WHO AND MENTAL HEALTH 1949-1961

WORLD HEALTH ORGANIZATION
GENEVA
1962
The World Health Organization (WHO) is one of the specialized agencies of the United Nations. Through this organization, which came into being in 1948, the public health and medical professions of more than 100 countries exchange their knowledge and experience, and collaborate in an effort to achieve the highest possible level of health throughout the world. WHO is not concerned with problems which individual countries or territories can solve with their own resources. It deals, rather, with problems which can only be satisfactorily solved through the co-operation of all, or certain groups of, countries—the eradication of diseases such as malaria, the control of cholera, plague, yellow fever, smallpox and rickettsiosis. Progress towards better health throughout the world also demands international co-operation in many other activities: for example, setting up standards for biological substances, for insecticides and insecticide spraying equipment; compiling an international pharmacopoeia; drawing up international sanitary regulations; revising the international lists of diseases and causes of death; assembling and disseminating epidemiological information; recommending non-proprietary names for drugs; and promoting the exchange of scientific knowledge. In many parts of the world, there is need for improvement in maternal and child health, nutrition, nursing, mental health, environmental sanitation, public health administration, professional education and training, and health education of the public. Thus a very large share of the Organization’s resources is devoted to giving assistance and advice in these fields to countries and territories whose health services are in an early state of development and which are therefore weak points in the common front against disease.
WHO AND MENTAL HEALTH 1949-1961

3 Introduction
7 The development of psychiatric services
12 Mental health and the public health services
17 Some problems of prevention and treatment
28 Education, training and research
38 Programme development
46 WHO reports and studies on mental health
This publication is a reprint of a series of articles that appeared in *WHO Chronicle* between March and July 1962.
"If policy makers open the way to the acquisition of further knowledge, if practitioners in the mental health field co-operate with scientists in thoughtful experimentation, if the fruits of research can be applied without losing respect for the diversity of human beings, concern with mental health may improve the quality of living." 1

INTRODUCTION *

From the end of the eighteenth century new ideas on the subject of mental health began to make some headway against the traditional view that the insane should be kept under restraint in institutions. In Europe and America Chiarugi, Pinel, Tuke, Dix, and Korsakoff—to mention but a few of the reformers—contributed to the fundamental ideas governing modern views of mental disorder: that mental ill health is disease just as much as physical ill health, and should be studied in the same way; and that humane treatment of the mentally ill effects far greater improvements in their state than forcible confinement and rough handling.

The nineteenth century was a century in which international collaboration in the field of health developed greatly, with the aim primarily of preventing the spread of such diseases as cholera and plague. 2 In the first half of the century Mediterranean Sanitary Councils met at intervals, to be followed from 1851 on by International Sanitary Conferences that continued to be held periodically right up to the foundation of the Office International d'Hygiène Publique (OIHP) in 1907. There was a parallel, though somewhat later, movement in the field of mental health, the first International Congress of Alienists taking place in 1867. Still later came the mental hygiene movement in the USA. This movement was started by Adolf Meyer, a psychiatrist, and Clifford Beers, a gifted layman who had himself been insane, and together they founded in 1909 a national committee for mental hygiene that aimed at improving the treatment of mental patients and removing the stigma attached to mental illness. The programme of the committee included analysis of the statistics of mental ill health, hospital surveys, legislative reform, investigation of delinquency and criminality, the fostering of child psychiatry and social work, and the study of the effects of industrialization on mental health. Similar national associations were founded in many countries, following the example of this committee. In 1910, a group of Canadian and US psychiatrists and laymen met for a conference that led to the foundation of the first international mental health association.

The high incidence of psychiatric casualties in the First World War gave impetus to the search for methods of prevention, and two international congresses on the subject were held between the wars, the first in Washington in 1930, the second in Paris in 1937. However, neither the OIHP nor the Health Organisation of the League of Nations seems to have taken much interest in mental health. For the whole period 1920-1945 the entire bibliography of the technical work of the League contains only four items listed under mental hygiene, and these deal only with certain aspects of mental deficiency. Attempts by the International Committee for Mental Hygiene, an authoritative non-

---

governmental body, to collaborate with the League and secure the appointment of a psychiatrist to the staff of the League's Hygiene Division proved abortive. The League showed some concern with the possible ill effects on mental health of the economic depression of the 1930's, but its few desultory inquiries were not pursued.

The Second World War, like the First, stimulated psychiatric thought. The effects of environmental stress and social psychiatry in general aroused much interest, and a new kind of psychiatrist emerged, engaged largely in preventive work away from the institutional atmosphere and with many opportunities for operational research and for fitting men into jobs for which they were mentally and temperamentally suitable. The lessons learned proved of value for many peacetime problems of mental health. Many of the leaders of postwar psychiatry occupied key positions in the psychiatric services of the Allied armies. The first postwar International Congress on Mental Health (i.e., the third meeting of the old Congress of Mental Hygiene) was organized by Dr J. R. Rees, who had been head of the psychiatric services of the British Army; it was at this Congress, which was held in London in 1948, that the World Federation for Mental Health, the successor of the International Committee for Mental Hygiene, was formally constituted. The first Director-General of WHO, Dr Brock Chisholm, was a psychiatrist who had been head of the psychiatric services of the British Army; it was at this Congress, which was held in London in 1948, that the World Federation for Mental Health, the successor of the International Committee for Mental Hygiene, was formally constituted. The first Director-General of WHO, Dr Brock Chisholm, was a psychiatrist who had been head of the Canadian Army Medical Services; and the first chief of the Mental Health Section in WHO, Dr G. R. Hargreaves, had been Dr Rees' wartime deputy.

The role of WHO

At the end of the Second World War much urgent rehabilitation, necessarily including some aspects of mental hygiene, was carried out by UNRRA; and when the Technical Preparatory Committee for the International Health Conference met in Paris in 1946 mental health was one of the problems very much in the minds of the delegates. The nascent World Health Organization was urged to face the new needs arising from difficult psychological situations. Dr Chisholm's view was that "The ills from which the world is suffering are mainly due to man's inability to live at peace with himself..." and he called for an understanding of the psychological evils that stand as barriers in the way of physical and mental well-being. The draft proposals for the WHO Constitution put forward by the delegates of France, the United Kingdom, USA, and Yugoslavia all referred to the importance of promoting mental equally with physical health. Later in the same year the International Health Conference, meeting in New York, approved the final form of the Constitution. The preamble to the Constitution begins with the definition of health as being "a state of complete physical, mental and social well-being", and later clauses state that "Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development" and "The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health." Article 2 lays down that the functions of WHO shall be, inter alia: "to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment" and "to foster activities in the field of mental health, especially those affecting the harmony of human relations".

The mental health programme of WHO in 1949

In 1948 the First World Health Assembly, meeting in Geneva, allotted priorities for WHO's future activities. Mental health was given fifth priority, coming after what were then considered the more urgent categories of malaria and other endemic-epidemic diseases and of public health administration.

A WHO Expert Committee on Mental Health met in 1949 and carefully considered the principles that should govern WHO's future activities in mental health. In view of the gross disparities in therapeutic

---

facilities between even the well-developed countries, and the impracticability of attaining in the foreseeable future the optimum ratio of one psychiatrist to 20,000 population, WHO should—the Committee held—encourage the preventive applications of psychiatric knowledge by promoting the incorporation into public health work of responsibility for the mental as well as the physical health of the community. In advanced countries there were highly developed therapeutic facilities but almost no preventive services, prevention being the part-time activity of therapists (if carried out at all). Thus the situation differed essentially from that of somatic disease. It should be WHO’s task—the Committee considered—to build up the preventive aspects of mental health work, not by turning public health workers into psychiatrists, but by encouraging training and specialization in mental hygiene. To coordinate preventive activities, each ministry of health should develop a mental health section that should not, as in the past, be chiefly concerned with the legal aspects of psychosis. In the view of the Committee, each country also needed an institute of mental hygiene to eliminate as far as possible those factors in community life that are conducive to mental disorder.

A second principle laid down by the Committee was the desirability of concentrating especially on the therapeutic and preventive psychiatry of childhood, since adult mental disorder may be prevented by treating minor psychological disturbances in childhood and preventive measures make their greatest impact at that time of life.

The Committee felt that techniques and methods developed in one country, however advanced, were not necessarily of any value when transplanted to another country. The best scientific knowledge available should be used to solve local problems, not by automatic application without regard to the circumstances, but in an attempt to discover methods appropriate to the local situation. In some areas, for example, it might be more appropriate to treat patients through family care than to build up a system of mental hospitals.

A final principle laid down by the Committee for the future development of WHO’s mental health activities was the importance of integrating them whenever possible with other WHO activities such as public health administration, maternal and child health, nursing, etc., and with the work of the United Nations, the specialized agencies, and non-governmental organizations.

Implementation of the programme

WHO was the first intergovernmental organization to undertake the encouragement of mental health work. It inherited no traditions and had to evolve methods suitable for international work in a comparatively young specialty where few workers could be spared for long-term assignments and where the language barrier presented a greater hindrance than in most other fields. The general direction of its activities and the details of its programme were to be determined according to the needs in different parts of the world and the available services, and in the light of previous national and international endeavour. The Organization had to proceed by stimulating and supplementing—not transplanting—the efforts of individual states; and by adopting an approach that not only utilized the newest techniques of investigation and treatment but also scrutinized the activities of mental health planners themselves. It was appreciated that the wholesale transplantation of techniques from one country to another could create as many problems as it solved; and that what mattered was to make the best skills from the more developed countries available for use as seemed wisest under local conditions. It was realized that this might necessitate some re-thinking: the psychiatric hospital of European or North American pattern might prove less suitable for Asia than some form of community care; and existing programmes of child guidance might need to be modified.

The organizational structure of WHO is well known, with its Headquarters in Geneva and its Regional Offices for Africa, the Americas, South-East Asia, Europe, the Eastern Mediterranean, and the Western Pacific. Human and physical environment and social
organization obviously vary widely from Region to Region, and indeed within each Region, as does the degree of development of psychiatric services, which are complex and expensive in Europe and North America and almost totally lacking in parts of Asia and Africa. The task of WHO in the psychiatric field is not to impose unity on this diversity; this would be as impossible as it is undesirable. It is a question rather of discovering, or uncovering, the basic needs of Member States or of whole Regions and of delineating those areas where effort may be most usefully expended.

The Mental Health unit established at WHO Headquarters in 1949 has the task of providing leadership, of co-ordinating and stimulating the activities of the Regions. It is concerned with policy and with the promotion of a body of knowledge that can be utilized in public health administration. The mental health work of the Regional Offices consists of the local application of this information; and, as the European Office is not so preoccupied with the communicable diseases as the other Regional Offices, it is not surprising that it has given a lead in mental health work of a high standard.

To review and revise policy, WHO calls from time to time on the Expert Committee on Mental Health established by the Second World Health Assembly. This Committee, of varying constitution, is drawn from an advisory panel of nearly 100 members in 38 countries. From time to time seven or eight of these members are convened to report on a subject of interest in respect of current needs and future practice. The reports of these meetings—eleven have been held since 1948—provide an illuminating survey of the development of international thought in the field of mental health over the last twelve years. The first of these reports has been summarized above in some detail. Other meetings of the Committee have been concerned with the promotion of mental health through public health services, with community mental hospitals, with psychiatric hospitals as centres of preventive activity, and with social psychiatry and community attitudes. Legislation affecting treatment, the epidemiology of mental disorder, and the mental health problems of aging have been other topics. One meeting was devoted to undergraduate training in psychiatry, another to the role of public health officers and general practitioners in mental health. In 1960, an important meeting reviewed the work of the preceding years in the light of the experience gained since 1949 and laid down a new programme for the future.

All these meetings dealt in broad outline with basic mental health topics. More specific subjects—inter alia, alcoholism, epilepsy, drug addiction, and chemotherapy in mental illness—have been discussed by the Expert Committee in conjunction with other Expert Committees of WHO, or, less formally, by study groups constituted for the purpose. At seminars and conferences organized by WHO, often jointly with other bodies, representatives of developing countries in need of information on mental health have had the opportunity of hearing experts on the subject from different parts of the world; at others, subjects having a bearing on mental health work have been discussed with non-psychiatrists.

WHO has assisted the development of psychiatric services in Member States in other ways, notably by making available the services of highly qualified short-term consultants who could not be spared for longer periods, but who have often been able to make return visits and advise on further progress. Experts have been sent in response to governmental requests for advice on matters ranging from the development of entire mental health programmes to more specific issues such as the training of psychiatrists or the provision of child guidance facilities. Some half-dozen countries every year have requested and received such assistance since 1949. A complementary activity has been the award of fellowships to enable suitable persons, nominated by their governments, to attend seminars in their own Regions; more than 500 such fellowships have been awarded in the field of mental health. In addition, nearly 300 health workers from 50 countries have been awarded mental health fellowships enabling them to
study abroad for periods of up to two years; these awards have usually been for studies of the broader aspects of the subject, such as child psychiatry, psychiatric nursing, and child welfare.

A valuable outcome of all this activity, and one of considerable educational import, has been the building up of a library of publications on mental health topics. WHO has now published—either in its Monograph Series or as Public Health Papers—many authoritative studies in this field by experts of high international reputation. The monograph by Bowlby on Maternal Care and Mental Health is an outstanding example.

The wide scope of these studies—whose subjects range from hospital architecture to epidemiology—has further extended WHO’s educational influence in the field of mental health.

Finally, WHO has collaborated extensively with other international bodies, both governmental and non-governmental, in discussions concerned—sometimes only indirectly—with mental health. It was fortunate that 1948 saw the birth of a powerful professional organization, the World Federation for Mental Health, with which WHO has maintained a cordial and productive association. Although the main responsibility for international work in this sphere has fallen to WHO and the World Federation for Mental Health, they have not been alone in fostering such work. UNESCO has encouraged the introduction of mental health ideas into teaching practice and their application to problems of leisure, and its work in the fields of social science and education, of racial prejudice and international tension, is also of relevance to the promotion of mental health. The United Nations Bureau of Social Affairs has taken an interest in the origins of juvenile delinquency, as well as in its more juridical aspects, and in problems of urbanization and adoption. WHO has participated with the United Nations, ILO and UNESCO in many meetings, and has been able to offer expert advice on the psychiatric aspects of the problems at issue and to gain from the experience of the other organizations in allied fields.

THE DEVELOPMENT OF PSYCHIATRIC SERVICES

In many parts of the world organized psychiatric services barely exist or are only being started; and this, though it makes their development an urgent matter, also provides an opportunity to experiment and to profit from the experience and the mistakes of the more advanced countries. Even in these countries there is much scope for development, the current trend being away from the closed institution to a psychiatric service closely linked with the life of the community. In psychiatric work everywhere, there is an increasing emphasis, which WHO has fostered, on the preventive aspects: the conventional primary prevention of mental disorder; secondary prevention, i.e., treatment, preventing further deterioration; and tertiary prevention, i.e., the rehabilitation of the mentally disabled.

The community mental hospital

All psychiatric services may be considered as based either on the psychiatric hospital, whose influence in the community is extended by extramural activities; or on a medico-social team which deals with all the mental health problems of the community, using the hospital as one of its tools. The former pattern exists in many countries with long-established mental hospital networks; the second may prove more satisfactory in countries just starting to build up their psychiatric services. WHO has always stressed the importance of training staff before proceeding to construct centres, for otherwise patients may deteriorate in the absence of

---

5 Bowlby, J. (1952) Maternal care and mental health, Geneva (World Health Organization: Monograph Series, No. 2).
proper care. In its fifth report,² the Expert Committee on Mental Health stated that services should be based on a small active treatment unit—with out-patient facilities and perhaps some mobile units—which could serve as a clearing-house. This unit could be independent, and might have a day or night hospital attached; or it could form part of a general hospital, with an associated unit for chronic cases. A service organized in this way could be integrated into the basic public health structure.

