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**LEGISLATION AFFECTING  
PSYCHIATRIC TREATMENT**

**Fourth Report of the Expert Committee  
on Mental Health**

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**WORLD HEALTH ORGANIZATION**

PALAIS DES NATIONS

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## EXPERT COMMITTEE ON MENTAL HEALTH

### Fourth Session

Geneva, 1-6 November 1954

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# LEGISLATION AFFECTING PSYCHIATRIC TREATMENT

## Fourth Report of the Expert Committee on Mental Health \*

### 1. The Changing Attitude of Society towards the Mental Patient

Because of the strangeness of his behaviour and the frequently unpredictable nature of his reactions, the mental patient seems always to have inspired fear. In certain societies he was considered as a being of a divine nature and as such he was both respected and feared. At other stages in the evolution of human ideas, he has been considered as being possessed by an evil power, by a demon, and consequently has been either ill-treated, driven out of the community, or killed. The aim of such ill-treatment, moreover, was to expel the evil spirit rather than to cause suffering to the individual, so that it marks the beginning of a therapeutic attitude.

At a later stage, at least in Western countries, he was considered as a being differing in nature from other men, and therefore alienated from humanity, but although feared he became also an object of pity. At this stage it was thought sufficient to shut him up in asylums, preferably far away from towns, so as to rid society of his presence, while at the same time protecting him against himself.

The advances made in therapy have led to these persons being considered simply as sick people capable of being treated and cured. However, the feeling persists even in some highly developed communities that only those who are not dangerous and whose recovery appears possible are *sick*, whereas all the others should be certified *insane*. This accounts for the presence and even the extension of two systems of treatment in certain countries, namely the "service libre" and the "service

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\* The Executive Board, at its fifteenth session, adopted the following resolution :  
The Executive Board

1. NOTES the fourth report of the Expert Committee on Mental Health;
2. THANKS the members of the Committee for their work; and
3. AUTHORIZES publication of the report.

(Resolution EB15.R11, *Off. Rec. Wld Hlth Org.* 1955, 60, 4)

fermé”<sup>1</sup> in some and temporary hospitalization and commitment in others. This necessitates the still frequent intervention of the judicial authority to regularize the position of patients certified insane.

It is quite certain that, to treat a patient who is unaware of his state or not willing to accept treatment, the intervention of an authority backed by society is necessary. This authority is still very commonly the judicial one, above all in societies where there is little differentiation among institutions. The most recent legislation tends to delegate this power to an authority comprising both physicians and judges or to a health authority placed under the control of the law.

As the health authorities become more autonomous with respect to the other institutions of the State and as their authority becomes recognized, it is they who should take the necessary measures for the treatment of all categories of patients, whether aware or unaware of their state, whether willing or unwilling, subject to the right of appeal to the law in the event of abuse of authority.

As the concept of alienation gradually weakens and is replaced by that of illness, the fear felt by society diminishes and the patient, instead of being rejected, tends to be integrated into the community.

Instead of being merely shut up in asylums far away from the towns, the patient now tends to be treated in psychiatric hospitals, as open as possible, and situated near the community they serve. Better still, an attempt is made to avoid hospitalization and to make more and more use of out-patient treatment, vocational assistance, and boarding out.

Thus, the aim of health and social measures should be not to provide means of segregating those whose social capacity is inadequate, but to give everyone a place in society corresponding to his needs and abilities.

## 2. Criticism of Existing Legislation \*

The true functions of legislation affecting the mentally ill and mentally subnormal are to enable treatment and care to be given and at the same time to protect the patient and society. Most existing mental health legislation is unsatisfactory, although in some countries laws based on outmoded concepts of mental abnormality, when interpreted liberally, can

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<sup>1</sup> In certain countries “services libres” are hospital services not subject to the provisions of the legislation on the insane; “services fermés” admit only patients certified insane.

\* A survey of legislation on the hospitalization of mental patients in more than thirty countries has been published by WHO in *Int. Dig. Hlth Legis.* 1955, 6, 3.

be made to work fairly well in practice. But good mental health legislation should be a help rather than an obstacle to psychiatric care. The Committee reviewed some of the main weaknesses of existing legislation in different countries.

The greatest single weakness is that purely legal considerations are given too much weight, and medical considerations too little. In many countries, before admission to a mental hospital can be secured numerous legal formalities have to be satisfied. Sometimes the patient must be arrested by the police and placed in gaol pending an appearance before a judge or magistrate who will certify him as insane. These proceedings are often surrounded by great publicity, and in one or two places trial by jury with a full report to the public takes place. Scarcely less unsatisfactory than an appearance before a judge is the system whereby only the administrative authorities are empowered to authorize the admission of a mental patient to hospital. In many other countries, a mentally ill person must be seen by more than one doctor and certified as insane by a judge before he can be admitted. Elsewhere he or his relatives must sign a form or even several forms. Few countries make it possible for a mental patient to enter hospital on a truly voluntary basis and even fewer allow such provision for the mentally subnormal.

Once a patient is admitted to a mental hospital there must in many countries be frequent and often unnecessary reports sent to a central authority by those in charge of the hospital. Sometimes degrading and harmful limitations may, by law, be placed on the patient's liberty; terminology which is offensive to the patient may be employed; and civil rights may be automatically forfeited. Some of these restrictions, which poison the atmosphere of a hospital, were discussed more fully in the third report of the Committee.<sup>1</sup> Legal aspects are referred to later in the present report (see section 4, page 11).

