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THE COMMUNITY MENTAL HOSPITAL

Third Report of the Expert Committee on Mental Health

	Page
1. Prevalence of psychiatric disorders	3
2. Essential mental hospital accommodation	4
3. Steps in the development of community mental health services	6
4. Inpatient services	16

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EXPERT COMMITTEE ON MENTAL HEALTH

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THE COMMUNITY MENTAL HOSPITAL

Third Report of the Expert Committee on Mental Health¹

1. PREVALENCE OF PSYCHIATRIC DISORDERS

One of the difficulties which the committee faces in making recommendations for the provision of psychiatric medical care is that there is little exact information on the extent of psychiatric morbidity. It is important for two reasons to encourage the carrying out of surveys designed to provide reasonably accurate information on the prevalence of psychiatric disorders. Firstly, because without a knowledge of the approximate number of cases in need of psychiatric medical care no rational planning of psychiatric services can be undertaken, and, secondly, because comparative studies of the incidence of psychiatric disorders in different types of communities and in different social and occupational groups are of immense theoretical importance.

Certain workers who have attempted a study of this matter in economically underdeveloped countries have the strong impression that psychiatric disorders are much less prevalent in some of these areas. The view has been put forward, for instance, that the incidence of psychiatric disorders in tribal Africans is one tenth of that usually found in western Europe and North America. Other workers, on the other hand, hold the view that whereas the incidence of those psychiatric disorders believed to be largely provoked by environmental circumstances varies considerably from place to place, other psychiatric disorders have a rather constant frequency

¹ The Executive Board, at its twelfth session, adopted the following resolution :
The Executive Board

1. NOTES the third report of the Expert Committee on Mental Health ;
 2. THANKS the members of the committee for their work ;
 3. AUTHORIZES the publication of the report ;
 4. REQUESTS the Director-General to draw to the attention of Member States the desirability of bringing this report to the attention of all authorities responsible for the planning and management of mental hospitals ; and, further,
 5. REQUESTS the Director-General to bear in mind the principles and recommendations contained in the report when planning future WHO activities in this field.
- (Resolution EB12.R11, *Off. Rec. World Hlth Org.* 49, 4)

in all societies. All are agreed, however, that the clinical picture of psychiatric disorders, and even their prognosis, varies very greatly from one society to another. There is no doubt, however, that in western Europe and North America psychiatric disorders, which fill about 40% or more of the total hospital beds, form a major health problem.

From a practical point of view, therefore, the committee strongly recommends that countries beginning to develop their mental health services should attempt to carry out, if necessary with the assistance of WHO, surveys of sample communities in order to arrive at a working estimate of the prevalence of psychiatric morbidity. The techniques involved in such a study are not those with which the psychiatrist can be expected to be familiar, and therefore the provision by WHO of consultant services in the field of statistics, in both the planning and carrying out of such surveys, would be of great value. Apart from their practical value, comparative studies of the prevalence of psychiatric morbidity which compare that found in different communities, different social groups, and different cultural patterns are of very great theoretical importance, since they may well throw light on important etiological factors and thereby open the way to more effective prevention. The committee therefore strongly recommends that the World Health Organization should begin to collect and study what information already exists in this field and should do all in its power to stimulate national workers to undertake studies of this type, which should then be brought into relation with work being done in other countries. This epidemiological approach to the problem of psychiatric disorders has hitherto been almost completely neglected.

2. ESSENTIAL MENTAL HOSPITAL ACCOMMODATION

Later in this report it will become evident to the reader that the committee considers that the need to provide more psychiatric hospital beds is at present being over-emphasized in some countries of western Europe and North America to the detriment of the provision of other services which would reduce the need for admission of patients into psychiatric hospitals or alternatively reduce the length of stay of those patients who must be admitted.

Nevertheless, in considering the position of those countries which are at an early stage of economic development, it must be recognized that a certain minimum provision of psychiatric beds is essential to make possible the segregation and treatment of individuals who are mentally sick and are at the same time, because of their behaviour, a danger to themselves and to others, or otherwise create a grave social problem in the community

in which they live. This type of patient can be handled only in a psychiatric hospital.

It is evident, however, that as a community's economic development progresses the functions of the psychiatric hospital will extend beyond the care of this particular group of patients, as has already happened in all the countries of western Europe and North America.

Nevertheless, it is necessary to make some recommendation of the absolute minimum provision which any country, regardless of its level of economic development, should aim to provide to deal with this particular group of patients. In the western countries, three psychiatric beds per 1,000 of the population are usually available; of these, about one third (or one bed per 1,000 of the population) is devoted to the care of the particular type of patient described above. On the other hand, it has been suggested that to provide accommodation for all patients of the same type who would be found in a rural community in tropical Africa one psychiatric bed per 10,000 of the population would suffice. Psychiatrists working in some of the Asiatic countries have reached the conclusion that a figure between these two would be appropriate for their communities—namely, the provision of five psychiatric beds per 10,000 of the population. Another fact should also be borne in mind—namely, that it appears that a higher degree of provision is necessary in urban than in rural societies.

Therefore, while it is impossible to lay down hard and fast rules about the number of beds that should be provided for the type of psychiatric patient who must, by virtue of his behaviour and his illness, be segregated from society for his own sake and for the sake of the community, it can be said that any community—however economically undeveloped—which has less than one psychiatric bed per 10,000 of the population will be unable to provide even this crudest level of what might be described as “emergency psychiatric inpatient care”, and that, depending on the rising level of economic development and increasing urbanization, probably any community will ultimately find it necessary to provide at least one psychiatric bed per 1,000 of the population for the custodial treatment and care of these most flagrant cases of psychiatric disorder.

Once this level has been reached, however, it must not be assumed that the next step in the development of psychiatric services is to increase the number of psychiatric beds. It is probably preferable that, the moment the provision of beds to this level has been reached, those responsible for planning psychiatric services should devote at least as much attention to the development of extramural treatment facilities and other psychiatric activities within the community, side by side with any further increase in the provision of psychiatric beds. There is no doubt that in the past too much attention has been given to the mere provision of further psychiatric

beds and too little to the development of a real community mental health service.