The Expert Committee’s third report,³ which dealt with the community mental hospital, postulated a general minimum of 1 bed per 10,000 population as essential for the care of patients so disturbed as to endanger themselves or others. The stresses of increasing urbanization might well multiply this figure. Once this basic need had been met and as more staff became available, attention would have to be directed to developing new external services rather than to providing extra beds. With better preventive services and consequent earlier treatment, fewer patients would need admission and their stay would be shortened. The responsibilities for chronic patients would remain heavy, but priority should be given to active treatment units, especially in areas building up new services, the long-stay departments being complementary. In many countries chronic patients could be satisfactorily cared for at home or boarded out. The mental hospital, stressed the report, should function as a therapeutic community in which the good relations within the professional team would make for good relations between staff and patients and among the patients themselves. As patients retain initiative and self-respect more readily when encouraged to take responsibility, an important part of the treatment should consist of planned activities ranging from simple training for the grossly deteriorated to administrative duties. Architecture (see below) may also be used to emphasize the community aspects of a psychiatric hospital.

Rehabilitation

In progressive countries it is taken for granted that even the most severely physically disabled persons should be afforded the opportunity of rehabilitation; the mentally handicapped do not always have the same opportunity, though their rehabilitation is rewarding both for the help it brings to the individual patient and its contribution to the general well-being. In an unpublished report, two WHO consultants (M. Jones and A. Stoller) define rehabilitation as the attempt to enable patients to achieve the maximum range of activity within the community compatible with their personalities, interests and capacities; this is a definition applicable to the schizophrenic and the fracture case alike.

The selection of patients for rehabilitation rests with the doctor, yet many doctors—particularly in large mental hospitals—are unaware of the possibilities it offers. Neurosis centres would seem to have special advantages in this work, as they lack the stigma attaching to the mental hospital and are staffed by doctors interested in dynamic psychiatry. A rehabilitation selection committee might usefully consist, as in the United Kingdom, of a doctor, a disablement resettlement officer, and an experienced social worker. Wherever psychiatric rehabilitation is practised, occupational therapy and organized activity satisfy the patient’s creative needs and contribute to his feeling of security; and psychotherapy should be available for psychopaths or other possible disturbing elements.

Progress has been made with units for the rehabilitation of employees in industry. These have real value in allowing convalescents to bring into the open their resentments against authority, and can also be used to instruct managerial staff on the tensions that may arise in working relationships. Therapy through participation in community work has always been a feature of rehabilitation methods in the USSR. More sheltered employment is valuable for the severely disabled, but it can advantageously be replaced by competitive employment as the public becomes more broadminded in its attitude to mental illness. The final transition to ordi-

---

nary social life is the vital stage of rehabilitation and, in re-establishing everyday patterns of behaviour, it may be valuable to make use of intermediate communities and out-patient assistance. Finally, as much care should be taken over the employment and working conditions of patients who must remain in hospital as over those of patients who can be resettled outside.

Architecture and mental health services

In a WHO publication two psychiatrists and an architect have considered the architectural requirements of a modern psychiatric service. It is their basic contention that, as far as possible, patients should remain self-supporting in the community; that if they cannot they should be treated at home; and that hospital care should be provided only if treatment at home proves impossible. It is important that the hospital environment, in its physical as well as its emotional impact, should be such as to encourage good human relations and a sense of purpose. Rehabilitation is one of the most important aims of psychiatry, and tendencies to regressive behaviour due to illness should not be aggravated by the environment. A badly planned hospital can also affect the quality of the psychiatric services it provides. Buildings for the mentally ill should reflect the trend away from the large self-contained and custodial institution towards smaller and freer units linked with the community. It is both financially and therapeutically unwise to have large blocks accommodating 1000 or more patients.

The WHO publication just mentioned also deals with the needs of out-patient clinics, day and night hospitals, after-care homes and working settlements. The architectural design of each element of an integrated psychiatric service is considered, and a block plan of a hospital of the recommended small size is given, with details of ward arrangements permitting adequate day space. For workshops, group therapy centres, and residential and administrative quarters, the units should be grouped like those of a college or village to create living communities. This facilitates the resocialization of the individual patient through membership of a series of groups gradually increasing in size. A hospital on these lines has been built near Paris under the direction of Dr Sivadon and, after careful preparation with a nucleus of staff and patients, is now coming into full operation.

Day and night hospitals

Patients who are not in need of full-time care may benefit from treatment in a day hospital attached to the community mental hospital, returning home at night. This is useful for the treatment of severe psychoneuroses, as therapy can sometimes be given more intensively under such conditions than in an ordinary out-patient clinic, and without the disadvantages of complete hospitalization. On the other hand, patients still capable of working but too disturbed for ordinary family life may benefit by continuing to go out to work, returning to a night hospital where they can receive sedation and psychotherapy.

Out-patient clinics

An out-patient service may well begin with the provision of consultant advice by the staff of the community mental hospital to general practitioners and to the medical staff of any associated general hospital. From this will develop the opportunity for treating the earlier stages of mental disorder; and if the mental hospital doctors also work in the out-patient clinics they can bridge the gap between hospital and community in preparing patients for admission and watching them after discharge. As facilities allow, special clinics will eventually be required for children, for epileptics and alcoholics, and for psychotherapy.

Basic requirements

The development of psychiatric services so far outlined presupposes a favourable psycho-
social environment, a suitable legislative framework, and—perhaps most important of all—a sufficient number of adequately trained staff so disposed as to maintain continuity of care. These three requirements will now be considered in more detail.

The psychosocial environment

The need to relate psychiatry more closely to the community is being increasingly felt, for only if society learns to collaborate will psychiatric advances enable many patients to resume normal life. Since progress largely hinges on a greater measure of such collaboration, "Social psychiatry and community attitudes" was the theme of the seventh report of the Expert Committee on Mental Health.5

Social psychiatry may be defined as the sum of preventive and curative measures aimed at fitting the individual for a satisfactory and useful life within his own social environment, i.e., measures aiding those with actual or incipient mental illness to retain or regain their contacts and functions in society. In planning any co-operative endeavour in the field of mental health it is necessary to have a clear picture of the position of the mentally sick within the community. As, in many cases, the only information available comes from ill-defined impressions of social usage, detailed research has been initiated into the public attitudes commonly adopted towards psychiatrists and their patients. Much still remains to be done in this direction, and in finding ways of favourably influencing the climate of opinion. One obvious need is to improve and extend those treatment facilities—such as child guidance clinics—that are linked with everyday life. It is also important to disseminate information about the nature of mental disorder, and to conduct research on the best means of doing so. In many instances, and particularly in the less developed countries, surveys of community attitudes may well be combined with the wider approach of cultural anthropologists and with the epidemiological research into mental disorder now envisaged by WHO.

Legislation

The third report of the Expert Committee on Mental Health postulated that legislation on psychiatric care should be based on the full extent of knowledge in this field. Much existing legislation is misdirected, being more concerned with placing checks on patient and physician than with guiding and promoting the public provision of psychiatric services. In 1953, to encourage the adoption of modern legislation in this field, the WHO Secretariat undertook a comparative study of different national procedures for the admission and discharge of mental patients and the special provisions for epileptics, criminals, alcoholics and psychopaths. This study was later expanded and published.6 Safeguards against improper detention, notification, inspection of institutions, and appeals against detention were also reviewed. The survey showed that some countries had brought their legislation up to date; others still enforced outdated laws emphasizing the protection of society rather than the care of the patient.

The fourth report of the Expert Committee on Mental Health7 confirmed the main defects of mental health legislation: the emphasis on legal rather than on medical considerations, the unnecessary infringement of civil liberties, the absence of concern with minimum standards of care. It stated that future legislation should encourage the development of mental health services, rather than hospitalization of the unwilling patient; if services improved, the occasions for compulsion would be fewer. The Committee considered it possible, with careful planning, to exercise control with less prejudice to the medical and social status of patients than results from some judicial methods.

It is not for a mental health act to lay down detailed standards for psychiatric services; this should be done by a body possibly established by legislation, but designated by the central health authority. It is for this body at the national level, and for local health authorities at a lower level, to license and inspect mental hospitals and other institu-

---

6 *Int. Dig. Hlth Legis.*, 1955, 6, 1-100.
tions. Special legislation to provide for mentally subnormal children and for others mentally handicapped is undesirable, existing powers usually being adequate. The movement of the mentally deficient between hospital and community should not be too rigidly controlled. In sum, the whole basis of mental health legislation should be the provision of treatment, guardianship and supervision for mental patients in accordance with their medical needs and social abilities. The application of this principle will naturally vary according to the traditions of each country. There seems little doubt that some governmental changes in legislation have been influenced by the standards promoted by WHO; for instance, many proposals of the Expert Committee on Mental Health have been given effect to in such recent legislation as the British Mental Health Act of 1959.

Staff

The main problem in establishing efficient psychiatric hospitals and services is that of providing and training medical and nursing staff, for in many countries there is a serious shortage of psychiatrists and psychiatric nurses. Much of the advice given to governments by WHO consultants, and many of the fellowships awarded by the Organization, have been concerned with the training of such staff. The entry of many new, particularly African, States into WHO, though it may accelerate the pace of development of psychiatric services, has increased the demand for assistance with training.

It is here that the WHO regional seminars, by bringing together workers in the public health and mental health fields, may be particularly valuable. The first African mental health seminar, held in Brazzaville in 1958 after a preliminary meeting in Bukavu had surveyed mental health problems against the historical background, considered the two most important requirements of African services to be trained staff and out-patient centres, hospitals being of subsidiary importance. It saw possible advantages in using general rather than psychiatric hospitals as bases, and suggested the use of psychiatric field units where there are no rural dispensaries. The mobile medical team is already a feature of African life, and parallel psychiatric teams could include psychiatrists, welfare workers, nurses and psychologists. Such teams would need to survey an area’s requirements as well as to dispense treatment, and would be well placed to conduct education in mental hygiene. In this task they would have to co-operate with political and legal bodies, and with religious and tribal authorities.

It is important when staffing problems have been solved—and possibly even more important while staffing remains inadequate—that all the services dealing with the different stages of mental health care should be fully integrated. This not only makes for the most efficient use of the existing personnel, but also for continuity in treatment from prevention and diagnosis to full social rehabilitation. Integration and continuity of treatment are necessary in all branches of medicine; they are especially so in psychiatry, which moreover is particularly well placed to exert a unifying influence on medicine in general. As Kerbikov, dealing with psychiatric education in the USSR, has pointed out, although medical specialization and progress have led to some fragmentation of medical studies and practice, there are certain integrating elements. One of these is psychiatry, which has therefore a special place in the curriculum for senior medical students in the USSR: “To a large extent it is psychiatry which . . . supplies the impetus, so necessary for modern medicine, towards a combined integral solution of problems of health and disease. . . . There are grounds for believing that this role will increase in importance in the future.” If this is to be the case, it is obviously necessary to increase the psychiatric understanding and responsibilities of the general practitioner and public health officer.

The importance of mental health personnel working together as a team has been emphasized in a number of WHO publications and meetings. In countries newly developing their services a team comprising one or two psychiatrists, two welfare workers, a nurse

---

with some training in psychiatry and a psychologist may well form the basis of a psychiatric service before consideration is given to the development of more elaborate facilities.

Assistance to governments

It has already been indicated that very considerable assistance has been rendered by WHO to Member States in the development of their psychiatric services. A number of consultants have been sent at the request of individual governments to survey local psychiatric needs and facilities, to help settle priorities, and to advise on the pattern of development. With this has been coupled the provision of fellowships for training and the organization of regional or sub-regional seminars. No detailed account of these activities will be given here. Every Region has benefited in a manner appropriate to the existing resources and the extent of local needs. Thus, extensive consultant advice has been provided to countries of the Eastern Mediterranean Region, while such advice has been less in demand in the countries of the European Region, where seminars and conferences have proved more useful. An important principle underlying the pattern of WHO's assistance in the development of mental health services is that it should be continuous. Consultant aid may remain available over several years—as in India between 1955 and 1960 in connexion with the establishment of the All-India Psychiatric Institute and the planning of student training—or consultants may return after the lapse of a year or two to note progress and make further suggestions. By such continuity the maximum fertilizing influence is achieved.

MENTAL HEALTH AND THE PUBLIC HEALTH SERVICES

The second report of the WHO Expert Committee on Mental Health ¹ outlined the areas where mental hygiene—i.e., those activities and techniques that promote and maintain mental health—is the concern of the public health services, and laid down principles for incorporating the practice of mental hygiene into public health work. In its third report ² the Expert Committee reiterated that, at the national level, mental health work should be organized by a division within the ministry of health, or equivalent government department, under the direction of a physician experienced in this field.

The application of mental hygiene principles in public health practice, through closer co-operation between hygienists of every category, was considered at WHO seminars for the European, Eastern Mediterranean and Western Pacific Regions in 1953. Some of the practical problems involved were discussed by a study group held in Monaco in 1955 by the WHO Regional Office for Europe, and the whole subject was reviewed by a WHO European Conference on Mental Hygiene Practice that took place in Helsinki, Finland, in 1959. The conclusions of these meetings and of similar meetings with which WHO has been associated are discussed below.

Maternity services

All health workers concerned with obstetric services must have a thorough appreciation of the emotional significance of childbirth for both parents. The hygienist needs to be well acquainted with the psychological aspects of pregnancy, and should be given time to foster good personal relations with the mother by discussing family problems and the normal anxieties of this period with her. Fears arising from ignorance and superstition can often be dispelled by simple scientific information given tactfully to women, at the right time, individually or in groups, with an opportunity for free discussion. In many cases the family equilibrium is disturbed by

pregnancy, or pregnancy may complicate an already disturbed situation, and here the principles of ordinary social work may be applied. It is important throughout to maintain a continuous satisfactory relationship between the mother and her doctor, nurse or midwife, and to promote effective liaison with any separate agency, such as a hospital, assisting in the actual delivery.

**Infants and pre-school children**

Parents should be guided towards flexibility in the management of young children, and to an understanding that rigid feeding and sleeping schedules, fussy and premature toilet training, and restriction of movement may be psychologically harmful and prejudice the child's later mental development.

A basic requirement for harmonious development in the early years is a good uninterrupted relationship with the mother, or with her substitute, and public health workers must strive to maintain this bond even under conditions alien to traditional public health practice and even, perhaps, when the child's physical needs might be better served under other arrangements. The doctors and nurses concerned with infant health services should find the time to help mothers understand the normal pattern of their children's emotional and intellectual development and their fundamental needs, including respect for personality and individuality. The claims of illegitimate children in this sphere are particularly important. It is obvious from these requirements that the status of the health workers concerned should be such as to ensure candidates of good calibre, and that nursery schools and similar institutions should habitually co-operate with the medical services, particularly in the care of disturbed or backward children.

**The care of homeless children**

When a child cannot grow up in his own family it is best that he should be placed in the affectionate care of a substitute family—relatives, foster parents or adoptive parents—from an early age.

A joint United Nations/WHO expert meeting discussed the mental health aspects of adoption in New York in 1952, stressing that adoption, usually the best means of securing a stable background for a homeless child's development, should start as soon after birth as possible. The mothers of the illegitimate children so often concerned must therefore make an early decision. Though they should be assisted to keep their children, if able and willing, circumstances too often compel them to give them up at a time when adoption is so delayed as to be disturbing to all the parties involved. In such late adoptions the change to a new home should be gradual and the child should be allowed to retain some links with the old home. In every adoption the need to find a suitable home must be balanced against the disadvantages of delay. The most important qualities of the prospective home are the opportunities it offers for forming loving ties with the new parents, whose motives for adoption should be correspondingly mature. They should be of normal parental age and, ideally, the new child should arrive as the youngest member of an existing family and be made fully aware of the facts of the situation at an early date. Adopted brothers and sisters ought to remain together, or be kept in close contact. Adopting parents should not set their standards for the health, intelligence and family background of the child too high; they must be willing to take the risks that every ordinary parent takes, and should realize that the child's intellectual and personal development will depend to a large extent on its surroundings and on communicated attitudes.