Discharge from hospital is commonly more difficult to secure than admission. In many countries it can be authorized only by the administrative authorities, who may disregard medical opinion. Neither the patient himself, nor his relatives, nor even the doctors in charge of the case, may have the power to effect release. Elsewhere there are cumbrous procedures which must be gone through.

The restrictions placed on entry to and exit from a mental hospital arise in part from society's fear of mental illness and in part from a real desire to protect the liberty of the individual. What must be emphasized, however, is that very often they fail in this latter object. By giving the appearance of a guarantee of personal liberty without its substance they

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, 73, 17 (section 4.1.1)

may lull the public into a sense of false security and prevent the realization of a true freedom. They also make more difficult the work of the doctor in a hospital, who must spend a considerable part of his time in reporting to his superiors rather than treating his patients.

Most existing laws fail in other respects in which good laws could be of real service. Too few countries have minimum standards, laid down by law, to which the psychiatric services must conform. In many cases the law is instead used to relieve the administrative authorities of their obligation to provide services. A notable example of this is to be found in laws under which mentally subnormal children are excluded from the public education system.

It would seem, in short, that most existing legislation is misdirected in its aim. It is concerned too much with placing checks on the mental patient and his physician and too little with the public's responsibility for providing services for the mentally ill. It does little to foster a positive approach to mental health.

### 3. Essential Requirements to be Met by Legislation

#### 3.1 *General*

Although there seems no doubt that satisfactory legislation cannot fail to contribute to the development of psychiatric treatment and care, it must be recognized that, in quite a number of countries, good treatment facilities are not accompanied by legislative provisions adapted to present psychiatric requirements. Certain countries with ample facilities have no particular law covering mental patients, or if they have such a law and it no longer meets requirements they apply it as little as possible. Consequently, legislation must be so conceived as to encourage the provision of facilities without hampering progress in treatment and care. The danger would reside in providing psychiatric hospitals without at the same time ensuring their satisfactory operation. The psychiatric hospital can be the best or the worst thing possible for a patient; if it is a real "therapeutic community" as defined in the third report of the Committee,<sup>1</sup> it can exert an incomparable curative influence, but if, on the contrary, it is an instrument of desocialization and restraint it may irremediably aggravate the patient's condition.

It may be possible to imagine the existence of good treatment establishments in spite of the absence of any particular law on the subject, but it is quite impossible to conceive of the existence of adequate psychiatric

<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, 73, 17 (section 4.1.1)

facilities without a sufficient number of specialized medical and auxiliary staff.

It may therefore be said that in all countries the first necessity for which the law should provide is the recruitment and training of specialized professional staff.

Treatment facilities corresponding to the requirements of the community should be envisaged only to the extent that this need can be satisfied. Good psychiatrists without specialized hospital establishments would render greater service to patients and to the community than psychiatric hospitals without adequate professional staff.

Once requirements as regards professional staff and institutions have been covered, legislation should provide for the treatment without their consent of patients who are unaware of their condition or who are dangerous, and should also guarantee the necessary measures of guardianship and medical supervision. The application of these provisions for the treatment of unwilling or dangerous patients and of measures providing for guardianship and medical supervision will depend, in turn, on the quality of the physicians and of the institutions for the treatment of mental patients. The more highly qualified the physicians, and the better equipped the hospitals, the greater the likelihood that the vast majority of patients will consent to undergo treatment. On the other hand, if facilities are inadequate, coercive measures will tend to be used more often.

Finally, the whole organization must be co-ordinated through a specialized health authority operating on the national and also on the local level.

Thus it would appear that the following needs should be covered :

- (1) recruitment and training of the essential medical and auxiliary staff ;
- (2) provision of care and treatment institutions ;
- (3) establishment of measures permitting treatment of patients who are unaware of their condition or who are dangerous, and ensuring guardianship and medical supervision when the patient's state calls for this ;
- (4) setting up of a specialized health service, i.e., a community psychiatric service.

### *3.2 Recruitment and training of medical and auxiliary staff*

One of the main problems to be solved in connexion with the rapid and effective treatment of mental patients is that presented by the training of professional staff. The following requirements should be met :

- (1) instruction of all doctors, during their training, in the principal problems of psychiatric medicine and the role of the general practitioner

in the prevention, diagnosis, and emergency treatment of mental disturbances ;

(2) training of highly qualified specialists in sufficient numbers to staff the community psychiatric services and to provide specialists for private practice ;

(3) adequate information of all persons liable to play any role in prevention and case finding, as well as in the treatment and social rehabilitation of mental patients (nurses, social workers, magistrates, administrators, police officers, ministers of religion, industrial executives, etc.).

It is important for training to be co-ordinated with needs. Consequently, the universities should give such training in close collaboration with the various services for the treatment and care of mental patients in which the physicians and nurses will be called upon to work. Theoretical training based on examination of arbitrarily selected patients should be avoided ; a large part of the instruction should be given by specialists actually practising in the psychiatric services.

Special difficulties arise in connexion with the training of specialized professional staff in certain regions where there are no treatment establishments complying with modern technical requirements. The Committee considers that it would be desirable to set up, in each region representing a cultural or linguistic unit, one or more training centres for physicians and nurses. It may, in fact, be harmful to employ medical and nursing staff whose training is based on cultural concepts differing too widely from those of the population among whom they work.