3. STEPS IN THE DEVELOPMENT OF COMMUNITY MENTAL HEALTH SERVICES

3.1 Extramural Activities (Preventive and Educational)

Once the provision of beds for essential custodial care has been achieved, priority should be given to the development of psychiatric activities within the community which the hospital serves at least equal to that given to the addition of further psychiatric beds. Even when considering the addition of further psychiatric beds, those responsible for their provision should consider the problem in terms not of how many more psychiatric beds should be provided but rather of how any new psychiatric beds could be used most advantageously.

If the psychiatric staff of the hospital which provides essential custodial care is to begin to undertake activities within the community, it will need to be augmented. It has been shown in highly developed communities that a considerable part of the time of the psychiatrist on the staff of a community mental hospital can fruitfully be spent on preventive and therapeutic work in the community which the hospital serves. Before adding further beds, therefore, sufficient extra psychiatric staff should be provided for the existing hospital to enable them to spend about a third of their time on community activities. Probably the first such activities to which they should devote their attention are the spreading of information to the public and the development of mental health education within the community, and the study of both the mental health problems in the community and the ways and habits of the community which are relevant to the solution of these problems.

3.1.1 *Public information*

The first type of information which needs to be spread concerns the activities of the hospital itself and the nature of psychiatric illness. It needs to be spread on both a professional and a popular plane, reaching other members of the medical profession, such as family doctors and specialists, and reaching the general public. In the past, the attempts to pass this information to the latter group have usually been made through mass propaganda methods, employing lectures, posters, radio talks, and public lectures. It is, however, becoming evident that such mass methods are less effective than the approach to small groups of key individuals in

professions which influence popular opinion and understanding, such as public-health nurses, teachers, community leaders, industrial supervisors, trade union officials, and ministers of religion.

3.1.2 *Mental health education*

Although the spreading of information regarding the existing psychiatric services in the community is desirable so that full use may be made of these facilities, there has been in recent years a tendency in some countries to extend this activity chiefly in the direction of teaching on the subject of mental illness and its treatment. In some cases it is possible that this trend has gone too far, with the danger of creating within the community a hypochondriacal attitude on the subject of psychiatric disorders.

Mental health education should preferably take the form of attempting to disseminate knowledge on the fostering of mental health rather than on the types of mental illness. Mental health education, therefore, is probably best focused on the psychological needs of different periods of development in the life of the human being and the different types of stresses characteristic of such situations as the home, the school, marriage, and work, so that understanding may be spread of the way in which these stresses may be diminished and the individual assisted to reach a satisfactory resolution of the various problems which inevitably face the human being in these situations.

Public education of this type, therefore, is one of the first activities which the psychiatric staff of the mental hospital should undertake within the community which they serve. It is important to emphasize that such mental health educational activities in the community should not be conducted as an isolated programme unrelated to other health-education activities. On the one hand, they need to be integrated with any general programme of health education which is developing in the community, and, on the other hand, they need to give attention to the mental health aspects of other health work, to ensure that any health activity, whether it be a school health service or control of infectious diseases, does not neglect opportunities for fostering mental health and is not conducted in a way which creates mental health problems. In this connexion, the second report of the Expert Committee on Mental Health will be found of value, since it is entirely devoted to the mental hygiene aspects of general public health activities.²

One group of health workers, namely, the public-health nurses, have particularly important opportunities in this respect. By virtue of their

² *World Hlth Org. techn. Rep. Ser.* 1951, 31

work they develop close and intimate relationships with people in their own homes and especially with people who may be undergoing emotional stress. The public-health nurse's first contact with a woman will, for instance, often be during her pregnancy and during the care of her newborn child. If the public-health nurse is to take advantage of the great opportunities for mental health education which this relationship gives her, one of the psychiatrist's first duties in the community must be to equip her with a knowledge of the mental health aspects of child development and of the significance of the mother-child relationship, in order to enable her to use her opportunities constructively.

The psychiatrist should also bring his influence to bear on those responsible for the basic training of public-health workers and other groups, such as teachers, so that knowledge of this type can be incorporated in their training.

The method by which public information is disseminated and mental health education carried out merits some discussion. A great deal of such work is at present carried out in a didactic manner in which the public or the professional group concerned is looked upon as a passive recipient. Modern educational techniques suggest that such a method is fundamentally unsound, and that the more actively the community participates in these activities, the more effective they are likely to be. The participation, for instance, of voluntary workers or groups of workers in the activities of the mental hospital is likely to prove a far more effective means of disseminating knowledge about the hospital than pamphlets and posters. The same is true of the community work of the psychiatrist himself. He will often find better opportunities of promoting the development of an understanding of mental health work in the community by active participation as a citizen in the affairs of the community his hospital serves than by lecturing to passive audiences. The holding of small study groups led by the psychiatrist, through the opportunity of discussion it provides, is also a valuable means of health education in this subject for the intelligent layman.

3.1.3 *Mental health research*

It must be recognized that although certain important aspects of the fostering of mental health now rest on the foundation of definite knowledge, there still remain large gaps which only further research can fill. It is essential, therefore, in public education that the psychiatrist should not dogmatize on issues which still remain unsolved. Much further research on the etiology and prevention of psychiatric disorders remains to be undertaken before any comprehensive statement on this subject can be made.

WHO can do much to stimulate interest in specific research problems which appear likely to throw light on the etiology of psychiatric disorders. The WHO monograph *Maternal care and mental health*³ is a useful example of a survey of research throughout the world on one particular etiological hypothesis. Further similar comparative international studies of research on specific issues are needed, and should be undertaken both by WHO and by any non-governmental organizations which are in a position to carry them out.

Although a great expansion of research is needed, there already exists etiological knowledge which is not being applied; all possible steps should be taken to stimulate public-health workers to incorporate this knowledge into public-health practice. In its second report, referred to above, the committee has already discussed this matter at some length.

Stimulation of mental health research at the national level is also desirable; in most countries it receives little official support. The establishment of a national institute of mental health has in certain countries given a powerful stimulus to work in this field, and any country setting out to develop its mental health services should give consideration to the advisability of setting up such an institution.

3.1.4 *Medical liaison*

Another type of community activity which the psychiatric staff of the mental hospital should early undertake is the development of working relations with other physicians in the community. Such activities should include consultative services in general hospitals and activities designed to increase the understanding of psychiatric problems among family doctors, school physicians, and all others whose work brings them daily into contact with patients suffering from various degrees of psychoneurotic or psychosomatic disorder.