The foster care of children was the subject of United Nations seminars held, with WHO participation, in Oslo in 1952, in Paris in 1954, and in Frankfurt in 1955. Foster care is mostly resorted to for children removed from "bad" homes; but to remain in an unsatisfactory home may prove less damaging than to live with strangers or to change background frequently. If familiar relatives will undertake his care, the child may be

spared removal to totally strange surroundings; but even strange foster parents are generally to be preferred to institutional care for small children. It is more important for a foster home to promote stability, trust, and the conditions for eventual independence than merely to provide material comfort; and the social worker must be skilful in matching child and home. Success depends on this, and on preparing all concerned, especially the child; good contacts should be maintained between all parties, including the biological parents. Particular care is therefore needed in the selection and training of social workers for this task. It is important that the status of the foster parents should be duly appreciated and that they should receive adequate remuneration.

Institutional care is necessary when no other workable solution exists for the problem of the homeless child; but it runs the risk of failing to provide the close and continuous relations with a mother figure that are so important for young children. Small institutions, where the children are distributed in groups cared for by house mothers and fathers in scattered cottage homes, may prove a good substitute for ordinary family life. Residential nurseries are not a really satisfactory environment for very young children, though group residential care may be useful—even indispensable—for maladjusted children after the age of six, or for adolescents.

The child in hospital

The emotional deprivation that a child may suffer through a stay in hospital can cause more harm than is generally realized. A WHO Study Group on the Child in Hospital, held in Stockholm in 1954, agreed that—where feasible—sick children should not have the anxieties of separation added to those of physical illness. It is important that any hospitalization that is unavoidable should be so planned as to ensure that the child, who has little concept of time or illness, should not develop an idea of permanent rejection. The mother should remain with him for a while after admission, ideally during the whole of his stay; and he should be cared for in small unpretentious wards by doctors and nurses he knows, without—as far as possible—the employment of alarming or unexplained procedures. The advantages of frequent parental visiting (and this applies also to visits by children to parents in hospital) are great and must be balanced against the theoretical disadvantages; in most instances no serious risk of infection appears to be involved and any temporary emotional upset that results is probably only an index of a sound and persistent attachment. The discharge of a child, even to his own home, after a prolonged stay in hospital also has its adjustment problems and needs to be carefully prepared. To help promote better standards of institutional care for children, WHO supported the production by the Tavistock Clinic, London, of the well-known film entitled A Two-Year-Old Goes to Hospital. Hospital staffs to whom this film was shown were often remarkably unaware of the existence of the common and painful phenomena it illustrates.

The nursery school

The nursery school, which is an important stage in the path along which the child passes from its exclusive relationship with the mother to a wider relationship with society, was the subject of a joint WHO/UNESCO meeting of experts in 1951. The task of this type of school is to encourage individual development while fostering group cohesion and, in co-operation with the parents, to help children in their problems. These problems are far from trivial. The nursery school child often passes through a period of intense instinctual conflict; and, by providing an atmosphere less emotionally charged than the home and an opportunity for relations with adults other than the parents, the school is well placed to encourage maturation. The staff must be prepared to

---

deal with periods of regression, and to help children overcome through constructive play the guilt attached to aggressive impulses. Thus the role of the nursery school is to supplement the functions of a good home; the teacher should not try to supplant the mother, but should rather reassure the child by maintaining cordial relations with the home. Every nursery school teacher should be aware of the phases of normal growth and be prepared for sudden changes in behaviour, fluctuations between dependence and independence, and some confusion between right and wrong, fantasy and fact, on the part of the children in her care. Hence the importance of techniques for selecting mature teachers capable of free and natural contact with children, especially as one task of the nursery school is the early diagnosis and management of maladjusted and otherwise handicapped children.

Schoolchildren and students

Medical officers and nurses can profit from the periodic physical examinations they carry out at school clinics to discuss the mental health problems of children with their parents and teachers, and to direct children towards child guidance clinics or other specialist help when necessary. Especially in residential schools, health workers and school staffs should collaborate in creating an atmosphere favourable to personal development. They can also help to solve the emotional problems of children handicapped physically, balancing any need for lengthy hospitalization against the possible ill effects on the child's emotional well-being.

In 1954 WHO was represented on a UNESCO Expert Committee on Psychological Services for Schools and Other Educational Institutions, which described as the main object of such services the fullest possible development of every child's personality consistent with social requirements and limitations. In school, mental hygiene activities extend from the detection of maladjusted children to more constructive and preventive work. School methods and curricula should be adapted to the individual rhythms of child growth. The psychologist can co-operate with the teacher in solving some of the problems created by the present trend towards greater freedom in education. Through the children psychological services can reach parents involved in domestic misunderstandings; and the continuing study of children by teachers and psychiatrists working together will spotlight problem cases.

Public health responsibilities for mental hygiene among students at universities and other centres of higher education have still to be fully developed. Such services as do exist function mostly under private or collegiate auspices. As the university years are a notorious testing time for the mental stability of adolescents and young adults, some closer association in prevention and treatment between the public health and academic authorities is often indicated.

Occupational health services

The first report of the WHO Expert Committee on Mental Health referred to two factors relevant to mental health in industry: the training of industrial supervisors in the essentials of human relations, and the employment of physically and psychologically handicapped individuals under suitable conditions. A WHO consultant visited Scandinavia in 1950 to discuss mental hygiene problems arising in industry, and a number of training courses concerned with these problems were later organized by WHO in France, Italy, the Netherlands and the United Kingdom. Fellowships for training in this field have also been awarded by the Organization.

Mental hygiene is important in industry since at least one quarter of all absences from work are due to mental disorder of some kind, usually neurotic. A common cause of neurosis is lack of social contact during employment. The mental health of industrial personnel is also closely linked with the soundness of human relations at the place of work,

and with the efficiency of vocational selection and the quality of supervision. The size of a factory may increase the anonymity, and hence the anxieties, of its workers. Stress may also result from the monotony of increased mechanization, with its demands for unwearying attention and lack of any openings for initiative. Physical strain, poor working conditions, grievances and unsuitable jobs all carry obvious hazards for mental health. The principles of mental hygiene cannot be written into working conditions without obtaining the co-operation of managements, either by the instruction of managerial trainees or through special courses for established staff.

As most of the responsibility for industrial welfare inevitably devolves on the industrial medical officer, he should be so qualified as to gain general acceptance and respect. Though not required to be primarily a psychiatrist, he should be well acquainted with psychiatric problems and know when to refer cases to a specialist. An advisory group convened by the WHO Regional Office for Europe in 1956 to consider human relations and mental health in industry suggested that industrial medical officers might even begin their introduction to the psychiatric and sociological factors important to industrial mental health before final qualification. Established medical officers should receive postgraduate training in problems of human relations, and there should be frequent refresher courses in this field.

Psychiatrists are most useful in industry in advising on problems of morale, in dealing with tensions in human relations, and in interviewing, training and general counselling. They are rarely required for individual problems; but occasionally psychiatric clinics have proved useful in particular plants in treating early cases of psychoneurotic disorder. The general expansion of industrial medical services into the whole field of human relations can be achieved only by the closest co-operation between industrial medical officers and managements, social psychologists and psychiatrists. In this field trade unions have an essential role to play. At a joint ILO/WHO European Conference on the Industrial Medical Officer's Contribution to the Psycho-Social Environment in Industry, held in London in 1959, a considerable degree of unanimity was reached between doctors and representatives of both workers' and employers’ organizations.

Rehabilitation of the physically disabled

The full emotional significance of physical disability must be recognized by public health workers. The problem is often complicated by excessive reactions on the part of both employers and employees which adversely affect the resettlement of the disabled. Health workers are better placed to help with practical solutions if they understand human reactions, including their own, to deformity and disability. It is important to recognize that there can be no physical rehabilitation without mental rehabilitation, and vice versa.

These principles were discussed at a European Seminar on the Rehabilitation of the Adult Disabled held by the United Nations, with WHO participation, in Belgrade in 1954. Properly cared for, a few mature disabled persons make a healthy adjustment to their new condition. Others less well endowed may be helped to do so. Various morbid complications may occur: overcompensation, pessimism and ineffectual resentment may lead to refusal to resume work of any kind or even to a serious withdrawal from reality. To be successful, rehabilitation must satisfy the basic human need for security and provide vocational retraining in group surroundings fostering resocialization and the growth of independence. The aim throughout should be restoration to a life differing as little as possible from the normal.

Care of the aged

At the end of life mental hygiene retains, or even gains, importance. The care of the aged is an increasing problem in some countries and some social classes, for medical and social advances and a declining birth rate have in many places greatly increased the proportion of old people in the population.
In some countries a mounting burden of responsibility for old persons is borne by the mental hospitals, and the general medical services are also severely strained. This may be due, not so much to a genuine increase in senile mental disorder, as to a deterioration in the willingness or the ability of the family to take on the burden of caring for its aged or aging members.

Some of the implications of this situation were considered at Geneva in 1958 by an Expert Committee which dealt with mental health problems of aging and the aged. The pattern of such problems naturally varies from place to place according to the demographic background and to the speed at which the local culture is changing. An understanding of the normal psychological changes of the elderly is useful in maintaining their mental health, the most important principle being that they should retain a feeling of usefulness to society. It is always preferable to organize comprehensive geriatric services that aim at keeping old people in their own homes wherever possible—if necessary with domiciliary help—and, if hospitalization becomes unavoidable, at reintegrating them into everyday life at the earliest opportunity.

Poverty, enforced retirement and isolation are important sources of senile disturbance. Premature aging and physical degeneration also make their contribution, and admission to a mental hospital is usually decided by a combination of physical and mental ailments. The community can greatly benefit from the experience of the old, and should be kept aware of their needs and potentialities. The traditional pessimism in the prognosis of geriatric illness is now slowly disappearing. Recent experience has shown that many of the mental health upsets of old age are reversible and full social rehabilitation is successful if expert medical attention is made available at an early stage. Care for the aged is most effective against the family background. WHO attaches increasing importance to this aspect, and a seminar held in Athens in April 1962, under the auspices of the WHO Regional Office for Europe, discussed mental health and the family.

* * *

There are, finally, very few fields of public health work that are not concerned in some way with mental hygiene. Even apparently routine procedures, such as the isolation of patients with acute infectious disease or the treatment of those suffering from venereal diseases, can cause acute mental distress, and this should always be borne in mind by the public health workers who carry them out.

SOME PROBLEMS OF PREVENTION AND TREATMENT

Mental health problems in childhood and youth

The briefest reference to the subject matter of the conferences, seminars and study groups organized by WHO, or to a list of WHO publications, will indicate the importance attached by the Organization to the mental health of children in both its preventive and therapeutic aspects. This has formed possibly the largest single part of its mental health programme, and WHO consultants to countries engaged in developing their psychiatric services have often stressed the need to give priority to facilities for children, since these are more likely to be beneficial in the long run than facilities for the disturbed adult. Some aspects of public health practice as it concerns the mental health of children have been discussed in the preceding section and so will not be considered in detail here.

Normal and deviant patterns of development were discussed at a seminar on mental health and infant development held by the World Federation for Mental Health in 1952, and at a UNESCO Conference on Education and the Mental Health of Children in Europe held in Paris in the same year; WHO was represented at both these meetings, the second

of which based part of its discussions on a joint UNESCO/WHO report on mental hygiene and the nursery school. A course on social psychiatry in childhood took place in Paris and London in the following year under the joint sponsorship of UNICEF, the International Children’s Centre, and WHO. All these meetings stressed the importance to the child’s maturation of harmonious and emotionally secure early development.

One valuable feature of mental health work in WHO and in other international organizations is the opportunity it affords for comparing findings from very different societies. In 1953, a WHO seminar on mental health in childhood, held in Sydney, Australia, brought together welfare workers from Western Pacific and South-East Asian countries with different traditions of child rearing. The importance of preserving the family unit was stressed at a mental health seminar held in Montevideo, Uruguay, in 1955 by the Pan American Sanitary Bureau, which acts as the WHO Regional Office for the Americas; and mental health and family life was the subject of the seminar for Asian countries held in the Philippines in 1958 under the joint sponsorship of the Government of the Philippines, the Asia Foundation, the World Federation for Mental Health, and WHO. Compared with those of Europe and North America, Asian and Pacific societies tend to have a more relaxed discipline with children, permitting earlier independence from the parents. However, social patterns are rapidly changing under the influence of European and North American culture—and also in Europe and North America themselves as the social system becomes more complicated. In most societies the weakening of the parental role and the growing complexity of the social environment threaten the mental health of children; but stability may be preserved by maintaining consistent parental attitudes and a satisfactory parent-child relationship.

Maternal deprivation: the Bowlby report

The view expressed by Dr J. Bowlby in the WHO monograph Maternal Care and Mental Health, is that prolonged deprivation of the young child of maternal care may have grave and far-reaching effects on his character and so on the whole of his future life. Though how prolonged deprivation must be to produce these effects consistently is still a subject of controversy, and though the validity of the thesis has been questioned, it seems undoubted that deprivation—particularly during the first year of life—may produce an affectionless psychopathic individual, and that the damage can be mitigated by providing good alternative mothering in time. Deprivation may also produce anxiety and depression.

The growing personality needs intimate personal relationships at critical periods of growth, and children lacking proper mothering run a particular risk of being mentally disturbed. Under the influence of Bowlby's work changes have taken place in many institutions for children. Surveys in various European countries have amply confirmed the disadvantages of institutional upbringing. Although the separation, absence, illness or death of parents are important factors—as also is illegitimacy—, a common cause of deprivation in industrial societies is neglect caused by the inability of unstable parents to build good family relationships; and where family failure is due to parental psychopathy the problem is often difficult to solve. In such cases, it is important to ensure that the children are cared for as long as possible in their own homes. Every social device, such as rest homes for mothers and marriage or child guidance services, should be used to prevent family breakdown. It is better (and cheaper) to give parents assistance than to place their children elsewhere. Maladjusted children can be helped at specially staffed day schools; though for older children, boarding schools may be temporarily useful to interrupt home tensions.

Since Bowlby's views have often been popularized in a somewhat naive way, it is important that expert advice should allay, rather than create, anxieties on child care. The whole subject is reviewed, and some of
Bowlby's original theses disputed, in a publication on maternal deprivation appearing in the WHO Public Health Papers series.

Child guidance

A number of seminars on, or relating to, child guidance have been held by WHO, including a Scandinavian seminar on child psychiatry and child guidance work in 1952; a Western Pacific seminar on mental health in childhood in 1953; and seminars held by the WHO Regional Office for Europe in Switzerland and Belgium in 1956 and 1960 respectively. An important WHO monograph based on some of the material from these discussions was recently published.3

Child guidance clinics deal with many types of disturbed development and therefore utilize a multiplicity of diagnostic tests: physical examination, possibly supplemented by electroencephalography, psychiatric interview, intellectual assessment by a psychologist, and study by a social worker of the home situation. In the case of very young children, most information is obtained by the patient observation of their spontaneous activities. Parents must be included in the examination, for the child's disturbance is often an index of family difficulties. Parents often resort to child guidance centres at times of crisis without genuine belief in the capacity of the staff to obtain better results than themselves; the staff should therefore seek to relax their tensions, allay their grievances, and increase their understanding of their children and of themselves. Careful history-taking alone is often therapeutic. Viewed as a whole, the data obtained usually indicate whether a disturbance is likely to be only temporary or of a more chronic nature, but prognosis is always difficult; blatant symptoms may subside without necessarily indicating cure, or may reappear as psychosomatic disorder.

The treatment of disturbed children includes many forms of individual and group therapy and institutional management, which are all described in detail in the WHO monograph. The progress of each patient should be discussed at every stage by a team consisting of psychologist, social worker and psychiatrist; and, ideally, all children should be followed up after the cessation of treatment until early adult life.

The selection of patients for treatment is often difficult, not only because their needs may be hard to assess but because facilities may not be available for all. The final choice of patient must depend on the available staff and the size of the community; a vast case-finding system is not justifiable if treatment cannot be guaranteed. In certain areas some specialization may be possible, so that there may be special centres dealing, for example, mainly with delinquents.

