF PRIORITY PROGRAMME IN YOUR COUNTRY

Your name: Your country:

POLICY BASIS
(e.g. relevant statement or recommendation in national health programme or other plan for action)

PROBLEM DEFINITION
(description of problem that the programme aims to solve, including factors contributing to the problem)

OBJECTIVES AND TARGETS
(Formulate exact objectives of programme, and give time limit and if possible, quantifiable targets)

Please use back page if necessary.
DESCRIPTION OF PROGRAMME
(Describe approach leading to attainment of objectives and actual targets; give essential components and steps in programme)

CONSTRAINTS TO YOUR PRIORITY PROGRAMME
(Describe difficulties and obstacles encountered or expected)

Please use back page if necessary.
### Data Recording Sheet for Outpatient Census

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Project identification</td>
<td>WHO COORDINATED PROJECT ON MONITORING OF MENTAL HEALTH NEEDS</td>
</tr>
<tr>
<td>2.</td>
<td>Country code</td>
<td>ombo</td>
</tr>
<tr>
<td>3.</td>
<td>Code for study area</td>
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</tr>
<tr>
<td>4.</td>
<td>Code for outpatient facility</td>
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</tr>
<tr>
<td>5.</td>
<td>Leave</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Leave</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Name of person who fills in this sheet</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Date of census</td>
<td>20-25</td>
</tr>
<tr>
<td>9.</td>
<td>Patient's number</td>
<td>26-29</td>
</tr>
<tr>
<td>10.</td>
<td>Place of residence</td>
<td>1. in study area, 2. outside study area</td>
</tr>
<tr>
<td>11.</td>
<td>Sex</td>
<td>1. male; 2. female</td>
</tr>
<tr>
<td>12.</td>
<td>Date of birth</td>
<td>32-37</td>
</tr>
<tr>
<td>13.</td>
<td>Age in years</td>
<td>38-39</td>
</tr>
<tr>
<td>14.</td>
<td>Civil Status</td>
<td>1. single; 2. married, 3. widowed, 4. separated or divorced, 9. unknown</td>
</tr>
<tr>
<td>15.</td>
<td>Patient lives</td>
<td>1. alone; 2. with family; 3. in institution; 4. other; 9. unknown</td>
</tr>
<tr>
<td>16.</td>
<td>Date of first attendance</td>
<td>42-47</td>
</tr>
<tr>
<td>17.</td>
<td>Frequency of attendance</td>
<td>48-49</td>
</tr>
<tr>
<td>18.</td>
<td>Appropriate placement</td>
<td>50-51</td>
</tr>
<tr>
<td>19.</td>
<td>Diagnosis in terms used at facility:</td>
<td>(a) primary psychiatric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(b) other significant mental or physical handicap</td>
</tr>
</tbody>
</table>
20. ICD code for
   (a) primary psychiatric condition
       ICD 8th rev. ICD 9th rev. (optional) 52-59
       ICD 8th rev. ICD 9th rev. (optional) 60-67
   (b) other significant mental or physical handicap

21. Nationality
   1. Kuwaiti;       2. Arab non-Kuwaiti; 68
   3. Asian non-Arab; 4. Europeans and Americans; 69
   5. Others;        9. Unknown 70

22. Religion
   1. Moslem;       2. Christian; 68
   3. Hindu;        4. Others 69

23. Education
   1. Non-literate; 2. Primary 70

24. Size of household
   1. 1;            2. 2-5; 71
   3. 6-10;         4. 11-15; 5. Above 15

Appropriate Placement Category (item 18)
Definition: the service which is considered the best possible for the client irrespective of whether or not it is available in the study area.

01 = No change
02 = Psychiatric Hospital
03 = Psychiatric ward in general hospital
04 = Out-patient psychiatric care
05 = Out-patient medical care
06 = Chronic disease or geriatric hospital
07 = Acute general hospital
08 = Day hospital
09 = Night hospital
10 = Nursing home with strong psychiatric support: mental nursing home
11 = Nursing home with strong medical support
12 = Half-way house
13 = Old People's Home
14 = Therapeutic community, etc.
15 = Work village
16 = Residential school or training centre for the mentally retarded
17 = Hostel
18 = Boarded out in family care
19 = Living in own home with home help, 'meals-on-wheels', etc.
20 = Living in own home, independently
21 = Other, specify
WHO COORDINATED PROJECT ON MONITORING OF MENTAL HEALTH NEEDS