The Committee considers that one of the chief problems to be solved in connexion with the recruitment of medical and auxiliary staff of the right quality is that of offering them conditions for the practice of their profession which will be sufficiently attractive and varied from the professional viewpoint.

Good doctors will always hesitate to devote themselves entirely to the treatment of chronic and incurable patients in inadequately staffed establishments far from any intellectual or scientific centre.

In the case of both nurses and physicians another point which seems important is that their activities should keep them in touch with all the various aspects of psychiatric medicine. To this end, provision should be made for them to devote part of their time to extramural services and, as far as physicians are concerned, to private practice.

Finally, it should be remembered that there is also the question of the training of other professional staff whose role is becoming increasingly important, namely psychologists, social workers, educators, occupational therapists, etc.

### 3.3 *Care and treatment services*

These are one of the subjects of study in the third report of the Committee.<sup>1</sup> They should include preventive services, extramural treatment services, psychiatric hospitals, special hospitals, after-care and home-care organizations, social and occupational rehabilitation centres, etc.

If such institutions are to be "therapeutic communities" in the sense in which the term is used in the Committee's third report, they should not be too large. One stumbling block to be avoided is specialization of establishments on the basis of concepts such as "acute" and "chronic", "curable" and "incurable".

Many systems of legislation tend to establish two categories of care and treatment, the main effort being concentrated on acute conditions, while patients who show little chance of recovery are left under mere surveillance in institutions at a distance from the towns. The Committee believes that all patients need treatment and that the difference lies only in the techniques to be used. It would therefore seem advisable to recommend the creation of a considerable number of small treatment establishments, all of which would treat various categories of patients, but some of which would be concerned more particularly with the use of specialized techniques. Since techniques are changing rapidly as our knowledge grows, laws should preferably not be too precise in their stipulations and, above all, should not include restrictive enumerations. The Committee is convinced that psychiatric institutions, no matter what their type or size, should in all cases, since they are therapeutic instruments, be under the direction of a psychiatrist. The Committee also believes that such institutions cannot maintain their character as therapeutic instruments unless they comply with the technical standards established by the advisory body and mentioned in section 5.1 (see page 16). Among these standards three appear to be particularly important:

- (1) adequate numbers of medical and nursing personnel;
- (2) absence of overcrowding;
- (3) technical facilities permitting abolition of mechanical restraint.

### 3.4 *Measures permitting compulsory treatment and guardianship*

This problem is dealt with in greater detail in a later section. Here only the essential requirements which such measures must satisfy are mentioned:

1. It must be possible to subject certain patients, who are either dangerous or unaware of their state, to treatment without their consent.

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, 73

There must therefore be some authority responsible for imposing such treatment, it being understood that the treatment imposed does not necessarily imply hospitalization. It is desirable that the procedure should be simple, that it should not include any measures prejudicial to the mental state of the patient, that it should be based essentially on medical information, and that it should provide all the necessary guarantees with regard to the protection of the liberty of the individual.

2. It must be possible to arrange immediate hospitalization of certain patients in cases of extreme urgency. There must therefore be provisions permitting such hospitalization, as a temporary measure, without any formalities except a medical certificate, it being understood that the formalities mentioned above will be complied with in due course.

3. Some patients are incapable of administering their property. Consequently, provision should be made for civil guardianship, the measures in this respect being as flexible as possible so that they may be applied and revoked with a minimum of formality. These guardianship measures should make it possible :

- (a) to advise patients who are capable of giving valid consent in connexion with the management of their private affairs ;
- (b) to assist patients who are only capable of giving an opinion on the management of their private affairs ;
- (c) to act for patients who are totally incapable of managing their affairs.

It should be possible to apply these measures to both hospitalized and non-hospitalized patients.

### 3.5 *The community psychiatric service*

This subject is dealt with in section 5 (see page 15) ; we shall confine ourselves here to indicating the need for such a service. As advances are made in treatment and care, it is essential that the organization and co-ordination of psychiatric facilities should be placed under the authority of a specialized health service attached to the central health authority and not to a judicial or police authority. Numerous and effective medical controls must likewise be established so as to keep pace with the multiplication of the types of treatment establishment and the adoption of more liberal methods of treatment for unwilling patients.

## 4. The Problem of the Unwilling Patient

In general, it may be said that the more adequate a psychiatric service, the less need will be felt for powers to compel a patient to accept treatment.

The better a psychiatric hospital, the more readily will patients enter it willingly, and, similarly, the more competent a psychiatrist, the more likely it will be that his patient will be persuaded of the need for hospital treatment.

This point must be emphasized; a law authorizing and regulating the compulsory treatment of patients is no substitute for a satisfactory psychiatric service, since it does nothing to reduce the number of such patients. It is important, therefore, that legislation should devote considerable attention to the development of satisfactory psychiatric services on the lines laid down by the Committee in its third report,<sup>1</sup> since such services will considerably reduce the number of patients for whom compulsion is required.

Nevertheless, even with good psychiatric services the need for compulsion will remain, although the patients to whom it will have to be applied will be few.

It is generally assumed that powers of compulsion are needed for only one purpose, namely the admission to hospital of an unwilling patient.

It will be suggested later (see page 14) that a form of compulsory "supervision" of an out-patient type may have a useful part to play in the work of psychiatric services and might, if it existed, reduce still further the use of powers of compulsory admission, but before dealing with this suggestion it will be convenient first to discuss the question of compulsory hospital admission.