In many countries child guidance centres have not yet been accorded the importance they deserve. Their aim is not only to assist children to develop their individual aptitudes to the full, but also to awaken society generally to the emotional needs of developing children. In the past WHO has assisted several countries—notably Ireland, Austria and France—to develop child guidance services, by providing consultant advice, training fellowships, and equipment. Plans for 1962 include the provision of similar aid to Finland, Greece, Israel, Italy, Portugal and Spain.

Mentally subnormal children

The problems of many subnormal individuals can be minimized by proper care during childhood, i.e., by preventive measures within a comprehensive framework of health and educational services, including vocational placement. These problems were the subject of a Joint Expert Committee convened by WHO in Geneva in 1953,4 with United Nations, ILO and UNESCO participation, and also of a seminar held jointly by the WHO Regional Office for Europe and the United Nations Technical Assistance Administration in Oslo in 1957. A seminar on the mental health of the subnormal child was held in Milan by the WHO Regional Office for Europe in 1959.

Subnormality may be defined as a general intellectual insufficiency, in which the mental capacities are sometimes so far below average.

---

as to require special arrangements or even institutional care. In several countries about 10-12% of all children are affected by some type of mental deficiency or backwardness. (Such estimates can only be approximate; it was noted at the Milan seminar that milder forms of handicap often pass unnoticed unless they are shown up by compulsory education or by the stresses of city life.) The causes of subnormality, though well understood, are often difficult to establish in individual cases, but even severely incapacitated children can usually be helped to find some place in the community. When there is only a minor degree of retardation or when retardation results from inadequate education of the physically handicapped, children ought to attain the position to which their capacities entitle them, but more could probably be done to enable subnormal children in general to develop their abilities to the full.

Early diagnosis is important and may devolve on the parents, teachers, or school nurse. Unnecessary secondary handicaps can be prevented by the early reference to clinics of children who are not developing normally. As a rule, such children should be dealt with by local clinics serving all kinds of normal and handicapped children, and not by special centres. Disinterested specialist advice helps the parents to face the realities of a difficult situation and plan the future objectively. The Expert Committee made extensive recommendations on welfare, education and legislation. Home care, even if it necessitates generous assistance, is usually better for the child and the family and cheaper than admission to an institution; though admission may be needed if a child is too disturbed, or too disturbing, or if caring for it unbalances the family budget—for it is possible to spend too much money and time on a backward child, at the expense of the rest of the family. Premature institutional care, however, may lessen an infant's chances of forming personal relationships. Though the old idea of the institution as the best solution to the problem of backward children is losing its sway, there is still a place for small institutions to care for such children for short periods, keeping in touch with their homes.

Subnormal children of school age should be the responsibility of the educational authorities. They need schooling devised to avoid too rigid a categorization by intellectual capacity at any given time and allowing for development. Small classes, personal attention and suitable techniques help the subnormal to make the best use of their abilities and of vocational training. Legislation concerning these children should form part of legislation for the care and protection of children in general; existing services, rather than new ones, should be used for backward children; and the interests of the whole family, rather than of the child alone, should be those considered. The costs of mental subnormality to the state are great and WHO has given considerable assistance in this field to various governments in the form of consultant advice and staff training.

**Juvenile epilepsy**

In 1955 a WHO Study Group on Juvenile Epilepsy defined this condition in terms of the well-known clinical forms of attack accompanied by the characteristic cerebral discharges. Reliable statistics are difficult to obtain because of the briefness of many attacks and the frequent concealment of even serious cases; some 5% of all infants have at least one fit, but in most cases there is no recurrence. The disease frequently originates from a temporal lobe lesion due to injury or infection, and it is then most likely to be associated with some intellectual impairment. When the diagnosis of a disturbance is obscure, behaviour disorders and epilepsy may be mistaken for each other. The possibilities for psychological treatment in epilepsy are important and often overlooked. The fits alarm the parents and may provoke conflicts unfavourable to the child, who ought to lead as normal a life as possible, attending school under surveillance and being placed in work by an informed employment officer. The doctor and nurse can help to lessen public prejudice and to create a favourable home atmosphere.

---

UNICEF and WHO jointly assisted the Austrian Government in 1950 and after to develop its juvenile epilepsy programme, and WHO also helped to equip the Abassia Mental Hospital in Egypt for work in this field. In January 1960 there was inaugurated at Marseilles the Centre St Paul for the medical and social care of juvenile epileptics, planned and built under the leadership of Professor H. Gastaut in full accordance with the recommendations of the WHO Study Group on Juvenile Epilepsy, of which Professor Gastaut was a member.

Juvenile delinquency

In 1951 a WHO consultant, Dr L. Bovet, contributed a report to the United Nations programme on the prevention of crime and the treatment of offenders. Despite the clear-cut legal definitions of delinquency, Dr Bovet believed that no specific delinquent type exists and that delinquency is not an illness but a symptom of maladjustment between the individual and society in which the fault sometimes lies with the latter. Many delinquents, especially in times of social unrest, exhibit no signs of serious mental or physical disorder. Some certainly appear to suffer from a constitutional personality disorder; in other cases epilepsy or epileptiform processes may provoke, or be associated with, delinquent behaviour. The role, if any, of mental deficiency is hard to assess. Many forms of psychological disturbance may dispose towards delinquency; they may be the outcome of antisocial behaviour in family life, of alcoholism in the parents, or of early maternal deprivation. Delinquent behaviour may be a neurotic symptom or an alternative to neurotic breakdown. In most cases there is a basic insecurity that generates aggressive activity; and this, in turn, excites further anxiety and destructive behaviour.

Ten years after Dr Bovet's report, there appeared (also as a contribution to the United Nations programme on the prevention of crime) a study on juvenile delinquency by another WHO consultant, Dr T. C. N. Gibbens.7 If there has been an increase in delinquent behaviour of recent years, Dr Gibbens considered, this may be due to new opportunities for crime, or may reflect changes in previously unaffected sections of the community; but any statistics purporting to prove such an increase may merely be the outcome of refinements in the definition or detection of offences. The delinquent comes mainly from the poorer strata, the "delinquent areas" of cities, which have a "subculture" of their own. He feels himself to be of inferior status and restores his self-esteem, or resolves his emotional conflicts, by joining a group that defies and denies the values of the community. The original inferiority feelings, if not due directly to poverty, may have been the result of faulty upbringing marked by parental neglect and rejection. A biological factor of some relevance is the widening of the gap between physical and psychological maturity in industrialized society. Puberty is beginning earlier now that children are better nourished and at the same time the prolongation of education often postpones the assumption of adult responsibilities. (This is, incidentally, responsible for much promiscuity in adolescent girls.) In wealthy countries the high purchasing power of many teenagers tends to give adolescents a rather special position relative to both adults and children, and encourages the acquisition of expensive and sometimes vicious tastes. The economically determined changes occurring in family structure may tend to undermine the father's position in the family and breed tensions between the parents, whose insecure children may later reproduce the parental behaviour patterns. The complexity of the etiology of delinquency is shown by the way an increase in one country may not be paralleled in another of very similar social structure. But it is clear that a general factor is the rootless, secularized and impersonal nature of urban society. The press, radio, cinema and television are often blamed; but they probably only determine the content, not the incidence, of delinquency.

---

Stealing is the commonest delinquent act. It may be impulsive, or imitative, or committed to assert the delinquent's manhood or as a substitute for love. Stealing, sex crimes, violence, and alcoholism or drug addiction do not appear to be becoming much more common; but there is an increase in public hooliganism by youths wearing distinctive clothing and indulging in wanton damage or large-scale rioting. It is true that such activities may express hostility to the older generation, or a reaction to present-day insecurity in the absence of religious or other positive enthusiasms; but genuine delinquency usually has its roots in some disturbance within the family situation. Much of the anxiety publicly expressed on the subject is no more than the classical reaction of the older generation. In fact, delinquency may sometimes be a disorder of good prognosis and even a valuable safety-valve—an alternative to more intractable disorders.

The prevention of delinquency forms part of the general protection of the health and well-being of children. Delinquency really represents a failure of education in the home or in the school; and so the approach to the problem by teachers and parents, police and doctors, should be positive rather than punitive. It may be necessary to make some attempt at prediction studies, so that preventive therapy may be applied to children thought likely to become delinquent.

Because treatment is so diverse, and the wrong treatment may damage an individual's whole life, a full clinical and psychological review of doubtful cases is essential; and outpatient management is generally to be preferred to institutional care, which may foster feelings of rejection and resentment and associate young persons with more hardened offenders. The whole object of treatment, apart from the protection of society, is to enable those concerned to build more stable human relationships on a foundation of greater inner security. When the disturbance appears to be situational and the personality reasonably normal, it may suffice to make simple changes in the environment; but youths with any degree of personality disorder are likely to become adult psychopaths and are correspondingly difficult to manage. Although many mentally disordered persons can be treated outside hospital, this is much more difficult when the presenting symptom of disorder is delinquent behaviour.

The institutional treatment of delinquents was specifically studied by a United Nations seminar held in Vienna in 1954 with WHO participation. It was generally felt that when institutional commitment becomes essential its duration should, ideally, be determined by the length of treatment required. The primary aim of institutional care should be demonstrably therapeutic; nevertheless, it should be made clear that commitment is to some extent retributive. The staffs of institutions must be at least as well trained as teachers or social workers outside; and their directors, if not psychiatrists, should be in touch with modern psychiatric methods. Many young people in these institutions find it difficult to form stable personal relations, and psychoanalytic methods are proving useful in providing access to these affectionless individuals. But all forms of psychotherapy and group therapy find their application in the care of delinquents, and no treatment is complete without prolonged after-care. Supervision by a probation officer after discharge is an important feature of after-care; indeed, when this officer is of good calibre and has a good relationship with his charges, probation can often be used as an alternative to commitment.

Some mental health problems in adult life

The impact of technological change

Societies have a threshold of tolerance for rate of change which, if exceeded, must lead to some measure of social disorganization. Past experience has shown how great an effect industrial and technological changes may have on mental health, through their impact on family life and their disruption of old patterns of living. In this field, the immediate task is to find out more about the effects, prevention and control of social disintegration, and the reactions of individuals and groups to rapidly changing circumstances. It may even be that the best hope lies in training young people to come to terms with social
insecurity. The damage in industrial urbanized societies is already largely done; but in the developing countries it may, perhaps, be forestalled. With this in mind, WHO has held seminars on mental health and family life in Africa, South America, and Asia. It has also given particular attention to two specific technical innovations: automation in industry and the peaceful applications of atomic energy.

**Automation.** Automation, in the sense of the increasing mechanization of work previously carried out by men and women, is by no means new in the history of technical development. Nevertheless, any extension of recent innovations is likely to have something of the impact of the original Industrial Revolution. At present, only a small part of the working population of industrial societies is directly affected by these innovations; but it is certain that future developments will involve far greater numbers, with both positive and negative implications for their mental health. The problem was considered by a WHO Study Group in 1958.8

Reactions to the introduction of automation include both preoccupation with its possible consequences and the stresses of adaptation to new working and living conditions. There may be unreasonably optimistic hopes for improved living standards, as well as irrational fears of unemployment and bad working conditions. The complexity of the new machines and the effort of adaptation to changes in the rhythm of work are disturbing. Psychological stress may accompany the reduction of manual work if the operative has to become an unremitting machine-minder, only remotely connected with the industrial process yet with an increased responsibility since serious damage may sometimes result from a single error. Tension states may well accompany this need for continuous fixed attention unrelieved by physical activity; and the wider spacing of workers may lead to a depressing isolation. On the other hand, a high degree of automation, intelligently applied, could eliminate the need for meaningless repetition.

The individual may be affected by secondary social changes: changes in the location of industry, in the mobility of labour, a possible reversal of the urban drift; and these may work for, as well as against, mental health. Increases in shift work may threaten family cohesion or produce problems of leisure time. Automation may limit operatives' chances of promotion if there are fewer and more rigidly defined posts; but it may also, by increasing personal responsibility, bring the factory worker's conditions of employment closer to those of the office worker. The physical stresses of automation can be alleviated by human engineering studies and by improving the lay-out of machines, but in the long run the mental health problems can be solved only by the adaptation of both employers and employees to their new roles. The worker and his family can be prepared for new conditions, and the family stimulated to take an interest in the parent's work. Operatives should be kept informed of the meaning and importance of their duties, and of impending changes. Managements and planners must be advised on the human problems of technological change; they should for instance attend to housing conditions, minimize travelling time, and encourage the profitable use of leisure.

**Peaceful applications of atomic energy.** Many persons, including scientists, deny the existence of mental health problems in connexion with the peaceful uses of atomic energy; yet reports submitted to a WHO Study Group on the subject in 1957 9 show atomic energy to be widely felt as a force threatening the health of present and future generations. Such irrational fears are probably partly the outcome of the circumstances in which atomic energy was first released on a large scale, and partly also of the peculiar nature of ionizing radiation—undetectable by the unaided senses and, it is often feared, uncontrollable. These fears are stimulated by a tendency to present any news on the subject under scare headlines. In fact, the organic effects of the low dosages of radiation produced in the civilian applications of

---
atomic energy are negligible. The real problem may come if atomic energy accelerates too greatly the pace of social change. The equilibrium attained by industrially advanced countries may be jeopardized by this further innovation, and in less developed countries its impact may be even greater. Where the advent of the new source of power enhances the pace of industrialization it may add to social problems, whatever benefits it simultaneously brings. Thus, the psychological problems relating both to the public acceptance of atomic energy and to its possible social consequences—as well as the problems of public policy in the event of radiation accidents—are fairly urgent matters for study.

**Alcoholism**

Alcohol occupies a pharmacological position intermediate between the addiction-producing and the habit-forming drugs. A WHO Expert Committee on Alcohol and Alcoholism 10 agreed that the term “alcoholism” covers a variety of problems and that, despite the many analogies between alcoholism and drug addiction, a clear distinction has to be made for social, legislative and medical purposes. The Alcoholism Subcommittee of the Expert Committee on Mental Health, meeting in 1950, 11 noted the social importance of this often underestimated problem, which in some countries constitutes a greater scourge than tuberculosis. Alcoholics may be defined as excessive drinkers, irrespective of the cause, so dependent on alcohol as to be disturbed in physical or mental health, or in social activities. The assessment of consumption can only be made in relation to accepted local and national drinking habits.

In wine- and beer-drinking countries, alcoholism is marked by an inability to stop drinking; where spirits are more used, there are often typical drinking bouts separated by periods of abstinence, control being lost once drinking is begun. Excessive drinkers may begin by taking alcohol irregularly to relieve tension. This is not necessarily abnormal, though progressively larger amounts may be required; but habitual reliance on alcohol to deal with the stresses of life usually indicates an underlying abnormality of character. In advanced alcoholism social position and nutrition are neglected; and in the final phase, progressive moral and mental deterioration, sometimes amounting to frank psychosis, is added to loss of control. 12 Although compulsory treatment for severe cases exists in some countries—even special hospitals in particular instances—facilities for the treatment of patients in the early stages of the illness are generally few. These, the majority, can be treated in hospital clinics by psychiatrists or by physicians with some understanding of the motivation involved. The intensive therapy required for advanced cases is still possible in an out-patient department if there is sufficient staff. Aversion therapy using drugs that excite severe reactions to the ingestion of alcohol may be a useful adjunct. Chronic, psychotic and deteriorated patients often need hospital care. The rehabilitation of alcoholics is furthered by collaboration between clinical and social (sometimes juridical) agencies, including the lay societies such as Alcoholics Anonymous based on mutual aid.

Several WHO seminars have aimed at disseminating information on alcoholism: a European seminar in Copenhagen in 1951, a seminar in the Netherlands in 1954, and seminars in South America in 1953 and 1960. A WHO consultant on alcoholism has visited Argentina, Brazil, Chile, Guatemala, and Uruguay to inaugurate or advise on various projects; and consultant assistance in this field has also been rendered to Canada, Italy, the Netherlands and the Scandinavian countries.