The psychiatrist's aim in such work should be to teach, help, and encourage such physicians to deal themselves with many of the simple psychiatric conditions and to recognize those which are beyond their capacity. To succeed in this phase of the expansion of his work outside the community mental hospital may well demand from the psychiatrist a considerable reorientation of his own point of view. Many psychiatrists who have worked solely and continuously in psychiatric hospitals forget that the psychoses, statistically regarded, are rare, whereas the psychoneuroses are common. In many countries, 30% of the patients who seek the aid of a family doctor do so by reason of a psychiatric disorder, but,

³ Bowlby, J. (1952) *Maternal care and mental health*, 2nd ed., Geneva (*World Health Organization: Monograph Series No. 2.*)

among these patients, those suffering from the psychoneuroses are an overwhelming majority ; the family doctor only rarely sees a frank psychosis. The psychiatrist must therefore recognize that at this stage of the development of the mental hospital he will live, in a manner of speaking, in two worlds. Within his hospital the psychoses will predominate ; outside, in his extramural work, he will be chiefly concerned with the psychoneuroses. At a later stage, as the hospital expands beyond the role of emergency custodial care, a wider range of patients, including neurotics, will come under treatment as inpatients ; and, as the extramural facilities develop, they will make possible the after-care and even extramural treatment of many psychotics. Nevertheless, the difference between the clinical experience within the hospital and that in outpatient services will always to some extent remain. This makes it essential that the psychiatrist on the staff of the mental hospital should also undertake outpatient consultations, treatment, and other psychiatric activities in the community. Only in this way can the experience of a true general psychiatry be obtained and the present unfortunate schism which exists in many countries between " office " and " hospital " psychiatry be bridged.

3.2 Extramural Treatment

3.2.1 *General outpatient services*

The work of liaison with other physicians, the mental health education work, and the participation of the mental hospital psychiatrist in the affairs of the community will lead towards the setting up of an outpatient service. The committee considers that, when a demand for such a service arises, the most favourable setting in which to establish the service is the principal general hospital which serves the community. At first, the activities of this service will be predominantly diagnostic, providing consultative opinions for other medical colleagues. The need for therapy of a type beyond the competence of the general physician will, however, soon assert itself, and the psychiatric outpatient clinic will then have to develop to fill this need. The outpatient service also plays a valuable role in providing after-care for the discharged inpatient by consultation and by home visits and can often give much preliminary care to patients about to be admitted to hospital.

At first sight, it may seem that to establish a psychiatric outpatient service as soon as the need for emergency custodial care is met is an unrealistic way in which to employ the staff of the community mental hospital. But upon reflection it will be evident that the outpatient work is in effect the antenna of the community mental hospital, and that from the clinical experience of this service may be derived the most reliable

indicators of the direction in which the hospital should develop if it is to meet the needs of the community it serves.

3.2.2 *Specialized outpatient services*

The general psychiatric outpatient service is also a means of assessing the need for specialized psychiatric outpatient services. Only by the study of the clinical experience of the general psychiatric outpatient service can the need for more specialized services be deduced. Experience suggests that the first of such special needs to become evident may often be that for special provision for the psychological disorders and behaviour problems of childhood.

3.2.2.1 *Children's outpatient services.* As soon as the number of patients justifies it, a separate children's outpatient service, for example, is desirable. The diagnosis and therapy of children suffering from psychological disorders demands a physical setting different from that in the adult clinic, both in furniture and equipment, and the organization of staff that the work requires also differs from that necessary for the treatment of adults. Nevertheless, the committee would certainly not wish to imply that the mental hospital psychiatrist should not participate in the handling of the problems of child psychiatry. On the contrary, outpatient experience with children should in future be considered an essential part of the experience of the general psychiatrist. As the psychiatrist develops, however, it is inevitable and desirable that he should specialize in the aspect of psychiatry in which he is particularly interested. Perhaps, therefore, one can best summarize the view of the committee by saying that all psychiatrists should have experience of child psychiatry, but that specialization in child psychiatry is also inevitable and desirable if the most senior positions in this field are to be adequately filled.

If the psychiatrist on the staff of the hospital is to play the roles described above and those that are suggested in the following sections, it is evident that his training must be broader than has often been the case in the past. He must understand the psychoneuroses as well as the psychoses; he must be taught psychopathology at least as thoroughly as neuropathology and must be interested in all types of treatment, in prevention, and in the health education of the public. He will need, in addition, insight not only into the work of his clinical colleagues in internal medicine and other specialities but also into the activities of public-health workers, both doctors and nurses, and into the work of the educator and the social worker.

3.2.2.2 *Psychotherapy.* The general psychiatric outpatient service will throw into relief the need for psychotherapy for certain patients. If so, it is often convenient to organize such treatment as a specific outpatient

service providing both individual and group psychotherapy. But although it may be desirable administratively to concentrate this activity into a specific service, it is also desirable that the mental hospital psychiatrist should participate actively in providing such therapy.

3.2.2.3 *Epilepsy.* The existence of a psychiatric outpatient service for children may soon bring to the foreground the problem of epilepsy, and it may soon become evident that a special outpatient service to which such cases can be referred is desirable. The investigation of this condition requires neurological facilities and, in particular, thorough electro-encephalographic study. But that is not to say that the psychiatrist should discard the problem to the neurologist. He must participate actively in the treatment. For example, the attitude of the child to his disorder and the attitude of his mother and others to it, the feeling of guilt that the malady provokes in her, and the anxiety that it arouses in his school-teacher are problems which cannot be dissipated by anticonvulsant drugs. They need the psychotherapeutic approach of the psychiatrist and the psychiatric social worker.

3.2.2.4 *Alcoholism.* In most countries the alcoholic does not spontaneously come to the psychiatric clinic, nor is he brought by his relatives, at a stage of his malady early enough to be hopeful. Although the psychiatrist could often help him, the alcoholic does not seek psychiatric help until it is much too late. One result of this situation is that the psychiatrist is usually unfamiliar with any but the terminal stages of this disorder. There is urgent need of outpatient services at general hospitals for alcoholics run by psychiatrists interested in the problem. Such services should label themselves honestly as alcoholic clinics rather than conceal themselves beneath euphemisms if they are to win the confidence of those they seek to help.