To the physician the admission to hospital of a mental patient whose condition prevents his appreciating his need for treatment is a medical matter, akin in some ways to an emergency surgical operation and in others to the isolation, in the interest of his fellows, of a patient suffering from an infectious disease.

To the jurist, it is a matter of individual liberty and of the safeguards which the law must provide to protect it.

To the citizen, both these aspects are important.

The psychiatrist is eager that individuals whose judgment is disturbed by mental illness, and whose condition threatens their own welfare or that of others, should receive treatment by means which avoid both a judicial pronouncement that they are of unsound mind and admission to hospital under the order of a judge, both of which are felt by the recovered patient, his relatives, and the general public to be serious and lasting stigmata.

Any law which deals with this matter has to attempt to recognize the needs of both medical treatment and legal safeguards.

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, 73

Much existing legislation uses the intervention of a judicial decision before admission as the main safeguard, but this inevitably creates the type of stigma which the psychiatrist, the patient and the patient's relatives wish to avoid. In more recent years, however, there has been a growing tendency to authorize compulsory admission, at any rate in emergencies, at the joint request of a psychiatrist and a relative of the patient, or at the request of some specified non-judicial authority, subject to judicial review after admission.

The period after which review is necessary varies in different countries, ranging from one or two days to several months. In one recent law, all compulsory admissions are made by a "temporary" procedure of this type and are not subject to formal judicial determination of the patients' mental condition until twelve months have elapsed.

The possibility of temporary compulsory treatment of this type extending for a period of twelve or eighteen months ensures in practice that the majority of patients who recover under treatment will do so without having been detained in hospital by judicial order or without their "state of mind" having been the subject of any judicial pronouncement. It is a procedure such as this that the Committee would recommend.

It is evident from this experience that certain countries have felt it possible to provide for compulsory admission without judicial intervention before admission or during a period of initial observation and treatment of variable length. In one country, judicial review has been entirely replaced by a special district board consisting of three members, of which only one is a judge. That these changes in administrative procedure have occurred may be due to a growing belief that appeal facilities, inspection procedures and methods of discharge can provide safeguards to personal liberty as effective as a judicial determination before admission and much less prejudicial to the patient from a medical and social point of view.

The Committee therefore feels that ready facilities for easy appeal should be open to a patient at any time after his involuntary admission. In most countries such appeal would be to a judicial authority, but it may be pointed out that in one country, recognized to be in the van of progressive legislation, it has been thought preferable for the appeal to be heard by a local board composed of a physician, a judge and a layman.

No matter what the composition of the body which authorizes compulsory detention may be, its purpose should always be to decide on the legality of the detention of the patient in hospital. It need not be, and should not be, to certify that a patient is insane or mentally subnormal. The distinction between the authorization of detention and the certification of an individual's state of mind is an important one.

Inspection is dealt with elsewhere in this report (see page 16) in as far as it concerns the psychiatric hospital as a whole ; this inspection should also provide another opportunity for appeal.

Methods of discharge are, in the opinion of the Committee, particularly important as a safeguard against wrongful detention in a psychiatric hospital. The more widely distributed they are, within reason, the better. The next of kin, for instance, should have power to discharge the patient, subject only to a veto by the medical superintendent of the hospital on the specific grounds that a patient is dangerous to himself or others. The next of kin should have a right of appeal against such a veto.

The medical superintendent should have the right to discharge a patient, as should medical inspectors of the health authority, the committee or other body responsible for the hospital, and the local or central health authority. It is particularly desirable that, with the exception of the specifically limited powers of veto of the medical superintendent, the powers of discharge should be unrestricted. In one country, for instance, the hospital psychiatrist has no power of discharge ; the power is vested in the administrative governmental authority of the district. In such a situation, one finds cases occurring where the administrative authority, over-cautious of public safety, refuses to discharge patients whom the medical superintendent considers fit to leave the hospital. It must be emphasized that from a social point of view the advantages of increased public control over a few persons of uncertain self-control are more than offset by the disadvantages that may accrue through the fear engendered in the general community that once one is in a mental hospital it is difficult to get out. These fears make people unwilling to seek treatment at an early stage in mental illness.

In all that precedes, it is, of course, assumed that the patient concerned is not one who has been committed to a mental hospital by judicial sentence arising from a criminal act. It is, as this report points out elsewhere (see page 21), undesirable for judicial authorities to have power to commit convicted prisoners to civil mental hospitals by reason of mental illness, as it would be for them to have power to commit tuberculous prisoners to civil general hospitals ; to do so is to stigmatize the civil hospital and create practical difficulties in the treatment of patients. The penal authorities should ensure that a mental hospital exists within the penal service to treat criminal cases. If, for a particular individual, this is considered either unnecessary or undesirable, the case could be dealt with by probation or a suspended sentence to enable the individual to be admitted to a civil mental hospital in the normal manner.

This point is emphasized since, as long as civil mental hospitals contain patients committed to them by judicial order, so long will they be stigma-

tized in the public eye, and the situation is made even worse if they contain patients who cannot be discharged on recovery by the medical superintendent since they are committed there by judicial order for criminal acts.

The fact that most legislation on this subject is chiefly concerned with the admission of unwilling patients to mental hospitals and with discharge procedures arises from the fact that the laws were drafted when the mental hospital was the only means available for dealing with patients suffering from mental illness.