**Drug addiction**

An Expert Committee on Addiction-Producing Drugs advises the Economic and Social Council of the United Nations, on behalf of WHO, regarding the medical aspects of the control of narcotics. In 1956 WHO also convened a Study Group on the Treatment and Care of Drug Addicts. 13 An addict

---

was defined as one who habitually and compulsively uses a narcotic—such as opium, opium alkaloids or their derivatives, cannabis compounds, morphine or its synthetic surrogates—so as to endanger the health and welfare of himself or others. Many addicts are amenable to treatment, especially when addiction results from hunger and poverty in countries where drugs are cheap and available. Good results are also obtainable when addiction is mainly due to social, cultural or environmental factors or is the sequel to illness. The most refractory cases are those of individuals of immature personality, incapable of dealing with ordinary anxieties. These may need intensive psychotherapy. Effective management also requires limitation of access to drugs, and this may be difficult in countries that do not, or whose neighbours do not, pursue such a policy. Although most addicts will not undergo treatment without the coercion of legal process, they should be treated humanely, not punitively, and their underlying personality disorder tackled. Drug withdrawal is painful, and must be performed at a pace suited to the individual case. Complete withdrawal may have to be deferred, but maintenance of addiction represents a failure of treatment. Final social rehabilitation may occupy several years. The last phase of reconditioning to the strains of normal life without the aid of drugs is the hardest, and the whole process may have to be effected in stages of diminishing custodial care. More information on the influence of social attitudes in the development of the various kinds of addiction is badly needed.

Adult crime

The problems arising in connexion with juvenile delinquency have already been discussed. In 1948 the United Nations Social Defence Section organized in Paris a meeting of interested agencies to study the prevention of crime and the treatment of offenders. This meeting dealt mainly with adult crime and was followed by similar meetings in the USA in 1949 and in Switzerland in 1950. A United Nations consultative group of experts in this field took part in a series of meetings held in Switzerland every two years from 1952. At all these gatherings WHO representatives advised on the medical and psychiatric aspects of the problem. Important reports dealing with the medical aspects of the causes and prevention of crime and the treatment of offenders \(^{14}\) and with the psychiatric examination of offenders \(^{15}\) were prepared by a WHO consultant, Dr M. S. Guttmacher, in connexion with two of the earlier meetings.

Crime, according to these reports, is evidence of a failure in social adaptation, and any rational programme of treatment or prevention must look at the causes of this failure. Criminality is not inherited, through heritable endowments affect the ability to become adapted to society. Some 25% of criminals show significant psychiatric abnormalities—mental subnormality is commoner among criminals than in the general population—but their most striking characteristic is emotional immaturity. The most important single psychiatric factor in the genesis of crime appears to be a defective childhood environment; and the best preventive a stable affectionate background for development under a consistent friendly discipline.

The first report of the WHO Expert Committee on Mental Health \(^{16}\) noted that psychiatric knowledge could contribute to the rehabilitation of offenders. As the objects of conviction—retribution, deterrence, reformation—do not seem to be frequently achieved, it would be desirable to establish institutes of criminology for the scientific study of offenders, possibly linked with university departments of forensic psychiatry. Recent studies that have increased our understanding of crime and criminals should be made available to the legal profession, though collaboration between jurists and psychiatrists does not imply that punishment is superfluous, or the judicial process unnecessary. The proposed institutes could make the information obtained from the records of offenders (particularly the relation between recidivism and sentence) available to judicial and prison

---


authorities, and they might also act as impartial assessors of the medical and psychiatric status of criminals when requested.

The Expert Committee accepted these principles and recommended a joint study by the United Nations and WHO of the categories of criminals requiring psychiatric examination. Many of these points were also discussed at a seminar on the medico-psychological and social examination of offenders (Brussels, 1951), a Latin American seminar on the prevention of crime and treatment of offenders (Brazil, 1953), a seminar on the institutional treatment of offenders (Vienna, 1954), and a Congress on the Prevention of Crime and the Treatment of Offenders held in Geneva in 1955. All these meetings were held under United Nations auspices with WHO participation. WHO has collaborated in similar work with the non-governmental International Society for Criminology, and was represented at an International Congress on Criminology held by the latter in London in 1955. In 1958, the WHO Regional Office for Europe organized a seminar in Copenhagen on the psychiatric treatment of criminals, which was attended by psychiatrists, prison officers and criminologists from many countries. At all these meetings it was agreed that some attempt at understanding the personality of the offender should accompany the administration of justice. Society should be protected, not only by punishing the criminal, but by seeking to eliminate the causes of his crime. Court procedures might be so modified as to consider the prisoner's interest as well as the common interest during trial. Though opinions on criminal responsibility differ widely, it was considered that some abnormal offenders need special treatment, that all criminals need to be rehabilitated, and that psychiatry has some place in the management of offenders. Length of sentence should be related to the time required for treatment; indeed, in some countries—for example, Denmark—a deliberately indeterminate sentence is pronounced in certain cases to permit detention until the offender is judged sufficiently improved to rejoin society. But national legal systems vary widely, and no general agreement is yet in sight on the precise contributions to be made by psychiatry to legal decisions.

The treatment of criminals may be pursued in ordinary penal institutions, in special centres for abnormal offenders, in mental hospitals, or while they are on probation. Treatment during probation offers the advantages of easier social reintegration and can greatly reduce the risk of repeated offences; it is not, however, feasible for dangerous criminals. In ordinary prisons it is often difficult to gain the co-operation of offenders, and unfortunately imprisonment itself may produce severe mental disturbance—punitive and psychotherapeutic measures tend too often to be mutually exclusive. The prison medical officer must be a good general practitioner with an interest in psychotherapy. Individual psychotherapy for criminals would appear to be an unattainable ideal, but techniques of group therapy based on psychoanalytic doctrine can be usefully employed, and special institutions for such therapy exist in some countries. Dynamic group treatment aims at initiating developmental processes that encourage resocialization and the liberation of energies for creative work. Treatment and observation should be continued for some years after discharge. Centres for the active treatment of criminals who are seriously disturbed mentally need a very high concentration of skilled staff, both psychiatric and non-medical. It is unfortunate that in most countries there is a serious shortage of such staff, even for the treatment of mental illness in the general population.

Aging

This is one of the major psycho-social problems of adult life; it was discussed in the previous section.\textsuperscript{17}

Schizophrenia

Schizophrenia is the commonest and most important public health problem of clinical psychiatry, its victims being largely young adults who are withdrawn from society for many years during what would normally be

\textsuperscript{17} See page 16.
the most productive years of their lives. In 1957 schizophrenia formed the main topic of the Second International Congress of Psychiatry in Zurich; and WHO called on the services of some of the experts from this Congress to examine the extent of current knowledge of the disease and ways of dealing with the problems it presents. No specific preventive measures exist; but presumably any factors promoting positive mental health help to forestall some of the manifestations of schizophrenia, and it may be possible to limit deterioration or chronicity in established cases. Diagnosis is desirable at an early stage so that schizophrenics may be kept in hospital for treatment for the shortest possible time. Almost all can benefit from a conjunction of modern physical and psychological methods of treatment; but much has still to be learnt about this disorder and no treatment is regularly effective. It is particularly important to evaluate objectively the new forms of treatment that are constantly being introduced. Research into the nature, causes, prevention and treatment of the disease is not only humanitarian but a sound economic investment.

Psychotropic drugs

The discovery of the tranquillizing and hallucinatory effects of certain chemical compounds, some of which had been traditionally employed in their crude forms in various parts of the world, has stimulated interest in the effects of drugs on mental function. In 1957 a WHO Study Group on Ataractic and Hallucinogenic Drugs in Psychiatry examined some of the problems raised by the use of these agents. It deplored the current lack of knowledge about these drugs, which is partly to be attributed to the intensely subjective nature of their effects. Moreover, it is only recently that knowledge of the micro-chemistry and minute anatomy of the nervous system—essential to a better understanding of the targets of these drugs—has become available. On the basis of their effects on the cerebral centres controlling patterns of expression and behaviour, the psychotropic drugs may be grouped into major and minor tranquillizers, anti-acetylcholine drugs with psychotropic effects, and hallucinogenics. This classification is necessarily provisional, since at present laboratory data can be only tentatively related to clinical effects. The relation of drug-induced mental changes to psychoanalytic theory and their value in psychiatry are also of practical importance.

The psychotropic agents have very much eased the management of mental patients, enabling many chronic cases to leave hospital for rehabilitation. The handling of seriously disturbed patients has been simplified, partly because they are rendered accessible to personal influences. This offers psychotherapy new possibilities, and may even affect the use and structure of mental hospitals. The problems raised by the use of these drugs vary in different settings. According to some authors, toxic manifestations during treatment are fewer in the less developed countries. Among the difficulties of investigating psychotropic effects are individual variations in reaction, the possibility of the "placebo response", and the absence of defined terms for the subjective changes produced.

As to the public health aspects of the use of these agents, it is difficult to say to what extent they are responsible for the reduction of the number of patients in mental hospitals—though it would appear that they largely contribute to it—and proof of their lasting efficacy requires the application of epidemiological techniques that are still immature. It is therefore difficult now to predict whether these drugs will continue to be as widely used as they are at present, and, if so, what their ultimate effects will be on the health of the community. Meanwhile public health authorities will need to recognize the hazards attending their use, notably in self-medication by persons not in hospital and not under close medical supervision.

EDUCATION, TRAINING AND RESEARCH

Education and training

Mental health education of the public

The first report of the WHO Expert Committee on Mental Health \(^1\) stated that the success of preventive mental health work largely depends on developing in parents, teachers and others attitudes favourable to the mental health of those under their control and subject to their example. Such attitudes may be created through daily contact between the public and health workers of all categories, and many problems can be clarified in small discussion groups. The cinema, press, radio and—perhaps particularly—television also have a part to play; but any mass campaign must be carefully planned so as not to generate anxiety or alarm and thus defeat its own ends. The Committee’s third report \(^2\) suggested that mental health education of the public should be a primary activity of the staff of mental hospitals, giving them an opportunity to concentrate on positive and preventive aspects rather than on therapy alone.

Mental health education is closely bound up with the aims of social psychiatry, which is concerned with equipping the mentally ill person for a useful life in his own social environment. And the success of this approach, in turn, is largely dependent on community attitudes toward psychiatric patients and psychiatry in general. The subject is fully discussed in the seventh report of the Expert Committee. \(^3\) Social psychiatry assumes that mental patients can be restored with some degree of success to their original—or, at any rate, a favourable—social background, and that mental illness can be mitigated by improving the opportunities for social contacts. These assumptions, however, will be borne out in practice only if the community accepts mental illness on the same basis as it accepts physical illness. For his part, the psychiatrist needs to have an adequate understanding of the patient’s environment, and of traditional public attitudes to the mentally ill and those who treat them. Collective reactions to such patients vary greatly with the type of community. In peasant societies mental disorder may be no bar to ordinary family life; but in urban communities mental patients are often secluded from society in large institutions remote from daily life. The attempts of social psychiatry to reintegrate the patient into ordinary life after treatment are made very difficult if there is a total absence of communication between the community on one side and the patient, hospital and psychiatrist on the other. It is useless to bring the patient to the threshold of normal living if he is received in a hostile or mistrustful fashion.

A better appreciation of public attitudes may be obtained by planned surveys of opinion, and by studying popular and legal terms for insanity. Legislative measures are an interesting pointer to community attitudes to mental disease and they also influence these attitudes profoundly; for if the main function of legislation is custodial it necessarily implants the idea of punishment, while if it is therapeutic it favours the concept of mental patients as sick persons in need of aid. Social approaches and reactions to mental disorder are complexly determined. What is considered normal behaviour in one society may be thought abnormal in another, and current social attitudes can have some influence on forms and fashions of mental disturbance. Public reactions also reflect the nature of the disturbance itself; there is a tendency to fear or feel hostile towards violent or “peculiar” patients, and an inclination to call for punishment for dangerous psychopaths, but there is also some indulgence towards mental defectives. Public attitudes will be affected by the extent to which care of the mentally ill burdens the community. Attitudes to psychiatry itself, and to its practitioners, are important. So long as the major-

ity of patients are treated in the relative isolation of the mental hospital, the community will be little inclined to participate in their treatment and rehabilitation. Fortunately, the arrival of the open hospital, the decline of the barrack-like institution, and the growing importance of out-patient treatment are all encouraging the development of a more co-operative attitude.

Improvement in the community’s attitude to psychiatry can be achieved only by developing active forms of treatment not requiring segregation of patients, by making such treatment an integral part of general medicine, and by creating an informed public opinion. The educators must understand that the subject, which is charged with emotion and prejudice, needs to be approached cautiously. In this respect the non-medical auxiliary staff—the nurses, social workers and others who work with the psychiatrist—are important. General physicians also have the opportunity to implant sound attitudes. Other responsible individuals who can play a part in teaching the community to be more sensible about mental illness include legislators, industrialists and trade unionists, teachers, the clergy, and—perhaps most important of all—parents, for parents help to form the social conscience of future generations. It is obvious that a good deal of research into the relevant roles of geographical and social environment and of cultural and economic influences is required to help make a success of this work.

Mental health in the training of professional staff

Doctors. In many countries medical education has, in the past, failed to give the medical undergraduate any real grasp of psychological principles and of the origins of mental disorder; and this despite the fact that a very large proportion of a general practitioner’s patients seek help for psychogenic disturbances of one kind or another. In its first report, therefore, the WHO Expert Committee on Mental Health recommended that syllabuses should be recast so as to provide better training in the management of the simpler psychiatric conditions and in recognition of the early signs of more serious states. Such training would have to encourage, and to be based on, an ability in general practitioners and particularly in hospital physicians to treat their patients as persons, despite the pressures of routine.

In 1960 the Expert Committee reported at length on the undergraduate teaching of psychiatry and mental health promotion. Although psychiatry has come of age as a specialty and has had its foundations strengthened by many recent advances, it is still without an adequate place in the curriculum and the psychiatric training a student receives still depends too much on local circumstances. The general aims of instruction should be to teach recognition of the main psychiatric disorders and of the psychological factors important in physical disease; to depict mental illness as one part of the whole pattern of life; and to demonstrate the influence on the course of such illness of the doctor’s own behaviour. The part the doctor can play in improving both mental health and public attitudes to mental disorder can ultimately derive only from an awareness of the patient as an individual member of a social group. As the Expert Committee’s report states, “Mental health promotion can never be made effective by the psychiatric specialist alone. The collaboration of many others... is urgently required, but nobody has more opportunities in this field than the general practitioner... mental hygiene will remain an empty promise if he is not enabled to act as its main agent in the community.”

During the medical course the relation of the basic sciences to mental health is best stressed by emphasis on function rather than structure, and on the evolution of behaviour and consciousness. In the teaching of neurology stress should be laid on certain aspects of neurological physiology—the influence of emotion on bodily function, the electrical activity of the cerebral cortex, the role of conditioned reflexes in learning processes. Medical psychology and sociology are to be ranked as basic sciences, and used to demonstrate the essential malleability of human personality and behaviour against different
social and cultural backgrounds. Although the powers of observation required in psychiatric work largely accrue from practical clinical experience in psychiatry and in general medicine, a good deal of time must be given to formal psychiatric instruction. Students should be introduced to every type of case: mental subnormality, behaviour disorders, psychosomatic disease, neuroses and psychoses. Their course should cover the acute psychiatric emergencies as well as chronic disorders, stress the fallibility of classifications, and impart some knowledge of the legal aspects of the subject. It should also convey what treatments are available in modern psychiatry, and which types of case may be safely handled by the non-specialist. A compulsory qualifying examination in psychiatry would do much to raise basic standards.

The eleventh report of the Expert Committee \(^6\) deals extensively with the part public health officers and general practitioners have to play in fulfilling the unmet mental health needs of the community, their tasks in combating noxious environmental factors—both mental and physical—and their place in diagnosis and treatment (including co-operation with specialist psychiatrists). The report also analyses their functions in connexion with prevention and rehabilitation, and discusses the part they may play in research. The expansion of training necessary for the accomplishment of these tasks was given considerable attention by the Committee.