This report, however, is not the place in which to elaborate the details of the outpatient treatment of alcoholism. Suffice it to say that the committee endorses completely the recommendations of the first and second reports of its Subcommittee on Alcoholism.⁴

3.2.2.5 *Supporting activities.* There is one type of extramural activity which is in effect the provision of support to those who have been in-patients in the psychiatric hospital and are now attempting again to resettle themselves in the community after their discharge from hospital.

When the patient leaves the hospital, one of two attitudes is often observed: either he tends to deny his illness and to sever all contact with the hospital and its doctors; or else he is overcome with anxiety caused

⁴ *World Hlth Org. techn. Rep. Ser.* 1951, 42; 1952, 48

by a more or less conscious fear that he will be incapable of confronting his responsibilities and supporting the moral isolation and, often, the sheer loneliness which await him outside.

These two modes of behaviour, although apparently contradictory, show the persistence of an attitude with regard to the illness which may prevent resumption of normal social relations, and consequently impede the social rehabilitation of former patients. Old-patients' clubs have been found an excellent way of meeting these problems. They are constituted by groups of old patients and are preferably run to a considerable extent by the patients themselves. In fact, such persons are more likely than any others to understand those who have undergone the same difficulties as themselves; their group constitutes, therefore, the most favourable environment for supporting the patient who has just left a mental hospital. The activities of these clubs can be very varied. It is important that they should have concrete as well as social objectives—such as are provided by sports groups, cultural groups, artistic and touring groups, etc.

Permanent headquarters, situated in the community and entirely separate from the hospital, should be organized by club members, who generally need to be assisted and, to some extent, directed by the psychiatrists who had treated them in the hospital and by other members of the hospital therapeutic team. The former patients are sure of meeting there, in an unrestrained and friendly atmosphere, not only former patients like themselves, capable of understanding and helping them, but also the doctors, nurses, social workers, and psychologists, who now appear in a new setting without any institutional character. A new kind of relationship is established between the former patient and the doctor, which considerably facilitates the latter's position as adviser to the patient and his family.

It is important that old-patients' club members should collaborate with inpatient clubs organized inside the community mental hospital and that those who are still inpatients should be able, during the weeks preceding their leaving hospital, to go to old-patients' club meetings. The members of the latter should also themselves participate in the organization of social life within the hospital by collaborating in the organization of social occasions.

It should not be considered either necessary or even desirable that the former patients should remain too long as members of old-patients' clubs. As they become freed of anxiety concerning their former illness it should be a matter of satisfaction to see them drop away from the club. Only the most frail will retain the need for this supportive environment, and probably only they will remain loyal to the club for many months or even years.

Not only the hospital psychiatrist should play an active role in the old-patients' club, but so also should the psychiatric nurse. The club provides for the discharged patient a bridge between the hospital and life in the community. Similarly, it provides an opportunity of giving to the psychiatric nurse her first extramural activity; it is a first step to some of the developments in psychiatric nursing which the committee discusses later in this report.

Before leaving the subject of the psychiatric patients' club it is worth emphasizing that, although such activities were originally developed for the support of discharged inpatients, it is now evident from recent experience that such clubs have an equal value in outpatient psychiatry and should form part of the supportive framework in which many psychiatric outpatients are treated.

Certain patients on discharge from a mental hospital need more support during the early weeks of their resettlement than can be given by an old-patients' club. For such patients it has been found valuable to establish a hostel, with an understanding but not necessarily highly trained staff. Such a hostel can provide temporary help to patients who, while able to return to work, are not yet sufficiently stabilized to manage their own domestic affairs or who are dependent, lonely people, too sensitive to make normal contacts. Again, it can be of value for patients as a transitional stage between residence in the hospital and independence in the outside world. The patients living in the hostel have access, through the warden, to the doctors of the hospital when this is necessary.

A certain number of patients undergoing psychotherapy as outpatients can also make use of the hostel. In the hostel, of course, the patients would be expected to pay for their lodging according to their means.

3.2.3 *All-day treatment—the day hospital*

For patients who require intensive treatment but who do not need hospitalization during both the day and the night, a day hospital has been found valuable. The economic advantage over full hospitalization is very great. Twice as many patients can be accommodated in the same floor space because of the saving in overnight bed space and in storage space for the patients' clothing and belongings. One shift of nurses is sufficient to deal with the patients, who arrive at 9 o'clock in the morning and leave about 4.30 in the afternoon.

One of the advantages of the day hospital is that the patient remains in daily realistic contact with the members of his home and his general social setting and avoids the regressive "escape into hospital". The full range of therapeutic facilities can be offered to these patients.

This new development seems likely to increase the efficiency of psychiatric treatment by filling several needs which existed hitherto. It has multiple applications. First, it can enable patients to be discharged from the hospital at an earlier stage than before, providing for them at the same time the opportunity of a re-adaptation to the outside surroundings and the continuation of active and continuous therapy. In this manner it appears possible to obtain better and quicker results than those obtained previously through a more prolonged hospitalization, while at the same time saving money for the community.

A second type of patient who may benefit from it is the one who is not sufficiently ill to need complete hospitalization but who could nevertheless not be properly cared for by an ordinary outpatient department. To this category may belong people with incipient or mild psychoses, or those who are disturbed on account of going through a period of difficult external circumstances and who need solicitous attention during this period. Another type of patient suitable for the day hospital is the one for whom it is difficult to decide whether full hospitalization is necessary. Treatment can be undertaken in the day hospital until it becomes clear whether full hospitalization is needed. In this respect the day hospital becomes one of the entrance doors to the psychiatric hospital.

But perhaps the largest group to benefit from this new development is formed by people suffering from severe psychoneuroses for whom the help of individual or group psychotherapy is not sufficient. They are people who need to go through a re-education with regard to their attitude to life and need to acquire new habits. The day hospital represents an opportunity for a guided acquisition of the capacity to establish relationships with other people and for learning to master anxieties. At the same time, it provides opportunities for learning professional skills which may re-orient the patient's life.

Finally, although the point cannot yet be considered proven, it seems probable that the day hospital also offers the possibility of diminishing the length of outpatient treatment by increasing its intensity ; such a result would be of importance both to the patient and to society.

It seems likely that, through these new possibilities which it offers, the day hospital may succeed in helping the recovery of various types of patient whom it was difficult to help until now. In the opinion of the committee it represents a distinct and important addition to the means of treating psychiatric patients and one which every community mental hospital should consider establishing.