The present situation is very different. Out-patient treatment, social work, after-care, and rehabilitation now play a major part in the treatment of the psychiatric case. Most patients never enter mental hospitals as in-patients, or, if they do, the period which they spend in hospital may be only one episode in the whole process of the treatment. Just as compulsion to enter hospital is necessary for a small minority of patients in their own interest and that of their relatives, so there is a need for some form of compulsory supervision for a small minority of patients who could be treated outside hospital. It is not, of course, suggested that any form of compulsory supervision is needed for any patient who can be satisfactorily treated in the community without it. But if such a process of compulsory supervision existed, it would enable certain individuals to be treated successfully in the community who at present can only be treated under compulsion in a hospital.

Psychiatric legislation to date provides no example of such compulsory supervision, although a draft law containing a proposal of this type is at present under discussion in one country; but, in practice, compulsory supervision of psychiatric patients does occur in many countries by other means. It is common, for instance, for the probation system or the suspended sentence to be used as a means of insisting that a drug addict, an alcoholic, or a sex offender should seek treatment. Unfortunately, such compulsory supervision cannot be used until the individual has committed a criminal act, and his treatment therefore inevitably appears as a punishment for his crime imposed by the judiciary. The Committee feels there is need for some type of compulsory supervision—a type of medico-social guardianship—which the next of kin and the psychiatrist concerned could request as soon as it is evident that the patient's condition seriously threatens his own welfare or that of others, but before the patient becomes involved in criminal proceedings.

The Committee would not wish to make specific recommendations regarding the type of body which should have such a supervisory function or the manner in which such supervision should be authorized, since this must depend on the situation in a given country. In countries where

compulsory admission to a mental hospital is dependent on a judicial order, the establishing of extramural supervision would presumably be a judicial function. In others, where compulsory admission to a mental hospital depends on the next of kin and the psychiatrist, the same procedure would presumably be followed in establishing extramural supervision.

Whatever means were used to establish such "supervision" or guardianship, means of appeal and authority to terminate it would have to be freely available. Finally, it should be pointed out that the type of supervision suggested by the Committee would only be possible with well-developed extramural psychiatric services. Where these exist, however, the Committee feels that the proposal merits serious examination by any government considering new legislation for psychiatric cases.

## 5. The Organization of the Psychiatric Service

The Committee has already set out in some detail in its third report<sup>1</sup> the community psychiatric services which it thinks desirable. For such services to be developed, a local and a central mental health authority are necessary. Although it is not the function of legislation to deal with the details of community services, it must deal with the establishment and functions of the central and local authorities. This report cannot deal with such matters in great detail, since they must be, to a great extent, shaped by the governmental structure, practices and traditions of the country concerned.

But the general functions of such authorities can be specified and the principle can be emphasized that legislation will not be effective unless it establishes appropriate controlling bodies capable of ensuring the efficiency of the service from the point of view of the treatment and welfare of patients rather than the more restricted and partial function of safeguarding their personal liberty.

### 5.1 *The central authority*

The Committee recommends that in any country in which a national health authority exists the central body responsible for the psychiatric services should be part of that authority.<sup>2</sup> Its actual composition, position,

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, 73

<sup>2</sup> In some countries with a federal constitution, many of the functions discussed here are delegated to the constituent states (cantons, Länder, etc.), and this subdivision may be the unit of central health authority. In such cases it is recommended that the psychiatric services should be part of that health authority, and the functions discussed below would be either wholly or in part carried out by this authority.

and relationships within the health authority depend on the nature of the central health authority and the Committee therefore does not feel competent to discuss them. It recommends, however, that this matter should be given special consideration in any discussion of the role and structure of the central health authority which may be undertaken by the Expert Committee on Public-Health Administration.

The central authority should be responsible for laying down the principles on which the mental hospitals and extramural services should function and for setting up technical standards. These principles and standards are necessary not only for State-operated hospitals but also as criteria by which to judge independent psychiatric institutions. Such principles and standards should be based on modern knowledge and practice; an advisory body is therefore desirable to advise the central mental health authority.

The central authority should also have budgetary responsibilities, and a sufficient degree of financial control of such central funds as are contributed to the work of the local mental health authority, and to independent psychiatric activities, to enable those funds to be withheld from any activity which fails to reach the technical standards it has laid down.

Inspection is another important function of the central authority. Its inspectors, who should be psychiatrically trained physicians, should have unlimited right of inspection of all psychiatric institutions, regardless of whether they are public or private, and regardless of whether they receive support from public funds.

It is most undesirable that the inspectors should be responsible to the branch of the central mental health authority that is responsible for the direction of hospital services; the inspectorate should report to the head of the health authority. In some countries where the health ministry has a central inspectorate responsible for all health activities, it may be desirable that the mental health inspectors should form part of that general health inspectorate.

The compilation of national statistics on psychiatric disorders should be another responsibility of the central mental health authority, where this function is not undertaken by a central health-statistics organization.

The central mental-health authority should have another type of responsibility not directly concerned with the psychiatric services: it should be the recognized adviser to all branches of government on matters of mental health. Its responsibilities in this respect are much wider than is generally realized. Within the health ministry itself many activities have important implications for mental health, e.g. maternal and child health work, venereal disease, tuberculosis, and general hospital services. In all these activities, the central mental health authority should be the recognized

adviser on the mental hygiene aspects of the work. The central authority should also have a recognized advisory function vis-à-vis other ministries whose work has mental health aspects. These interdepartmental advisory responsibilities of the central mental health authority make it still more necessary for it to have the services of a strong professional advisory body on technical matters.