As far as the general practitioner is concerned, a practical training is desirable that aims at modifying his attitude towards the mentally ill while simultaneously increasing his capacity for therapy. He also needs to be trained in the principles governing the interaction between the individual and his environment and might very well share a basic training in mental health principles with the public health officer. Such a training would deal, \textit{inter alia}, with personality development, emotional expression, and learning and defence mechanisms. After this, training would diverge on appropriate lines. The general practitioner would need to learn the special techniques of clinical examination required in psychiatric work and to acquire a great deal of information on such matters as problems of psychosomatic medicine and the main features of the neuroses and psychoses. Most important, he would need to appreciate the scope and the limits of a general practitioner’s activities in the mental health field, and how and when to secure expert collaboration. It is certainly proper for him to prescribe rest or work, to arrange rehabilitation, to use the psychotropic drugs with caution, and to conduct psychotherapy within his capacity (if possible, under specialist supervision). The postgraduate training for this work he may obtain as a clinical assistant in hospital, or in general practice, and from formal lectures; but it may prove that the most valuable experience is acquired in small discussion groups led by a dynamically oriented psychiatrist and conducive to an increased awareness of personal attitudes and motivations.

For established and practising public health officers, training in mental health work must necessarily take the form of short and rather intensive courses, though in future it should form a basic part of ordinary training. Mental hygiene principles could be presented in general fashion to the staffs of large public health units, and specialist courses could follow for the different categories of health worker according to whether they were mainly concerned with schools, maternity services, etc. The programme should cover normal as well as abnormal reactions. It should refer to the forces in play in personal relationships, the principles of interviewing, the importance of anxiety in determining conduct, and the significance of repeated pathological behaviour. The formal content of training courses must include material on the psychological development of the child, on psychological testing, on group relationships—their disturbance and therapy—and common problems of psychopathology. Any resistance manifested to the ideas presented can itself be utilized for teaching purposes. As far back as its second report,\(^6\) the Expert Committee had


recommended that WHO should sponsor experimental postgraduate courses in mental hygiene for public health officers as a step towards the integration of mental health in the public health syllabus. Training facilities were then suggested for specialist mental health officers within public health services, and some countries have made progress in this direction.

Nurses. The training of the specialist psychiatric nurse is discussed in detail on page 32. It is important, however, to incorporate into basic nursing training some elements of psychiatric nursing and an understanding of the psychological aspects of general nursing. The nurse's close contacts with sick persons afford a valuable opportunity for education in the dynamics of personal relations; and it can only help the treatment of hospital patients as individuals if nurses learn something of the principles of mental health. The WHO Expert Committee on Psychiatric Nursing,7 emphasizing this need to integrate the basic tenets of psychiatric nursing into nursing as a whole, pointed to the importance of understanding human behaviour and the social forces underlying personality development. The WHO Study Group on the Child in Hospital 8 also referred to the importance of the psychological aspects of the training of nurses in their capacity as members of the paediatric team.

Public health nurses. Of all paramedical health workers, public health nurses are possibly the best placed to exercise the principles of mental hygiene. Unfortunately, their training is in the main restricted to matters of physical care. A WHO Conference on Public Health Nursing held in the Netherlands in 1950 and a WHO European seminar on mental health aspects of public health practice in 1953, also in the Netherlands, devoted much time to this matter. The public health nurse should possess a mature personality enabling her to form sound relations with her patients in the stresses encountered during childhood, pregnancy, illness and old age. She has the opportunity to foster healthy maternal feelings, and to strive for the preservation of the union of mother and child wherever possible. If their separation is inevitable, she is there to plead the advantages of foster care, or of adoption, and to aid both sets of parents in dealing with the problems that inevitably arise in such cases. She can help maintain contact between hospitalized patients and their families and smooth the passage on discharge. She may be able to help alcoholics and their families. The industrial nurse becomes involved in all the problems of worker/management relations as they impinge on mental and physical well-being both inside and outside the factory.

Public health nurses come, in practice, to take all these activities in the stride of their duties; but their present basic training is insufficient for the purpose. Mental hygiene should form part of the curriculum, which should include instruction on the emotional development of children and clinical training in the practical problems arising during public health nursing, and—not least—should help prospective public health nurses gain insight into their own reactions to the difficulties of others.

Specialist training for psychiatric work

The first report of the WHO Expert Committee on Mental Health made it clear that the dynamic concepts of modern psychiatry require the concerted application of all relevant disciplines to the problems of causation and treatment of mental disorder. Prevention and management cannot be based on partial or biased views. The training of psychiatrists, as of psychologists and psychiatric social workers and nurses, should therefore be eclectic while remaining soundly based on local conditions. The training of specialists in Africa, for instance, would add to the universal principles of psychiatry the influences of tropical medicine and anthropology within the context of African conditions and traditions. Thus the seminar on mental health held at Brazzaville in 1958 by WHO and the Committee for Technical Cooperation in Africa South of the Sahara (CCTA), which was mainly concerned with
training, and other WHO regional seminars of a similar kind have all paid close attention to local circumstances and conditions.

**Psychiatrists.** A WHO Expert Committee will meet in 1962 to consider the education of psychiatrists. It will discuss basic training, advanced training, and training for teaching and research.

**Psychiatric nurses.** The supply of generally trained nurses willing to work in psychiatric hospitals is short, and has shown no great signs of improving. However, only for handling a proportion of psychiatric patients is general training necessary, and it might be possible to ease the situation by making more use of occupational and educational therapists and by raising the standard for nursing auxiliaries. Psychiatric nurses might also receive the whole of their professional training within the mental hospital, and, when fully trained, might elect to take up specialist therapy or extramural work. The shortage of nurses is particularly felt in countries just developing their mental health services, and every effort must be made to train nationals of the countries concerned—if necessary by importing tutors or by providing instruction abroad. When aides have to take the place of trained staff their instruction, rather than being academic, should consist of an apprenticeship in the proper attitudes to adopt to mental patients, and in practical rehabilitation techniques.

In 1955 a WHO Expert Committee on Psychiatric Nursing * noted that, as psychiatry progresses, the psychiatric nurse's role is becoming therapeutic rather than custodial. The knowledge and skill enabling her to adapt herself to this new role must become part of her daily life. In the therapeutic team the nurse's part as an observer of the patient's behaviour is often crucial to diagnosis, and at the same time she has an opportunity—during the daily routine of meals and medication—to encourage sociability and responsibility and to help patients understand some of their problems in living with others. All this requires more than book learning and more than mere apprenticeship. Training must allow for the needs of the nurse herself, a girl growing to adulthood and with her own aspirations. The strains of psychiatric nursing may well add to her normal anxieties; but a growing understanding of human behaviour will help her to meet challenging situations.

Study courses—preferably in small groups—should relate degrees of mental health and ill-health to the capacity for forming sound human relations. The specific content of courses and the proficiency expected will depend to some extent on the nurse's cultural background, and her instruction must be in the language of her country. A seminar on the training of psychiatric nurses was held by the WHO Regional Office for Europe in 1961.

**Others.** The special training problems of psychiatric social workers, psychologists and social psychologists are also under close study by WHO as part of a general reappraisal of the structure and function of the mental health team. Social case work is so important that a series of seminars on the subject has been held by the United Nations, with some WHO participation.

**Other WHO activities in mental health education**

In addition to the programmes specifically concerned with training, there are many WHO activities having a bearing on mental health education. The Expert Committee reports and the Headquarters studies on psychiatric topics and mental hygiene have received wide circulation, and seminars on mental health subjects have been designed to train those capable of exerting an influence on education in virtue of their professional position. Consultative advice has been given to governments on setting up training establishments and organizing the higher education of essential personnel. In the Regions local centres have been designated for WHO assistance in progressively raising the standards of mental health education and training, e.g., the Psychiatric Department of the National University of Taiwan for the Western Pacific, and the Asfurich Hospital of Beirut for the Eastern Mediterranean. One example of con-

---

continuing WHO assistance is the development of the mental hospital at Bangalore as the All-India Institute of Mental Health. A WHO consultant first reported on local conditions in collaboration with the superintendent of the hospital selected as the nucleus of the Institute. The Institute was opened in 1954 and WHO subsequently provided tutors for nurse training and a psychiatrist and a neurologist to work with the local staff in the developing fields of neuropsychiatry, neurosurgery and electrophysiology. Long-term fellowships were awarded for the training of teaching staff and contributions were made toward equipment.

Another example is the assistance given to the expansion of the Japanese National Institute of Mental Hygiene. Two consultants were sent in 1953 to discuss priorities in the training of mental health workers and the future role and education of Japanese psychiatrists. They helped select candidates for overseas training in child psychiatry and psychiatric social work, and WHO aided in the selection and purchase of books and equipment.

Research and collection of information

Research

In its first report, the Expert Committee on Mental Health noted some areas in which WHO should foster research; 10 and much of the work recommended has been accomplished or set on foot. Some of WHO’s activities in this connexion have already been mentioned—for example, the studies on alcoholism and delinquency, and the work of the WHO Study Groups on the Peaceful Uses of Atomic Energy and on Ataractic and Hallucinogenic Drugs in Psychiatry. Others are considered below.

Child development. The individual—as opposed to the mass, or epidemiological—approach in psychiatric research is represented by such WHO studies as those concerned with child development. Dr Bowlby’s survey of the effects of maternal deprivation has already been discussed; 11 and reference must now also be made to the WHO Study Group on the Psychobiological Development of the Child, which first met in Geneva in 1952. 12

During this meeting experts from overlapping fields attempted to correlate physiological and psychological data on child development. The science of animal behaviour was shown to have its relevance to problems of parenthood and childhood and to the effects of withdrawal of maternal love. The physiological and mental aspects of growth were considered in relation to electroencephalographic findings, revealing a need for more detailed inquiry into the growth of organization within the human brain. This preliminary discussion was continued in the following year, when psychiatrists and psychoanalysts reviewed the gaps in existing knowledge with electrophysiologists, anthropologists and others. Physiological growth was seen as a series of waves affecting different parts of the body at different times, without sharply defined critical points, and with varying susceptibility to outside influences. Its precise relations to psychological maturation remain obscure. However, as patterns of motor function are integrated in the cerebral cortex they can be compared with contemporary assessments of mental development; and attempts can also be made to relate electroencephalographic records to different aspects of personality. A psychoanalyst noted that any dislocation of instinctual responses during infancy might adversely affect conduct in later life. Finally, an anthropological review of child development showed that what is accepted as normal in one culture may not be accepted in another setting; rules of conduct, with their built-in sanctions, develop under different conditions of nurture and differing concepts of parental prestige.

When the Study Group met again in London in 1954, 13 a contribution on cyber-
of contributions from many sources created a research tool valuable for future projects; and it is just this type of multidisciplinary approach that appears to offer most hope for fundamental advances in social psychiatry.

Ethnopsychiatric research. The investigation of the peculiar qualities of mental organization in individual cultural groups affords a rich field of research that has, as yet, barely been exploited. A good example of such work is Dr J. C. Carothers’ monograph, *The African Mind in Health and Disease*, written during his service as a WHO consultant. This study of the rural African and the anthropological and environmental factors tending to produce in him mental characteristics differing from those of, say, European cultures has stimulated research into many related problems, even though it does not command general agreement on its particular theme. In Africa the influences on mental health of geography, of climate, of chronic physical ill-health and widespread malnutrition are very marked. African children are abruptly weaned after an indulged infancy, and adult life is moulded by taboo and dominated by thinking in terms of magic. Though it is doubtful whether any truly distinct African personality exists as such, the tribal African’s behaviour is impulsive and he may not achieve the personal integration of the European or the educated African. If he appears to escape many of their mental disturbances, it may only be because he has not yet been fully exposed to their stresses. This may also account for what has been regarded as a typical conservatism, an ability for routine tasks unaccompanied by marked powers of reflection or conceptual thought. In fact, little scientific work has been done to compare African temperament, intelligence and aptitudes with, say, standard European models (if such models exist); and comparative electroencephalographic studies reveal no marked difference in cerebral functioning between Africans and persons of other races. At present, despite the difficulties in assessing

...
incidence, it seems that mental derangement is less frequent in Africa than in Europe and North America. The illnesses that do occur are often difficult to classify in European or North American terms, and the advent of industrialization may well produce a very different picture. Many degrees of mental defect are never diagnosed; they may need the strains of urban life to make them apparent. Mongolism seems never to occur. Epilepsy, organic reaction types, and aggressive psychopathy are common. Hysteria is the commonest form of psychoneurosis, while anxiety and obsessional states are rather rare. The psychoses—particularly schizophrenia—tend to assume amorphous or abortive forms, perhaps as a result of lack of personal integration. Classical depression is also unusual, but mania is often encountered.

Kwashiorkor and mental health. Dr Carothers formed the impression that the apathy so often seen in children suffering from kwashiorkor resembled the reactions of the deprived European child. The Study Group on the Psychobiological Development of the Child had noted some parallels between psychological and electrophysiological stages of maturation, and so in 1954 research was conducted in Uganda, under WHO auspices, into electroencephalographic findings in children suffering from severe protein malnutrition. Although no consistent deviations were found it was noted that the mental state of these children differs from that of other sick children, personal contact being rejected, and that the emotional disturbance is transient and improves with physical improvement. It may well be that the abruptness of weaning contributes to both the malnutrition and the psychological malaise at the onset of the disease. During this investigation valuable material was obtained on many aspects of the intellectual and emotional development of African children.

Epidemiology: the mass approach to psychiatric research. In 1950 a Subcommittee on Hospital Statistics of the WHO Expert Committee on Health Statistics recommended that “Statistics of mental disorders causing admission to mental institutions be collected in several countries with a view to increasing knowledge of the incidence of hospitalized disorders of different types in populations according to the . . . measurable factors concerned in etiology; and also statistics of the immediate outcome of hospitalization.” It also recommended that these statistics should, if possible, be supplemented by sample studies of mental disorders in the population as a whole.

Particularly in recent years, WHO has made a special effort to stimulate research on the epidemiology of psychiatric illness. In 1951 a WHO Conference on Morbidity Statistics advised that mental hospital and clinic records should be used in planning preventive and treatment services and in assessing the part played by social factors in mental illness, as well as to guide research into causation. Following discussions within a small group of experts, an extensive survey of previous work in this field was made by Dr D. D. Reid, a WHO consultant appointed in 1957, and his report on the application of epidemiological methods to the problems of mental disorder was discussed in London in 1958 at a technical meeting on epidemiological method in mental health convened by WHO, the World Federation for Mental Health, the Milbank Memorial Fund, and the Medical Research Council of Great Britain. After submission to the WHO Expert Committee on Mental Health, this report appeared in the WHO Public Health Papers series.

Dr Reid's report was intended to help make epidemiological studies of mental illness in different parts of the world more precise and uniform, and so more comparable. Local surveys aimed at establishing the incidence of new cases under varying conditions must be reasonably uniform in their technical procedures. These include a preparatory reconnaissance, the actual sampling and case-finding (which depend for their validity on sound
methods of testing and agreed diagnostic criteria), and, not least, a reliable statistical interpretation of the results. Hospital admission data are useful in uncovering incidence patterns, especially where a unified hospital system serves a whole country; and industrial and insurance data may be of complementary value. Mortality figures are obviously of limited worth in this field, although methods of calculating the social and occupational factors involved in mortality may also be applied to morbidity surveys. Where data regarding the incidence of important social or occupational diseases are inadequate, prevalence studies are essential, but these must adhere rigidly to sampling theory and practice. One method of minimizing sampling errors is to examine large complete population groups. Another is the use of longitudinal or cohort studies to measure the incidence of disease directly. It is often difficult in mental disorder to establish valid correlations between morbidity and environmental circumstances. Nevertheless, studies by area or social group may suggest hypotheses about causation that can be tested in more detailed field inquiries. Retrospective inquiries into the place of personal factors in the genesis of psychiatric illness have both advantages and disadvantages: the value of retrospective research lies mainly in indicating useful lines for future inquiry. There is also a place for prospective inquiries where individuals are followed up over a considerable period. Certain techniques of investigation also exist that help to separate environmental from genetic factors in the origin of particular neuropsychiatric disorders.