4. INPATIENT SERVICES

4.1 The Community Mental Hospital

Parallel with the development of extramural services by the psychiatric staff of a community mental hospital, the development of the hospital itself will begin to take place. When the psychiatric hospital begins to undertake outpatient services and public education, it may expect to begin to receive patients earlier in the course of their disorder; and physicians in the community will begin to expect the hospital to undertake not only custody but active treatment.

This development will entail an increase not only in the number of beds provided, but also in the ratio of medical and nursing staff to the number of patients.

It would, however, be fallacious to deduce from this that the true cost of psychiatric medical care increases as the hospital develops its functions. The usual custom of comparing psychiatric hospitals according to the cost per patient per day is fallacious. It fails to take into account a variety of factors which help to assess the value of a mental hospital, some of which are set out below.

(1) *Average length of stay*

A superficial examination seems to indicate that three different categories of patient are encountered:

- (a) those who are discharged in less than a year (their average length of stay is about two to three months);
- (b) those who are discharged in less than 5 years (their length of stay can vary between 1 and 5 years, but the average seems to be about 18 months); and
- (c) those who stay more than 5 years, and who, in most cases, never leave the hospital.

Clinical experience suggests that there are optimal periods for the discharge of patients from hospital and that if these periods are passed the patient may pass from one category into another.

Precise statistical research would be of use for the confirmation of this impression.

For this reason and others, the publication of the average length of stay (in days) of patients (in categories) discharged as recovered (or sufficiently well to be able to resume work) is recommended.

(2) *The ratio between the number of discharged (cured or improved) and the number of entries in a given number of beds.*

(3) *The capacity of absorption, i.e., the capacity which a hospital has, with a given number of beds, of taking the mental patients from the community without having to transfer them to another mental hospital. The most important social value of a mental hospital is its function of transforming a desocialized individual into one who can adapt himself either to normal society, or to some kind of extramural care. One might therefore calculate an "index of absorption" by which 100 patients admitted into 100 beds (and not transferred to another institution) in one year, would give an index of 1.*

$$\frac{100 \text{ patients admitted}}{100 \text{ beds}} = 1$$

As an example, if a hospital of 250 beds admitted 381 patients and transferred 42 in a single year, it "absorbed" 339 patients. Its index is therefore

$$\frac{339}{250} = 1.35$$

Such an index enables one to make a comparison between hospitals admitting the same types of patient.

(4) *Average cost of stay*

It is more important to express the average cost in terms of average stay in hospital than of cost per day or per week. It is easily calculated :

$$\text{Average length of stay} \times \text{cost per day} = \text{average cost}$$

(5) *Ratio between patients relapsed and discharged*

This is based upon the proportion of patients re-admitted into hospital during a predetermined period (2 years or 5 years, for example), which can be ascertained in those countries which have a central index of psychiatric cases admitted to hospital.

4.1.1 *The atmosphere of the hospital*

The most important single factor in the efficacy of the treatment given in a mental hospital appears to the committee to be an intangible element which can only be described as its atmosphere; and in attempting to describe some of the influences which go to the creation of this atmosphere, it must be said at the outset that the more the psychiatric hospital imitates the general hospital, as it at present exists, the less successful it will be in

creating the atmosphere it needs. Too many psychiatric hospitals give the impression of being an uneasy compromise between a general hospital and a prison. Whereas, in fact, the role they have to play is different from either: it is that of a therapeutic community. As in the community at large, one of the most characteristic aspects of the psychiatric hospital is the type of relationship between people that are to be found within it. The nature of the relationships between the medical director and his staff will be reflected in the relationship between the psychiatric staff and the nurses, and finally in the relationship not only between the nurses and the patients, but between the patients themselves.

Another important element in the creation of this atmosphere is the *preservation of the patient's individuality*. In too many psychiatric hospitals still the patient is robbed of her personal possessions, her clothes, her name and, should her head be lousy, even her hair. Every step, therefore, that can encourage the patient's self-respect and sense of identity should be taken, even at the cost of considerable inconvenience.

Another element in this atmosphere is *the assumption that patients are trustworthy* until their behaviour proves the contrary to be true. The locking of wards creates the urge to escape; the removal of knives and other elaborate and insulting precautions have provoked many suicidal attempts. High walls, bars, armour-plated windows, bunches of keys, uniform clothing, and all the other paraphernalia of the prison make modern psychiatric treatment impossible. It has now been amply demonstrated that only a very small minority of patients needs to be in locked wards in a well-run mental hospital. This does not imply that disturbing behaviour on the part of a patient should be ignored. On the contrary, *good behaviour must be encouraged* and anti-social behaviour met by appropriate measures. The patient who disturbs others must be removed and told why—not as a punishment, but because he disturbs others—but he should be re-introduced at the earliest opportunity. It is also necessary to mention specifically the desirability of patients, being under the care of female nurses as far as possible. The introduction of female nurses into a disturbed ward improves to a remarkable extent the behaviour of patients and the atmosphere of the ward.

Patients must not only be assumed to be trustworthy; they must also be assumed to retain *the capacity for a considerable degree of responsibility and initiative*. The running of many activities, therefore, in the therapeutic community which the modern psychiatric hospital should be, should devolve upon the patients themselves.

The relationship of a hospital with the citizens of the community in which it is situated is an important element in the creation of this atmosphere. The locked door not only keeps the patient in; it keeps the public

out. Everything should be done to encourage visitors to the hospital who should have access to the hospital itself and not specially prepared and segregated visiting rooms. These visits should include not only the relatives of the patients but also the relatives of the staff. The life within the hospital should, as far as possible, be modelled on life within the community in which it is set. In a western country where men and women mix freely at work and in recreation, it is obviously desirable that they should do so when in the mental hospital. In a country where men and women use the same restaurants, it is obviously ridiculous that the sexes should be segregated for feeding in the hospital.

Finally, in a community where most people are actively engaged in working or learning, the same should be true of the mental hospital. *Activity*, in fact, is one of the most important characteristics of the therapeutic community. But it should be planned and purposeful activity, and the planning of the patient's day is probably the most important therapeutic task of the hospital psychiatrist. Similarly, the creation of the milieu of a therapeutic community and the fostering of the relationships and activities which compose it are the therapeutic task of the medical director. It is for this reason that the therapeutic community, as the committee conceives it, can never be created under the direction of a lay administrator; it is in essence a technical psychiatric task.