It is also desirable that the central mental health authority should have the right to provide consultant services on technical matters to local authorities and to psychiatric institutions. It should also have an obligation to stimulate and assist professional and public education and research in any aspect of mental health work which will accelerate the development of a satisfactory mental health service.

It is recommended that there should be an institute of mental health which would act as a co-ordinating and research centre and as a scientific consultant body for the various psychiatric services and for the other ministries (of labour, justice, education, etc.).

The central authority should have the obligation to keep the operation of the law and the regulations continually under review so that it may advise the government of the need for revision as soon as it becomes evident that the law is lagging behind current psychiatric knowledge and practice.

Finally, the direction of the central mental health authority should be in the hands of a physician with adequate training and experience in psychiatry. That such a recommendation is necessary may seem surprising, but there still exist countries where the central mental health authority is directed by an individual without technical training or experience of the work his authority is responsible for directing.

### 5.2 *The local authority*

The authorities responsible for mental health services at the local level should be part of the local health authority and should be under the direction of physicians with adequate psychiatric training and experience in psychiatry. They should have the responsibility for the administration of public psychiatric services and for co-ordinating the activities of public and independent psychiatric hospitals and extramural services. They should be responsible for advising on the support of independent psychiatric hospitals by the use of public funds.

Inspection is an important function of the local authority and here, as at the centre, the inspectors should be adequately trained and experienced in psychiatry.

The admission of involuntary patients, and the "supervision" of others, as suggested on page 14, should be a matter for which the local authority has a responsibility. The extent of this responsibility will depend on whether in the country concerned the unwilling patient is committed to hospital by a judicial order or on medical recommendation.

As at the centre, the local mental health authority must have advisory functions in the mental health aspects of activities outside the health services. This is particularly so in certain aspects of the educational system, the social welfare of children and matters concerned with industry and labour. It is desirable that the legislation should state this advisory function of the local mental health authority, for two reasons: firstly, because in many countries the boundaries of departmental responsibilities are jealously guarded and it may be difficult for the mental health authority to obtain the opportunity of offering its advice to other departments, at the outset, without the support of legislation; secondly, because it is undesirable to expand the direct activities of the mental health services to cover problems which could equally well be handled by the expansion of more general services.

The education of the mentally subnormal child is a case in point. This problem may be handled by relieving the educational service of the obligation to educate such children and setting up institutions for them in the health service. Alternatively, and more desirably, it may be done in the manner recommended by the Joint Expert Committee on the Mentally Subnormal Child,<sup>1</sup> by putting the responsibility for the education and training of *all* children on the educational authority and making the local health authority the technical adviser of the educational authority on the mental health aspects of all educational problems.

The same situation exists even within the health services. Many para-psychiatric problems in the health field can be dealt with either by the expansion of general services with psychiatric advice or by the development of psychiatric services. Health workers in the maternal and child health services and school health services could handle many minor psychiatric problems of childhood, given training and advice from the local mental health authority.

The provision of such in-service training and advice to all other branches of the local authority, particularly those engaged in health work, is one of the most important aspects of the local mental health authority's activities.

The Committee, in its second report,<sup>2</sup> has dealt very fully with the mental hygiene aspects of public-health practice, and that report indicated

<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1954, 75, 18 (section B)

<sup>2</sup> *Wld Hlth Org. techn. Rep. Ser.* 1951, 31, 5

the wide scope of the local mental health authorities' responsibility for the provision of advice and in-service training to public-health workers in the district.

In discussing the central authority (see page 16), the Committee pointed out the need for participation by an advisory body in the setting of the standards and principles on which the psychiatric services should be based. At the local level, where the responsibility for running these services lies, there is a need for the participation of the public. How this should be achieved must depend on the practices and the traditions of the country concerned. It can be achieved by participation in hospital management committees or boards of hospital visitors and in a variety of other ways. Such participation of local citizens in the management of the local mental health services is of great importance and can do much to change the public attitudes toward psychiatric hospitals from one of fear to one of understanding. Its influence on the hospitals themselves is equally beneficial.

## 6. Principles of Legislation Affecting Psychiatric Care

### 6.1 *General*

The principles governing good psychiatric legislation arise out of the need both for adequate mental health services and for care of the patient and the protection of society. In part, the need must vary with the customs and practices of society ; but some general rules can be laid down.

1. Bad psychiatric hospitals are worse than none at all. The law should not only oblige the central authority to ensure that facilities are available for adequate psychiatric care for all who need it, but should also ensure that standards are laid down to which the psychiatric services should conform. In practice it is unsatisfactory for such standards to be written into a mental health Act ; rather, the Act should appoint a body responsible for laying down regulations governing the mental health services. The following matters should be governed by regulation :

(a) the numbers of doctors and other professional workers per head of population at risk. (This is because, as has been argued in the third report of the Committee,<sup>1</sup> it is desirable that the same medico-social team should be responsible for all the mental health problems of the community. Therefore, while there should be regulations governing the numbers and quality of the staff of psychiatric hospitals, the

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1953, 73, 9 (section 3.1.4)

requirements of in-patient services should never be divorced from those of the total community.)