The future control of mental disease may conceivably lie in detecting susceptible individuals in advance, so that the rate and severity of attack may be modified by education and by manipulating the environment. The value of preventive measures needs to be tested by deliberate experiment, and careful field trials should precede any change in preventive policy. A WHO Expert Committee on Mental Health, which met in Geneva in 1959, discussed the definition and uses of epidemiology in mental health work with particular reference to the improvement of psychiatric classification and to the staffing and research needed for epidemiological studies.21

Operational research. This form of inquiry concentrates not so much on actual disease as on the processes of medical intervention and the various factors influencing the outcome of illness. The findings of this kind of research may well lead to some reappraisal and redistribution of functions among psychiatrists. Statistical analysis of the work of mental health services can be based on the routine returns from large populations, or on more specific information coming from individual treatment centres. Cohort studies of particular diagnostic groups are useful in assessing the efficiency of a hospital’s work, though the follow-up must continue for possibly a decade after patients have returned to the community if the final outcome of mental illness and the medical and social factors that have influenced this outcome are to be identified. Trends overlooked in daily practice may become apparent in the large-scale application of cohort analysis to administrative data, and constitute a valuable supplement to the traditional clinical pictures of the different mental disorders.

Although studies of this kind may require years of work by large teams, it is possible to survey quite large populations more economically by limiting the number of variables considered. It is true that studies of selected populations may not support wide generalizations; but they may reveal unsuspected aspects of current practice and lead to modifications of orthodox treatment and new lines of research, while etiological hypotheses suggested by extensive surveys can be probed in more individual and intensive studies. Finally, it would be wise to complement any comparisons of prevalence rates of mental disorder in different cultural conditions by some inquiry into community attitudes towards mental disorder. Such inquiries, which entail considerable difficulties, but whose importance was emphasized in the seventh report of the WHO Expert Committee on Mental Health,22

---

have been actively promoted by the World Federation for Mental Health.

An Inter-Regional Conference on Survey Techniques in the Epidemiology of Mental Disorders was held in Naples in 1960 and a similar inter-regional meeting is to be held in Manila at the end of 1962; the subject was also discussed at a conference convened by the WHO Regional Office in Copenhagen in 1961. More generally, WHO has begun to stimulate epidemiological surveys of mental disorder in a number of countries.

Psychiatric classification. International communication on psychiatric subjects and, in particular, any extension of epidemiological method into the mental health field are inconceivable without an accompanying improvement in psychiatric classification. The lack of a generally accepted classification has often in the past obstructed the useful comparison of observations from different countries. A greater measure of agreement on the value of specific forms of treatment for mental disorder also largely depends on an agreed terminology. WHO's Division of Health Statistics is doing important work in this direction, and the whole subject was surveyed by Professor E. Stengel in a paper presented to the WHO Expert Committee on Mental Health in 1959.

In some countries registration of psychiatric morbidity does not exist; in others it is very thorough. The psychiatric section of the current International Classification of Diseases has been adopted in only a few countries, and there is general dissatisfaction with present classifications of mental disorder, both national and international. Although the need for an up-to-date revision is widely recognized, it is not certain that all practising psychiatrists would be willing to accept the inconveniences of a change.

Sufficient agreement on terminology probably exists to make it possible to compile an acceptable list of categories; there are, however, differences about diagnostic ideas and it may be best, instead of seeking an explicit agreement on these ideas, to use operational definitions for classification purposes. An international classification of mental disease must not be too far ahead of its time if it is usefully to serve international understanding; nor should it appear to impose unwanted directives or attempt to replace classifications of proved local value for administrative purposes. So any new terminology must at first be conservative, reflecting the unevenness of present knowledge and the lack of a consistent nosology of mental disorder. Relative simplicity is also essential, for most patients are not hospitalized and out-patient data do not lend themselves easily to detailed classification.

Meeting in November 1961, a Sub-Committee of the WHO Expert Committee on Health Statistics discussed, among other topics, the reform of the psychiatric section of the International Classification.

The collection of information

The WHO Expert Committee on Mental Health stated in its first report that efficient planning would necessitate the central collection of information regarding mental health facilities and problems. The subjects considered of particular importance included; facilities for clinical treatment; statistics of psychiatric morbidity; alcoholism and drug addiction; the relevant aspects of crime and legislation; public attitudes towards mental illness; and administrative structures as they affect psychiatric practice and mental hygiene.

In the years that have elapsed since this recommendation much of the required information has been collected and critically reviewed, and a number of programmes initiated in consequence. Lately, a beginning has been made in planning an information centre at WHO Headquarters to collect and collate information of this kind on a world basis. Data have been made available from official sources in Member States of WHO and from individual members of the Mental Health Expert Advisory Panel, and various Regional Offices have engaged in similar activities. A particularly useful panel inquiry was that on facilities for undergraduate psychiatric

---

training, which was submitted to the Expert Committee on Mental Health in May 1960. It not only gave a valuable picture of the state of psychiatric education in a large number of countries, but also, equally important, an idea of the trends and the rate of change in this field over the preceding decade. This inquiry was of a kind that WHO is particularly fitted to undertake, and made it possible to evaluate the development of the undergraduate teaching of psychiatry against the standards recommended by the Expert Committee. The findings of another panel inquiry, this time on over-all development in the mental health field, were presented to the Expert Committee on Mental Health in October 1960.

The collection of information is not an easy task, for busy clinicians and administrators are not always eager to collaborate and it is difficult to devise a form of inquiry that is equally well understood by all and will elicit the informed critical comment so important in evaluating programmes. It is not surprising that replies are not always comparable, and that coverage is never complete. Despite these difficulties, the central collection of information is extremely rewarding and will become increasingly so as its uses in the epidemiological field develop. Finally, information is a two-way process; the material collected at WHO Headquarters is available for retransmission, so that each country may be kept aware of the standards applied and the progress achieved elsewhere.

PROGRAMME DEVELOPMENT

Since the foundation of the World Health Organization, a great deal has been achieved in raising the standards of mental health work in countries at all levels of development in many parts of the world. However, a great deal remains to be done. In its tenth report, which was prepared in October 1960, the WHO Expert Committee on Mental Health reviewed existing resources and facilities with a view to establishing priorities for a sound mental health programme to be applied on a world-wide scale. The findings and recommendations in this report are summarized below. They indicate not only the general direction in which WHO's own mental health programme is likely to develop, but also the general lines of national planning in individual countries.

Goals and approaches in mental health work

The appraisal of mental health is necessarily dependent, at least to some extent, on the system of values obtaining in the community within which the individual lives and works, so that it is impossible to lay down any absolute a priori standards of universal applicability. Partly because of this difficulty, it is not easy at present to evaluate the effects of mental health activities. However, their ultimate objective remains the promotion of "positive" mental health, even though this term may have different meanings under different economic, social and cultural conditions.

Closely linked to this objective is the preventive aim of mental health activities, consisting essentially of the defence of well persons against the risk of falling ill. Although much has been written about prevention of mental illness and the maintenance of mental health, there has been little scientific evaluation in this connexion and the need for appropriate research is obvious.

Early diagnosis and active treatment which aim at preventing further deterioration, and systematic measures of rehabilitation intended to restore the patient to the most normal social life obtainable under his particular circumstances have become important mental health goals.

A good deal of progress has been made over the last twelve years in establishing principles
of programme development for mental health promotion. This is largely due to the fact that sharing of information and experience has become increasingly widespread. New programmes have adopted useful and appropriate parts of old ones, and countries with well-developed programmes have been able to learn new methods from countries still developing their services. In outlining and fulfilling programmes, some difficult choices have to be made, choices that may involve the temporary continuation of previous neglect and poor treatment of many human beings while the available resources are used in developing adequate services for others. This is not a new problem for health administrators. "Health administrations were faced with a somewhat similar problem when dealing with tuberculosis several years ago. They had then to decide whether to give adequate attention to all or to concentrate their energy and resources on the fresh and relatively hopeful cases. Eventually they took the latter course." ² In the mental health field too, the long-term view has often to be given precedence over more immediate requirements.

Among the facilities needed in developing mental health services, one of the most important is a central mental health agency of major status in a ministry of health or health department, as recommended by the Expert Committee in 1949. Subsequent experience has shown the soundness of this original recommendation. The central agency, which should be directed by a psychiatrist with good qualities of leadership, is necessary to plan and administer the many differing activities represented in a well-rounded mental health programme.

It is also necessary to have a nucleus of well-trained psychiatrists, not only to practise their specialty but to assist in training physicians and allied personnel, and to act as consultants to other professional groups. They must be assisted by properly trained nurses, social workers, psychologists and auxiliary staff.

It is important that mental illness should be detected in its early stages, since treatment may then shorten the course of the disorder and forestall the development of more serious manifestations. This can only be accomplished by the adequate training in this respect of the professional groups to whom people turn for advice when unduly worried or distressed. These groups include, in addition to the categories already mentioned, the clergyman, the work supervisor and the police officer. All these should be enabled through training to detect changes in behaviour that may hint at impending mental disorder. It is for the mental health authority to assist in this training.

However well organized preventive efforts may be, there will always be some children and adults who need psychiatric care beyond the abilities of the family doctor. There must be provision for treatment facilities on an out-patient basis, preferably near the patient's home. There should also be a centre to which patients may be referred in an emergency, such as a crisis resulting in suicidal attempts or emotional outbursts. However long in-patient care may have to continue, the goal set from the beginning of treatment should always be the discharge and full social rehabilitation of the patient. Even when very long-term facilities are required for patients who fail to respond fully to treatment, partial rehabilitation is often possible.

It is an important matter to determine the relative priorities of the different approaches to mental health programmes. Even in countries at similar levels of development as far as mental health services are concerned, there may be marked differences in scales of priority, some favouring research, others concentrating on prevention and treatment facilities. WHO surveys have shown that it is fairly usual in countries expanding their mental health services for present resources of trained manpower and hospital beds to be small in proportion to the need, and for the new facilities created or projected to reflect in some cases a lack of careful planning.

The Committee emphasized that the training of skilled personnel should have first priority. Psychiatrists and psychiatric nurses should be trained first, in such a way as to become well acquainted with the principles

---

and techniques of public health and social medicine in the context of the community they will serve. The second group should consist of para- and non-medical workers to be trained for work with families or community groups, e.g., psychiatric social workers, and possibly also public health nurses. The third group for training would be non-skilled nursing attendants or aides. These should be trained on the job by the skilled staff and they should, as far as possible, be of the same social and educational status as the majority of their patients.

Next in priority comes the provision of physical facilities, particularly out-patient departments and active treatment centres, perhaps of the day-hospital type.

Outside the larger towns, mental health care may be entrusted to the community health centre, supervised periodically by skilled psychiatric staff and with a trained public health worker in more constant attendance.

Next will come the creation of psychiatric hospitals and psychiatric units in general hospitals sited close to the community they are intended to serve. It is important that rehabilitation should take place in close contact with the everyday life of the community. Plans must also include some facilities for the care of chronic patients who cannot be retained within the community.

It will of course be understood that this is only a general outline of the path of development of the new service and that such a service has great opportunities for flexible experiment and research. As mental health services become fully established, and as their staff resources become adequate, research will come increasingly to the fore.

Hospital and community

The concept of the hospital as a therapeutic community with an emphasis on early rehabilitation, and new techniques such as group therapy and the use of psychotropic drugs have brought about a revolutionary change in many mental hospitals. Intensive treatment and continued contact with the community facilitate readmission in case of need, so that many seriously disturbed patients can be cared for at home under the guidance of extramural services, with short spells in hospital at times of stress. Such advances are making the large static chronic populations of some mental hospitals increasingly accessible to rehabilitation.

The Committee noted that these changes have produced certain associated problems. A patient may become so well adapted to a hospital community as not to welcome life outside, and there are dangers in connexion with the use of tranquillizers of producing the “therapeutic malady” of apathy. If new opportunities for psychotherapy become available, there is not always an adequately trained staff able to provide it; and even when the patient has been prepared to rejoin the community there may be nowhere for him to go. The Committee therefore reaffirmed the value of providing out-patient clinics, day and night hospitals, sheltered workshops and working villages. It also recognized the advantages, in some areas, of mobile psychiatric teams and recommended setting up child psychiatric services, particularly out-patient departments, wherever possible.

In the words of the Expert Committee’s seventh report: “If society is to reap the full benefit of modern psychiatry, it must learn to collaborate in the prevention of mental disorder and in the thorough rehabilitation of the mentally ill. In other words, further progress now largely depends on the attitudes of the community towards mental patients and towards social psychiatry itself.”

The training of personnel

A number of the points raised by the Committee under this heading have already been dealt with in some detail in the preceding section, and therefore need not be repeated here.

The Committee considered that the psychiatric training at present provided in most countries is probably inadequate and needs supplementing by periodic refresher courses. The psychiatrist must be familiar with the

---

mental health problems of the community as a whole, and of its constituent groups, if he is to be able to evaluate the results of his activities; otherwise he may be well trained in the formal sense and yet be unable to organize mental health work on a community scale. Training should not be given too exclusively within the framework of psychiatric hospitals. A psychiatrist with community orientation will accumulate appropriate information on mental disturbances and influence those responsible for training public health officials, teachers, judges and others. He will also be able to give school medical officers and family doctors an improved understanding of psychiatric problems. The work of imparting this information itself requires special training. It is indispensable that psychiatrists should be trained in extramural activities which bring them into close contact with the environment of their patients and with other health workers.

Auxiliary personnel are essential to the proper operation of psychiatric services. Here, psychiatric nurses are of the first importance in view of their constant responsibilities to patients and their families. Nurses are also important in carrying out educational work. It is therefore essential that in their selection consideration should be given not only to intellectual ability, but also to the ability to establish contact with others, to work well in a group, and to assume responsibility. As has been pointed out in an earlier section, training within mental hospitals might be a more successful way of obtaining good staff than adding psychiatric nursing as a form of specialization after general nursing training.

The supply of psychiatric social workers remains relatively small. These workers need a twofold training in social science and in psychopathology. The staffs of most well-developed health services include clinical psychologists. It may also be necessary for some degree of instruction to be given to administrative staff working in the mental health field because of the importance of their contribution to the total effort of the mental health team.

What has been said above applies to specialized mental health personnel, but attention must also be given to personnel from other health professions. If community mental health services are to operate in an efficient and integrated way, the mental health team must work in partnership with all persons concerned with the health of the community. The tasks of prevention, treatment, rehabilitation and education are similar for both mental and physical illness. The doctors, nurses and others dealing with the latter possess skills adapted to the needs of the community, and can be led to apply their experience in the handling of individuals and groups to the field of mental health education. This will help in ridding mental disorder of any stigma that still remains attached to it and in dealing with it without prejudice, and encourage the public to think in terms of the similarities rather than the differences between physical and mental illness.

It is desirable to encourage an interest in mental health matters among specialist consultant medical hospital staff, so that the problems of mental health in relation to physical illness are not overlooked. It is perhaps particularly important for the training programmes of paediatricians to be revised in view of the need to integrate the physical and mental aspects of child health.4 Social workers have many opportunities for the application of mental health principles during their public health activities. The trained social worker needs some acquaintance with the motivation of human behaviour, since he or she is required to deal with many kinds of problems affecting the individual within the family or at work. Other health service personnel who should be considered for training in mental health matters are the lay administrators of public health services and the administrative staff of clinics and institutes.

Teamwork and integration of services

It is not always easy to arrange a productive team approach to mental health problems, but the benefits of a well-planned multi-

---

disciplinary mental health team make the effort worth while. It is usually essential to have a designated leader, for most health organizations—whether governmental or voluntary—require a single individual to assume responsibility for the work of the team. The highly trained professional men constituting such a team sometimes have difficulty in working together under a superior, but this difficulty can be minimized if the leader is carefully selected for ability and personality and if the group considers its leader to be adequate. He must be a recognized authority in his field as well as an able administrator, and a person of integrity capable of inspiring trust and confidence. The leader must respect his fellow workers and convince them of the value of their contribution. In this way he will be able to provide inspiration and to base policy decisions on genuine discussion, even though he must bear the final responsibility.