DATA RECORDING SHEET FOR INPATIENT CENSUS

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

7. Name of person who fills in this sheet

8. Date of census

<p>| | | | | |</p>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Place of residence
1. in study area; 2. outside study area

11. Sex
1. male; 2. female

12. Date of birth

13. Age in years

14. Civil Status
1. single; 2. married; 3. widowed; 4. separated or divorced; 9. unknown

15. Patient status
1. Voluntary; 2. Detained; 9. Unknown

16. Date of present admission

17. Admitted from
use code as indicated on reverse side of this sheet

18. Appropriate placement
use code as indicated on reverse side of this sheet

19. Diagnosis in terms used at facility:
(a) primary psychiatric
(b) other significant mental or physical handicap
20. ICD code for
   (a) primary psychiatric condition
      ICD 8th rev.  |  ICD 9th rev. (optional)
      |  52-59
   (b) other significant mental or
       physical handicap
      ICD 8th rev.  |  ICD 9th rev. (optional)
      |  60-67

21. Nationality
   1. Kuwaiti;
   2. Arab non-Kuwait;
   3. Asian non-Arab;
   4. Europeans and Americans
   5. Others;
   6. Unknown

22. Religion
   1. Muslim;
   2. Christian;
   3. Hindu;
   4. Others

23. Education
   1. Non-literate;
   2. Primary;
   3. Secondary
   4. University
   5. Higher

24. Size of household
   1. 1;
   2. 2-5;
   3. 6-10;
   4. 11-15;
   5. Above 15

Admitted from (item 17)

Use the following codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Self</td>
</tr>
<tr>
<td>20</td>
<td>Relatives and friends</td>
</tr>
<tr>
<td>30</td>
<td>Employer</td>
</tr>
<tr>
<td>31</td>
<td>School</td>
</tr>
<tr>
<td>32</td>
<td>Army</td>
</tr>
<tr>
<td>40</td>
<td>Psychiatric agency</td>
</tr>
<tr>
<td>41</td>
<td>Private psychiatrist</td>
</tr>
<tr>
<td>42</td>
<td>Mental Health Centre</td>
</tr>
<tr>
<td>43</td>
<td>General hospital, psychiatric unit</td>
</tr>
<tr>
<td>44</td>
<td>Psychiatric clinic</td>
</tr>
<tr>
<td>45</td>
<td>Other psychiatric facility</td>
</tr>
<tr>
<td>46</td>
<td>Institution or facility for retarded</td>
</tr>
<tr>
<td>50</td>
<td>Medical (non-psychiatric) agency</td>
</tr>
<tr>
<td>51</td>
<td>Other private physician</td>
</tr>
<tr>
<td>52</td>
<td>General hospital</td>
</tr>
<tr>
<td>53</td>
<td>Nursing home</td>
</tr>
<tr>
<td>54</td>
<td>Armed forces (hospital)</td>
</tr>
<tr>
<td>55</td>
<td>Medical (non-psychiatric) agency</td>
</tr>
<tr>
<td>56</td>
<td>Other private physician</td>
</tr>
<tr>
<td>57</td>
<td>General hospital</td>
</tr>
<tr>
<td>58</td>
<td>Nursing home</td>
</tr>
<tr>
<td>59</td>
<td>Armed forces (hospital)</td>
</tr>
</tbody>
</table>

Code

60 = Correctional agencies
61 = Police
62 = Court
63 = Other (specify)
70 = Welfare agency
71 = Missions
72 = Clergy
73 = Welfare
80 = Anonymous
90 = Other
91 = Government department
92 = Vocational rehabilitation
93 = Other public agencies
94 = Other (specify)
### Appropriate Placement Category (item 18)

**Definition:** The service which is considered the best possible for the client irrespective of whether or not it is available in the study area.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>01</td>
<td>No change</td>
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<td>Psychiatric Hospital</td>
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<td>Acute general hospital</td>
</tr>
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<td>08</td>
<td>Day hospital</td>
</tr>
<tr>
<td>09</td>
<td>Night hospital</td>
</tr>
<tr>
<td>10</td>
<td>Nursing home with strong psychiatric support: mental nursing home</td>
</tr>
<tr>
<td>11</td>
<td>Nursing home with strong medical support</td>
</tr>
<tr>
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</tr>
<tr>
<td>19</td>
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</tr>
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<td>20</td>
<td>Living in own home, independently</td>
</tr>
<tr>
<td>21</td>
<td>Other, specify</td>
</tr>
</tbody>
</table>