4.1.2 *Treatment*

As is evident from the previous section, the committee holds the view that the creation of the atmosphere of a therapeutic community is in itself one of the most important types of treatment which the psychiatric hospital can provide, and it is unfortunate that it is this aspect of treatment which is most frequently lacking. Once it has been created, however, more specific types of treatment can be built upon it. The activity to which the previous section referred can in fact become a range of occupational and psychotherapeutic group-activities in some of which each patient should participate. These group activities range from habit-training for the grossly deteriorated patient to cultural groups based on art and music. The activity of each group must depend upon the therapeutic needs of the patients who compose it, and not upon the quality of the product of the group. For some patients sand and water play, for instance, provides a more therapeutic occupation than any technical or craft activity.

In their gradual return to social effectiveness, patients often seem to need to recapitulate, not only the development of the interests and activities of the human being from childhood to adult life, but also the development of the human race itself. The group activities must therefore cover the scale from the archaic and primitive to the cultural and technical.

In the demand which these group activities make upon the patient they must provide for the wide range of social response on the patient's part, ranging from a dependent and infantile attitude to one of initiative, responsibility, and self-sufficiency.

In the early stages of a patient's treatment the creation of activity may often depend on the leadership of the nurse or some other member of the staff of the hospital, but as treatment progresses the responsibility for the creation and pursuit of the activity must be passed to the patients themselves. This is equally true of other aspects of hospital life. If the psychiatric hospital is to be a therapeutic community it must gradually impose upon recovering patients the responsibility which citizenship of the community implies.

At certain stages, also, most patients need the opportunity of solitary activity and individual achievement. It is an important part of the clinical skill of the psychiatrist to discern the type of activity which his patient needs as treatment progresses and to provide him with opportunity and encouragement to pursue it.

It is evident from this conception of treatment that more space should be devoted to such common activities than most mental hospitals provide. It is also evident that during the greater part of the day the patients will be away from their own sleeping quarters; and since, as will be seen later in this report, it is assumed that the nurse's principal task lies in the fostering of the activities outlined above, the nurses themselves will not be available to undertake much of the domestic work of the patient's living quarters which it has in some countries sometimes been customary in the past to expect them and the patients to undertake. Domestic staff are therefore necessary to undertake this work if the patients and the nurses are to be free to devote their day to therapeutic activity.

Although, however, it is clear that comparatively few patients other than those who are physically sick or undergoing physical methods of treatment will be in bed during the day, it must be remembered that to lock patients out of wards—which are in effect their "home" in the therapeutic community—would be in its way as damaging to the atmosphere of the hospital as to lock them in; the opportunity must remain for the patient who needs it to seek from time to time solitude or rest.

Apart from the groups devoted to activity and occupation, provision must also be made for groups of a specifically psychotherapeutic type. A much higher proportion of patients than is commonly realized can benefit from group psychotherapy derived from psycho-analytic principles. A smaller number of patients will also benefit from individual psychotherapy, although there are relatively few instances in a community mental hospital where classical psychoanalysis is justifiable on therapeutic grounds alone.

This activity, however, probably has a value as a research and educational procedure. Recent developments, for instance, in the psycho-analytic treatment of schizophrenia suggest that such research should be pursued by those institutions which can afford to devote some of their resources to it, even though it cannot be justified by its contribution to the therapeutic results of the hospital's work.

There is one difference which, in the opinion of those hospitals which have undertaken it, distinguishes the handling of group psychotherapy from other group activity—namely, that, whereas it is appropriate for the doctor responsible for the handling of the patient's daily life to take an active part also in the group activities in which the patient participates, it is undesirable for the doctor undertaking group psychotherapy to be responsible in addition for the general daily management of the affairs of the patients whom he is treating in this way.

In addition to these group activities and treatment, many patients will also receive at some time or other during their stay in hospital specific physical treatment, such as insulin therapy or electro-convulsion. It is often found technically more efficient and administratively more convenient to centralize such treatment in a special unit of the hospital, in order that certain members of the psychiatric and nursing staff who are particularly experienced in this matter can be responsible for them.

Even if this is done, however, it is still desirable that the patient throughout his stay in hospital should feel that there is one doctor who is his—one doctor who knows him well and whom he knows.

In addition, those who work in tropical countries emphasize the need for a unit for infectious diseases in the mental hospital when climate predisposes to both bacterial and parasitic diseases. Patients in mental hospitals suffering from such infections should be treated in the mental hospital itself. It is a psychiatric responsibility to cope with this task ; this also applies to tuberculous cases.

It is evident that the treatment of any individual patient is a team responsibility in which several doctors and several nurses will actively participate. If this teamwork is to be successful, there must be one psychiatrist responsible for co-ordinating this teamwork for the benefit of his particular patient, and there must be meetings and discussions between all those who play a part in the team.

All patients need to have their condition and their treatment reviewed from time to time by a psychiatrist other than the one responsible for their treatment ; this should take place however chronic the condition of the patient may be believed to be and however long the stay he may have passed in the institution. Review of treatment is especially important

when patients pass from one category to another (see section 4.1.(1), page 16).

Particular attention must also be devoted to two stages in the patient's treatment: firstly, his entry into hospital and, secondly, his discharge from it. Entering a new community is bewildering even for those who are mentally well; it is even more so for the individual who is mentally sick. The examination and investigation of a newly admitted patient, therefore, is not the hospital's only therapeutic duty towards him. Everything must be done to enable him to become familiar with his new environment as rapidly as possible and to enable him to feel at home in it. All new patients, for instance, have a right to meet the medical director of the hospital and this, in the size of hospital which the committee later recommends, is simply achieved by the medical director's meeting all newly admitted patients as far as possible in a group for discussion.

A guide book and a map are as reassuring to the new patient as they are to a foreigner in a strange town; and successful experiments have been made in the reception of new patients and their introduction to the facilities of the hospital by a group of older patients who devote themselves to that activity.