The choice of team members is no less important. Each member should be adequately trained in his own field and also prepared to subordinate his individuality in the solution of a common problem. No team can function effectively without free and easy communication between its members.

It frequently happens in connexion with programmes of extramural care that the skills of non-psychiatric workers, such as teachers and clergymen, are called on. Although these outside helpers are not members of the mental health team in the strict sense of the word, they should be given a clear sense of participation and their co-operation should be welcomed. The skills required in preventing mental disorder and in the general care and rehabilitation of the psychiatric patient are too numerous and too specialized to be encompassed by any single person. The representatives of all disciplines and of the community as a whole must co-operate to achieve the desired goal.

Research

In view of the world-wide expansion of research into mental health, it now seems necessary to find a way of conducting and co-ordinating research on an international scale. Advances in the mental health field are often held up through lack of opportunity for international clinical trials and incomplete sharing of information and techniques.

Basic research in various countries has developed psychotropic drugs that are of considerable assistance in the treatment of some forms of mental illness, and there has also been progress in research into child development, anthropology, chemistry, physiology, genetics and psychology that may prove to have promising applications in the mental health field.

The important areas of mental health promotion, the prevention of mental illness, and the control of socially deviant behaviour are still largely unknown territory. The problems here are very complex, and can only be solved by research conducted by workers from many different disciplines engaged in studying total populations or subgroups of populations against very differing cultural and economic backgrounds. It is here that international co-operation has the opportunity to accelerate the rate of progress. An international organization can play several roles in research. It is true in the main that basic research and much clinical and epidemiological work are most appropriate for local or national efforts, while international activity should consist of the operational testing of new theories and techniques in different parts of the world. But even some forms of basic research will need to be conducted on an international scale.

Research priorities

It is difficult to list research requirements in exact order of priority since this may differ from one country to another and from one period of time to another.

Brain function. The study of brain function requires the training of scientists in the special methods of neurochemistry and neurophysiology. It also requires considerable technical resources which are usually available only at the level of the best equipped research institutes. Some improvement of the present arrangements for reporting progress and new techniques to scientific workers of all nationalities is needed. It would seem
helpful for concurrent biological, social and psychological studies to be carried out by a co-ordinated team of scientists from each discipline and for some type of information exchange to be organized and operated on an international level. This would expedite the work in many laboratories by avoiding waste of time and handing on perfected techniques.

**Epidemiology.** The difficulties of epidemiological research—notably, lack of agreement on the terminology and classification of mental disorders—were referred to in the preceding section. For such research, the Committee considered it necessary to agree on the standard use of clearly defined terms which should be translatable into several languages. Symptoms should be identified and labelled by the most objective methods that can be devised and the data yielded should be in a form amenable to statistical handling, including mechanical methods of processing. Some form of counting and classifying cases must be agreed on if the statistics are to be useful in scientific work, for only a standard method will permit the comparison of any particular piece of research with other studies. There is also an urgent need for better ways of approaching field studies since, even if a standard terminology were available, the present variations in the approach to field work would still make comparisons difficult.

**Studies in communities undergoing rapid change.** Many changes important for mental health are produced in societies in which industrialization or other upheavals in ways of life are taking place. In some countries extensive investigations have been made to elicit important sociological and psychological data relevant to these changes. Unfortunately social planning is sometimes based on poorly supported theories. It is obviously desirable that is should be based on research studies to ensure that any changes made will favour desirable aspects of behaviour and discourage unwanted features. This does not mean that techniques for manipulating individuals should be developed but rather that persons should be enabled to accept changes in their way of life without suffering undue psychological trauma. Such research would add to the techniques for learning about the social causes of mental illness and social methods of preventing it. Obviously in this work patterns of family life and normal and deviant individual behaviour would be of particular interest before, during and after the transition phase.

**Hospital studies.** An interesting field for studying the effect of social dynamics on the care of patients is afforded by hospitals. Research has been directed towards interpersonal relations within groups of patients, between patients and staff, and between the staff members themselves. And in some hospitals the results of such studies have changed the general pattern of administration. It is important to know whether such changes genuinely reflect an improvement in group relations, and similar studies should be made in cultures other than those of European or North American pattern.

**Ecology of mental illness.** There is often a tendency to neglect the study of the natural history of mental illness in its various forms, especially in respect of their course and outcome. This is however an important aspect of research for which long-term projects are needed under different environmental conditions.

**Problems of aging.** Reference was made in an earlier section to the mental health problems of aging. Especially in North America and Europe, the increasing number of old persons in populations has led to a need for intensive study of the physical, social and psychological factors that contribute to the onset of mental disorder in the aged. Some nations are already faced with this problem in a fully developed form. Others, with a rising health curve, should begin to study the effects on family life and economic conditions of a prolongation of the average life-span.

**Nutrition and mental health.** Surprisingly little research has been conducted into the relation between nutritional deficiency and mental illness. Yet the elimination of pellagra had considerable repercussions on psychiatry,
and it is also known that nutrition in pregnancy influences the cerebral development of the foetus, and that mental symptoms are prominent signs in protein deficiency syndromes of children. It is possible that some of the mental symptoms of senility are the results of nutritional deficiency; some forms of alcoholic psychosis are known to be so. Unfortunately, quite complex investigations into groups of psychiatric patients are often conducted without regard to nutritional differences. It would seem important to conduct studies on the effect of nutrition on the course of mental illness, and also on the incidence and course of mental illness in populations with poor nutritional standards. Careful planning at an international level is needed.

Genetics. The science of genetics is rather poorly represented in current mental health research, although recent studies in this field would seem to indicate that knowledge of genetics could usefully contribute to mental health promotion and psychiatric treatment. There have been some notable studies of population genetics in certain mental disorders, and the chromosomal basis of mongolism has recently been discovered. There is some hope that new techniques in chemical genetics may increase etiological knowledge.

Mental health promotion. Research into mental health promotion is urgently needed because of lack of knowledge of efficient techniques for improving standards of health and building up resistance to mental illness. Indeed some of the efforts expended may have an effect contrary to that intended. Studies of the effects of promotional programmes are few and their results often inconclusive. Research in this field should deal with the effect of diet, hormones and drugs on brain function and the relation between mental activity and cerebral physiology and biochemistry. Research is also necessary into the influence of parental attitudes and child-rearing practices on the developing personality structure of the individual in different cultural conditions. It is also necessary to develop more precise techniques for educating the public in mental health matters. Various methods of individual and group discussion can be experimented with. It appears reasonable to continue to educate people with multiple and significant public contacts in sound mental health practice so that they may use this knowledge in their work, but further research is required into the most appropriate guidance to be given to community leaders of different professional backgrounds.

Therapy. It is important to be able to assess objectively the new methods of treatment of mental illness that are being constantly developed. Methods for treating behaviour problems in children and antisocial and neurotic behaviour in adults are so time-consuming that it is not possible at present to have enough skilled staff to treat all those needing treatment, and this situation will probably grow worse. Present methods of treating the mentally disturbed require a greater number of well-trained staff. Evaluation of the efficacy of therapeutic methods must clarify the essential features of the treatment programme and the minimal training requirements of the persons participating in the treatment. Studies are in progress on the effectiveness of psychotropic drugs, psychotherapeutic procedures, and social and administrative techniques for treating and rehabilitating the mentally ill. But these vary in quality of design and control and more careful planning and execution in the future would be desirable.

Other studies. Other areas of the mental health field into which research may profitably be conducted include the administration of mental health programmes, the size of mental hospitals, legislation governing admission and discharge of mental hospital patients, problems of leadership, the communicability of mental illness, and child development. Studies of child development in particular will be complex and expensive, and will have to extend over a period of many years.

The research recommendations made by the Expert Committee cover a number of projects requiring many workers and much
planning. But it is important not to overlook the advantages of more limited and less orthodox approaches, such as, for example, the observations made by individual clinicians. Simple and unsophisticated techniques should not be discouraged despite their lack of statistical design, and research administrations should organize some way of supporting the non-academic as well as the academic investigator.

**The role of WHO in future planning for mental health**

The Expert Committee was convinced of WHO's wisdom in seeking the co-operation of national bodies and in considering the co-operation between these bodies and itself as part of a process of mutual assistance. It also stressed the importance of WHO's activities in providing a maximum of reliable and up-to-date information on mental hygiene and allied subjects, partly by its publications, partly by meetings, and partly by WHO fellowships.

The Committee recommended the setting up of a clearing house of international mental health information and the fostering of international co-operation and co-ordination by the periodic convening of expert groups specially chosen for the discussion of suitable research approaches.

It also went into some detail on possible steps that might facilitate and stimulate research. It considered that research can be greatly advanced by an international organization able to grant research fellowships, matching scientists with the institutions in which they can best work. The international exchange of research information would facilitate the sharing of experience among scientists working on similar projects. It is important also to co-ordinate relevant information from other scientific fields, e.g., the co-operation of nutrition experts is valuable in considering the effect of diet on mental illness, and mental health studies of aging need the help of persons experienced in cardiovascular diseases. This is a form of co-operation which WHO, in virtue of its many specialist units, is in a good position to help. An international organization such as WHO is also able to use consultants or groups of experts in establishing a concerted plan for research programmes. Headquarters staff or consultants can advise on the choice and design of mental health programmes and suggest untested or unexplored projects. It might be useful to create a file of research projects and to convene an expert group to review it from time to time. The advantages of research to the general functioning of mental health services, in terms of morale and of a logical handling of problems by the staff, might be stressed in consultations with governments.

* * *

The immense social significance of mental ill health has long been recognized in history, but never to so great a degree as in recent decades. It is a problem that has to be dealt with, not only by psychiatrists, but by the medical profession as a whole and also by members of other professions.

Much has been done to improve the organization and staffing of mental health services, from the simple out-patient department to the national mental health department. Much remains to be done; but nothing is more needed at the moment than progress in research, and here an international approach would be extremely valuable.

It is not known to what extent the community can or should assume the role originally played by the family in protecting and educating the individual. The criteria of positive mental health are very far from having a universal application; the application of methods found successful in one territory does not mean that they will be successful in another—indeed, it may itself generate disturbances. Therefore the possibilities of the international approach should not be overrated. However, it may reasonably be hoped that WHO will continue to play its part in seeking to secure the mental as well as the physical health of mankind and thus to assist in generally improving what has sometimes been called "the quality of living".
WHO REPORTS AND STUDIES ON MENTAL HEALTH

Bulletin of the World Health Organization

BASH, K. W.
Mental health problems of aging and the aged from the viewpoint of analytical psychology. *Bull. Wld Hlth Org.*, 1959, 21, 563

GEBER, M. & DEAN, R. F. A.
Psychological factors in the etiology of kwashiorkor. *Bull. Wld Hlth Org.*, 1955, 12, 471

GEBER, M. & DEAN, R. F. A.

GUTTMACHER, M. S.
Medical aspects of the causes and prevention of crime and the treatment of offenders. *Bull. Wld Hlth Org.*, 1949, 2, 279

GUTTMACHER, M. S.

JACOBSEN, E.
The comparative pharmacology of some psychotropic drugs. *Bull. Wld Hlth Org.*, 1959, 21, 411

KLINE, N. S.
Psychopharmaceuticals: effects and side effects. *Bull. Wld Hlth Org.*, 1959, 21, 397

KOEKKEBAKKER, J.
Mental health and group tensions. *Bull. Wld Hlth Org.*, 1955, 13, 543

KRAPF, E. E.

LINDEMANN, E.
The relation of drug-induced mental changes to psychoanalytical theory. *Bull. Wld Hlth Org.*, 1959, 21, 517

LING, P. M.
La santé mentale dans l'industrie. *Bull. Wld Hlth Org.*, 1955, 13, 551

MACFARLANE, J. W.
The use and predictive limitations of intelligence tests in infants and young children. *Bull. Wld Hlth Org.*, 1953, 9, 409

MINDUS, E.

ROTH, M.
Mental health problems of aging and the aged. *Bull. Wld Hlth Org.*, 1959, 21, 527

SANDISON, R. A.
The role of psychotropic drugs in individual therapy. *Bull. Wld Hlth Org.*, 1959, 21, 495

SANDISON, R. A.
The role of psychotropic drugs in group therapy. *Bull. Wld Hlth Org.*, 1959, 21, 505

SIVADON, P.
Transformation d'un service d'aliénés de type classique en un Centre de traitement actif et de réadaptation sociale. L'expérience de Ville-Evrard (France). *Bull. Wld Hlth Org.*, 1959, 21, 593

SJÖGREN, T. & LARSSON, T.

STENGEL, E.
Classification of mental disorders. *Bull. Wld Hlth Org.*, 1959, 21, 601

TIZARD, J.
The prevalence of mental subnormality. *Bull. Wld Hlth Org.*, 1953, 9, 423

TOOTH, G.

TOWNSEND, P.
Social surveys of old age in Great Britain, 1945-58 *Bull. Wld Hlth Org.*, 1959, 21, 583
International Digest of Health Legislation

WORLD HEALTH ORGANIZATION
Hospitalization of mental patients: a survey of existing legislation. *Int. Dig. Hlth Legis.*, 1955, 6, 1. Also published as an offprint.

Monographs

BOVET, L.
Psychiatric aspects of juvenile delinquency, 1951, 90 p. (World Health Organization: Monograph Series, No. 1)

BOWLBY, J.
Maternal care and mental health, 1952, 194 p. (World Health Organization: Monograph Series, No. 2)

BUCKLE, D. & LEBOVICI, S.

CAROTHERS, J. C.

Public Health Papers

AINSWORTH, M. D. et al.

BAKER, A., DAVIES, R. LLEWELYN & SIVADON, P.
Psychiatric services and architecture, 1959, 59 p. (Public Health Papers, No. 1)

BLEULER, M. et al.
Teaching of psychiatry and mental health, 1961, 186 p. (Public Health Papers, No. 9)

GIBBENS, T. C. N.
Trends in juvenile delinquency, 1961, 56 p. (Public Health Papers, No. 5)

REID, D. D.
Epidemiological methods in the study of mental disorder, 1959, 73 p. (Public Health Papers, No. 2)

Reports of Expert Groups and Meetings

A. WHO publications

EXPERT COMMITTEE ON ALCOHOL AND ALCOHOLISM

EXPERT COMMITTEE ON MENTAL HEALTH

EXPERT COMMITTEE ON MENTAL HEALTH, ALCOHOLISM SUBCOMMITTEE

EXPERT COMMITTEE ON PSYCHIATRIC NURSING

JOINT EXPERT COMMITTEE CONVENED BY WHO WITH THE PARTICIPATION OF UNITED NATIONS, ILO AND UNESCO

JOINT UN/WHO MEETING OF EXPERTS ON THE MENTAL HEALTH ASPECTS OF ADOPTION
STUDY GROUP ON ATARACTIC AND HALLUCINOGENIC DRUGS IN PSYCHIATRY

STUDY GROUP ON JUVENILE EPILEPSY

STUDY GROUP ON MENTAL HEALTH ASPECTS OF THE PEACEFUL USES OF ATOMIC ENERGY

STUDY GROUP ON MENTAL HEALTH PROBLEMS OF AUTOMATION

STUDY GROUP ON TREATMENT AND CARE OF DRUG ADDICTS

B. Others

JOINT WHO/UNESCO EXPERT MEETING
Mental hygiene in the nursery school, Paris, UNESCO, 1951, 33 p. (Problems in Education, No. 9)

LIN, T.

STUDY GROUP ON SCHIZOPHRENIA

TANNER, J. M. & INHELDER, B., ed.

TANNER, J. M. & INHELDER, B., ed.

TANNER, J. M. & INHELDER, B., ed.

TANNER, J. M. & INHELDER, B., ed.