(b) the qualifications and experience required for recognition as a psychiatric specialist ;

(c) the maximum and optimum size of mental hospitals (discussed in the third report of the Committee<sup>1</sup>);

(d) the kind of inspection required for mental hospitals (strict standards of inspection enable the law to be liberal regarding admission to hospital).

2. The central authority should be given the power to approve and license hospitals and other establishments as being fit to receive mental patients, and only licensed hospitals should be permitted to operate. As outlined above, the central authority should be responsible for the inspection of hospitals and services. It should, in certain cases, be enabled to grant and to withhold sums of money to be used for treatment, teaching, research or other purposes.

3. The law should ensure that the general public, through visiting committees or other means, is drawn into the work of the mental hospital. It should stipulate that the directors of the psychiatric services and of psychiatric hospitals should be psychiatrists.

4. The law should also provide for adequate out-patient services for the mentally ill and mentally subnormal and should be able to assist families to care for their mentally abnormal relatives. It should make possible the "supervision" of patients who need it and it should, as a matter of course, lay down rules governing admission to and discharge from hospital.

5. Upon the education authorities should fall the obligation to provide services for all mentally subnormal or otherwise handicapped children.

6. In a mental hospital certain measures are to be avoided. Mental diseases have a disturbing effect on the patient's personality and all measures which belittle the patient will aggravate the disorder or at least hinder recovery. To this category belong regulations of the kind which require that a patient shall be deprived of his personal possessions (wedding ring, false teeth, spectacles, pocket book, diary, watch, etc.) or his own clothes. Labels and terminology which are derogatory to the patient should be avoided. The insistence on regulations which are contrary to normal life (for example segregation of the sexes for meals, recreation and work) is harmful to the patients, as is the location of hospitals far from urban centres, which makes contact with their families and with

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.*, 1953, 73, 29

normal society difficult. The transfer of patients to places far from their homes is usually prejudicial to recovery and should be avoided where possible.

Mechanical restraint and prolonged seclusion have no place in a good mental hospital. They are incompatible with modern and human methods of treatment and the need to use such measures indicates either that the hospital is poor in the quality or quantity of the staff or that the facilities made available to them are inadequate. Such measures if permitted at all must always be under the strictest medical supervision. It is preferable that they should be forbidden by law.

#### 6.2 *What kind of mental health Act is needed?*

Because of difficulties which many countries experience in amending mental health legislation (French practice, for example, is still largely governed by an Act of 1838 and English practice in part by an Act of 1890), as well as because good legislation is intrinsically useful, the Committee considered the kind of mental health Act that might best suit the needs of different countries. There was general agreement that a single mental health Act covering both the mentally ill and the mentally subnormal was the most useful form of legislation. Laws which set out in detail the kind of establishment to be set up or which lay down detailed provisions regarding the medical and nursing care of patients or the numbers of staff required are more likely to hinder than to assist the evolution of good psychiatric services. Such things are better left to regulation, and the law should merely prescribe who should make the regulations and who should ensure that they are carried out.

Questions of forensic psychiatry and criminal responsibility lay outside the scope of the Committee's discussion, but it was emphasized that, while it should be possible to transfer mental patients easily from prisons to mental hospitals, the mental hospital should not be asked to undertake the custodial care of dangerous criminals. These should be cared for in special establishments for criminals.

It is probable that in many countries much more use could be made of already existing laws and social services to provide for the needs of the mentally ill and mentally subnormal. The Joint Expert Committee on the Mentally Subnormal Child has set out in detail<sup>1</sup> the reasons why the greater part of the special services for the mentally subnormal should come within the framework of more general social services, and the present Committee agreed that some of these arguments applied with equal force to the mentally ill.

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<sup>1</sup> *Wld Hlth Org. techn. Rep. Ser.* 1954, 75, 41

## 7. Problems Raised by Certain Categories of Patients

### 7.1 *The mentally subnormal*

The Committee concurred with the recommendations made by the Joint Expert Committee on the Mentally Subnormal Child.<sup>1</sup> Mentally subnormal children, like disturbed children, require no special legislation to protect them; general legislation governing the protection and education of children is fully able to meet their needs. As a general principle, legislation which imposes statutory duties on already existing authorities is more likely to lead to advances in social welfare than is special legislation designed to cover explicitly certain categories of handicapped persons. Mentally subnormal delinquents should be dealt with under the same laws as other delinquents, and it should be an administrative responsibility to see that services are created to meet their special problem.

Mentally subnormal adults should be dealt with wherever possible on a voluntary basis. Voluntary placement in a hospital where this is necessary should be as easy for them as for the mentally ill. There should be the same safeguards and possibilities of discharge from hospital. The Committee believes that a parent, a relative, a friend or the local authority should be able to place idiots and imbeciles in hospital without legal formality. Mildly subnormal adults should be able to enter hospital of their own free will.

Mental subnormality as such is not a condition which justifies compulsory detention in hospital and the majority of the mentally subnormal could very properly remain at home if adequate services were available.

The Committee drew attention to a recommendation of the Joint Expert Committee on the Mentally Subnormal Child<sup>2</sup> that a distinction should be drawn between the mentally subnormal and those whose emotional development is stunted or warped, but who have normal intellectual capacities. It is not in the interests of either of these categories that they should be housed together, and separate institutions should be provided to meet the problems posed by the different groups.