Leaving hospital may appear to many patients as an even more frightening experience than entering it, if a severe illness has weakened their self-confidence, since it entails all the problems of resettlement in home and work. Everything must be done to make this experience not an abrupt change from one sort of life to another but a gradual transition. It should be prepared for by leave of absence for the day or weekend to visit the home or friends and by the provision of after-care facilities within the community. Such facilities include not only community workers attached to the hospital, such as social workers who can assist the patient during his period of resettlement, but also institutions in the community, such as old-patients' clubs, which have already been mentioned, at which the patient can keep in touch with other old patients of the hospital and with the staff as long as he feels the need. It has also been found valuable to allow some patients to take employment before they are finally discharged from hospital, going out to work by day but returning to hospital at night during the period when they are trying out their recovered capacity for social life in the community. In some cases, this principle has been extended to the provision of a night hostel, under the direction of the hospital but placed in the community, at which the discharged patient can stay during the period when he is convincing himself of his ability to live again effectively in society.

The provision of vocational advice and the opportunity of developing new work skills in sheltered workshops have proved of great value in

physical rehabilitation. Psychiatric hospitals will find such facilities of equal value in the rehabilitation and social resettlement of mental patients.

It might be assumed that the treatment programme outlined above necessitates elaborate equipment, special buildings, and a diverse and highly specialized staff. Such an assumption would be mistaken ; it depends far more upon the attitude of both the psychiatrists and the nursing staff and on their relations with each other and with their patients ; above all it depends upon the attitude and initiative of the medical superintendent.

4.1.3 *Inpatient clubs*

Among the techniques capable of modifying effectively the atmosphere within the hospital, the creation of patients' clubs can be recommended. They can be organized in many different ways. It is necessary, first of all, to specify that these clubs often tend to expand and then to fade away like any living organism. Their permanence should be neither assumed nor desired ; on the contrary, their frequent renewal should be encouraged. It is desirable that these clubs should spring from the initiative of the patients themselves as a result of their most concrete needs and even sometimes of their intolerance towards the situation in which they live. Thus, it may often happen that the first clubs to be created aim at the organization of distractions and games (sports clubs, holiday clubs, etc.). Others give rein to a feeling of dissatisfaction caused by certain deficiencies in the hospital, and thus we find groups being created to negotiate with the kitchen or general services. This form of expression of complaint and protest should be encouraged so that the aggressive tendencies it manifests can be directed towards useful activities which are derived in a logical manner from these very intolerances.

As an example, if patients protest against inaction and boredom they should be encouraged to create clubs for the organization of workshops, series of conferences, musical groups, and various instruction courses. In this way the patients are gradually led to accept some responsibility for the general atmosphere of the hospital. They can help to transform it into a community whose way of life is better adapted to their needs because they themselves have established it.

One of the most important activities of the clubs seems to be that which aims at the integration of the new arrival into the community. The recently hospitalized patient has, in many cases, just undergone many painful experiences ; he has lost both his social function and his liberty. Too often he has also been rejected by society ; it is important, therefore, that he should view his hospitalization not as a restraint but as an integration into a new social group. The patients' club has the very useful function of welcoming the new patient and giving him without delay a part to play

in the community. In a sense it can initiate him into the conditions of hospital life.

4.1.4 *Staff*

4.1.4.1 *Medical superintendent.* The medical superintendent's role has already been described as that of creating a therapeutic community and fostering the relationships and activities which compose it; only if he sees this as a psychiatric activity can the superintendent achieve it. Whereas the individual psychiatrist or nurse will be occupied with therapeutic groups of patients, the therapeutic group with which the superintendent must occupy himself is nothing less than the hospital community as a whole. Even though in doing so he may continue to devote some of his time to group and individual treatment, in so far as he succumbs entirely to a nostalgia for the practice of individual clinical psychiatry, he will fail to fulfil his function as the director of the hospital.

Nor can he fulfil this function adequately if his interests remain within the hospital boundary. The development of the community facilities which are sketched in the earlier part of this report will usually depend at the outset upon his initiative, and his leadership and participation in public education, in medical liaison, and in the outpatient services, are essential not only for their success but also for his own development.

4.1.4.2 *Medical staff.* The preceding section on treatment will already have indicated the role which the psychiatrist has to play in the modern community mental hospital; but no psychiatrist should devote the whole of his time to work within the hospital. The whole psychiatric staff should have the opportunity of participating in outpatient services; and although, as time goes on, each member of the staff may tend to specialize in the type of extramural work to which he is most attracted, and for which he seems the most fitted, it is desirable that during the course of this development all should have experience of general outpatient work both with adults and children. The medical staff also need the opportunity to continue to improve their own technical knowledge and skill. Training in psychiatry is a life-long process. All mental hospitals, therefore, should in a sense be training institutions in which in-service training for the staff is a continuing process.

A good library and the provision of technical journals are, therefore, not academic luxuries but an essential part of the hospital's equipment. The staff also needs the opportunity of teaching others. The nursing staff, the family doctors in the community, public-health workers, and many other special groups will welcome the opportunity of receiving the post-graduate teaching on the psychological aspects of their work which the psychiatric staff of the hospital can offer.

The opportunity of collaborating in research is likewise not a luxury but a need if the medical staff are to be provided with the conditions which will enable their full development to take place.

Such opportunities can be provided not only within the hospital itself but within the outpatient services which develop from it and the collaborative work which the staff undertake with other medical institutions in the community.

4.1.4.3 *Psychiatric nurse.* The role of the psychiatric nurse is in many respects different from that of the nurse in a general hospital. General nursing training and experience are, of course, appropriate for certain of the activities of the community mental hospital such as the care of physically sick patients, the conduct of physical treatment (particularly by means of insulin), and the care of infirm elderly patients. But these activities concern only a comparatively small minority of the patients in the hospital; the majority are not in need of such care since they are in good bodily health and should be engaged in activities appropriate to their mental condition. This situation has led to confusion regarding the true role of the psychiatric nurse.

The more closely the conception of psychiatric nursing is related to that of general nursing the more likely it is that the nurse's role in the mental hospital will be restricted to the activities which most resemble those of a nurse in a general hospital. In such a situation there will be a tendency to relegate those patients who are not in need of general nursing care to the supervision of "attendants" or "aides" who may or may not be directed by a trained general nurse. However, with the development of the conception of the community mental hospital, which the committee has outlined above, it becomes evident sooner or later that such a situation is unsatisfactory. Two principal ways of attempting to solve this problem have been developed.

The first of these, of which the practice of some mental hospitals in the United States of America is an example, has been to develop a range of new specialized professional workers covering functions that are beyond the general nurse's competence, such as occupational therapy, education therapy, and art therapy, while at the same time attempting to improve the standard of the "aides" by providing initial or inservice training for them.