### 7.2 *Old people*

The Committee could not consider in detail the problems of senility and psychoses of the senium. The greatest need for old people is clearly for services, in particular for small units, which can be easily integrated in the

<sup>1</sup> See *Wld Hlth Org. techn. Rep. Ser.* 1954, 75.

<sup>2</sup> *Wld Hlth Org. techn. Rep. Ser.* 1954, 75, 6

community and where old people who need it can be given care and treatment and suitable occupation. Because of the growing importance of problems of ageing, the Committee recommends that WHO should consider setting up an expert committee to study all the health problems of old people.

### 7.3 *Epileptics*

If an epileptic suffers from mental disorder he should be treated as a mental patient. However, the majority of epileptics need only medical treatment and assistance. The Committee was of the opinion that it is not desirable to segregate epileptics in special residential establishments. It is preferable, when they cannot remain at home, to allow them to live in communities which include other types of patients needing supervision. No special legislation seems to be necessary for them if there is general legislation entitling all individuals to education and to working conditions suited to their abilities. Diagnostic and treatment centres in the community would make it possible to follow up both patients living at home and those living in special communities.

### 7.4 *Alcoholics*

Alcoholism has been discussed by other committees,<sup>1</sup> which have stressed that public education and early treatment facilities are the most effective measures for handling the problem. Unless these exist, laws relating to alcoholism are likely to be ineffective. There should, however, be legislation which would make it possible for alcoholics who are dangerous to themselves or others to be obliged to submit themselves for treatment. The majority of the Committee considered that a mental-treatment Act should not provide for the compulsory treatment of alcoholics. Instead, compulsion should be imposed by the courts in the case of those who have committed crimes while under the influence of alcohol.

## **8. Application of Legislative Principles in accordance with the Type of Social Structure**

The fundamental problems of psychiatric treatment and mental health are the same in all countries, whatever their structure or degree of economic development. What is required in all cases is :

(1) to make available means of treatment and care (prevention, training of personnel, organization of facilities for treatment and care) ;

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<sup>1</sup> See *Wld Hlth Org. techn. Rep. Ser.* 1951, 42 ; 1952, 48.

(2) to provide for the guardianship and medical supervision of the mentally ill and mentally subnormal whose capacity for social autonomy is inadequate or who show themselves to be a danger to law and order.

But although the fundamental problems are the same, the way in which they are dealt with should vary according to the type of social structure.

As mentioned at the beginning of this report, ideas concerning mental illness vary from one society to another and even within one and the same society they change from one period to another.

In the first place, the law should be in keeping with the cultural and legal traditions of the society concerned. However, this involves the risk of perpetuating the customary usages and thus opposing change. It would seem that this danger might be avoided by advocating legal provisions which, while being adapted to the present stage of development of a society, leave the way open for future changes. For this reason it is desirable, at every stage of development, to introduce the basic elements of the following stage and, in that following stage, to modify the function of the preceding institutions.

For example, in a society where the mental patient is considered to be of a divine nature or possessed by an evil spirit, there can be no doubt that in most cases it is the religious healers who will first be turned to and consequently it will be difficult for the psychiatrist not to make use of their collaboration. However, it is advisable to provide, in a later stage, for the supervision of the activities of the healers by psychiatrists and a gradual reduction of the part played by these healers.

Similarly, in certain countries where the popular conviction persists that mental disease is, by its very nature, dangerous and incurable, judicial procedures are in common use. But at the same time we see regulations being established that allow a purely medical authority to compel a patient to be hospitalized. Furthermore, these medical measures of coercion are being restricted more and more to patients who are, in actual fact, both unwilling and dangerous.

It may be considered that at present, in almost all countries, very modern tendencies, whereby the mental patient is regarded as a member of the community in need of aid and treatment, co-exist with archaic cultural survivals, whereby he is regarded as a madman (an alienated person) whose state calls above all for measures of segregation and protection, with respect both to himself and to others. This co-existence in certain countries of very advanced laws and very primitive attitudes towards patients is very striking. Conversely, in other countries very effective psychiatric treatment and care have developed successfully, whereas the legislation reflects obsolete ideas.

The conclusion to be drawn from this is doubtless that the ideas held by the masses as regards mental disease are still, even in the most advanced societies, at a very primitive stage and that legislation should, above all, encourage change in these ideas without antagonizing them in too peremptory a manner.

There are two practical solutions to this problem : either the old laws should be retained while promulgating new ones and making increasing use of the possibilities offered by the more recent ones, the obsolete formulae being gradually allowed to fall into abeyance, or the law or regulations should provide for a permanent body responsible for their revision, which should take place at stated intervals. In this way it would be possible, on the one hand, to avoid passing laws which are inapplicable because too remote from local concepts and traditions and, on the other, to prevent changes being held up by an immutable legislative system.

To summarize, the problems raised by the treatment and care of mental patients are relatively simple. What is required is to give these patients facilities for treatment and the possibility of guardianship and medical supervision in accordance with their medical needs and social inadequacy. The different methods of solving these problems are extremely complex since they must vary according to the social structure of each country. No one system can be applicable to several different countries and even in one and the same country the systems advocated by some will be repudiated by others. Any system which comes into conflict with legal or cultural conceptions is inapplicable. It would seem, therefore, that preference should be given above all to establishing laws strongly integrated into cultural traditions while at the same time leaving the way open for possible changes.

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