In some countries, e.g., the Netherlands, Switzerland, and the United Kingdom of Great Britain and Northern Ireland, a different course has been followed. In these countries the professional associations of psychiatrists took the lead in establishing full training for psychiatric nurses within mental hospitals and set up both a nationally recognized examination and a national register for trained psychiatric nurses. At a later stage,

the conduct of the examinations and the maintenance of the register of trained psychiatric nurses was transferred to the same national authority as that responsible for the examination and registration of general nurses.

Under such a system, psychiatric nursing has developed as a parallel to general nursing, rather than as an offspring from it, in that the recruits for psychiatric nursing are not drawn from the ranks of registered general nurses. Nevertheless the training begins with the same general education in the sciences relevant to nursing as that found in the general nursing curriculum. In order to facilitate the obtaining of the double qualification, however, it is possible for the registered psychiatric nurse or the general nurse to obtain the necessary qualification for the other register with a further year's study. Under this system it will usually be found that the most senior positions in the psychiatric hospital, and those presupposing a high degree of general nursing skill, will be held by nurses with the double qualification, whereas the great majority of patients will be cared for by registered psychiatric nurses or student psychiatric nurses.

The committee would not wish to be dogmatic about the merits of these two different approaches, but it is noteworthy that the countries which have adopted the latter system seem to have been more successful in obtaining the staff they need for their mental hospitals. This success is, however, only relative in that most psychiatric hospitals have fewer trained nurses than their directors think desirable.

The approach which is adopted to the provision of nursing care in the mental hospital will, to a considerable extent, colour the conception of the role of the nurse herself. Where nursing in the mental hospital is derived from, and identified with, general nursing, the nurse's activity will tend to be very similar to that of the general nurse, and new professional groups will be developed to meet the therapeutic needs that the general nurse cannot fill. Where, on the other hand, registered psychiatric nurses exist, there is a tendency to incorporate these new therapeutic skills into the profession of psychiatric nursing itself. The occupational therapist, for instance, may then become, not the person who conducts occupational therapy, but one of the teachers and consultants of the psychiatric nurse. In some hospitals, therefore, the psychiatric nurse is now the principal worker concerned with group activity and occupational groups, and with all the other therapeutic endeavours that do not demand full psychiatric training.

In such a hospital, the psychiatric nurse may also undertake extramural activities in the outpatient clinic, the night hostel, the day hospital, the old-patients' club, and in home visiting, with the psychiatric social worker and other specialized workers as her consultants, teachers, and advisers. This may seem a far cry from traditional nursing, and yet it

has its parallel in the general nursing profession. The therapeutic community demands from the psychiatric nurse an understanding of her relationship with individuals and with groups, which becomes her most important nursing skill. She must elicit initiative from her patients and help them to recover their individuality and independence. In this respect, perhaps, she has more in common with her sister in public-health nursing than with the bedside nurse in the general hospital.

The whole question of psychiatric nursing is one which WHO should study with a view to the consideration of this matter in due course by a joint meeting of the Expert Committee on Mental Health and the Expert Committee on Nursing.

4.1.4.4 *Therapeutic team.* Although the main therapeutic activity is in the hands of doctors and nursing staff, the team concerned with treatment should also comprise various specialist technicians. The social workers, preferably with psychiatric training, should first be mentioned; they have a most important part to play. They have not only to study the circumstances and conditions which may have contributed to the onset of the patient's mental disturbance, but also to maintain and encourage contacts during the patient's stay in hospital between him and the outside world; moreover, when the patient is discharged they should do what they can to ensure that the main material and psychological problems which would otherwise face him at this time are already solved, so far as they can be.

The team should also include a psychologist. His main role is to carry out the examination of patients both from a psychometric point of view and also with the help of projective techniques. Under the supervision of the psychiatrist, he can undertake psychotherapy—especially group psychotherapy—provided he is first given appropriate training. Finally, he can act as consultant on the development of sociotherapy techniques. He is usually the member of the team most capable of considering these techniques in a scientific manner with the object of research.

Although, as has been described above, in some hospitals the new patient is received by a group of patients who devote themselves to that function, in others the interesting experiment has been made of having a particular member of the therapeutic team acting as a kind of "hostess". Such a role should be undertaken by a woman with a capacity for social contacts and with the personal qualities of sensitivity, intelligence, and an attractive personality. These qualities are more important than any theoretical training she may have had. This position could equally well be held by a nurse, a social worker, an occupational therapist, or a professional psychologist. Whoever undertakes this function will be the first to make contact with the patient; when he is admitted it is for the hostess to see

that this first contact is of a type which will diminish the patient's natural apprehension and transform an experience which is too often felt as a constraint, sometimes even as a humiliation, into a real welcome. The hostess introduces the new arrival to the other patients in the group, to his nurses, and to his doctors. She explains to him the ways of the hospital and tries from the outset to help him to integrate himself actively into the community by inviting him to take part in games or in social activities. Throughout, the hostess is particularly concerned with the material and psychological comfort of the patients ; if she is also capable of organizing the various activities normally called occupational therapy, it is an additional asset ; she will then be able to play her part in directing the patients to the different types of occupational-therapy workshops.

A specialist in vocational problems has also been found a useful member of the team. It is his function to study the patient from the point of view of his vocational aptitudes. This study would be carried out partly through direct observation of the patients during work therapy and partly through the psychotechnical and interview methods of vocational guidance. This technician can be particularly concerned with encouraging the patient's return to work on discharge from hospital, either by helping to obtain him employment suited to his aptitude or by making use of the legal provisions that exist in some countries for the encouragement of the vocational rehabilitation of the disabled. This kind of rehabilitation must be regarded as the responsibility of the mental health services, and, where justified by the number of patients likely to benefit from them, sheltered industries and semi-professional workshops should be attached to mental hospitals.

In addition, the team can very usefully include more narrowly specialized technicians, such as :

- (a) instructors in manual work, or occupational therapy, who can teach the nurses and conduct the occupation groups ;
- (b) physiotherapists to apply the techniques of massage, relaxation, active and passive kinesitherapy, and various other techniques (hydrotherapy, electrotherapy, etc.).

Finally, an adequate medical secretarial staff is essential ; it should be represented during team consultations so that the exchange of views can be noted and general co-ordination encouraged.

4.1.5 *Architecture*

In an earlier section it was suggested that many of the failures of mental hospitals have been due to a tendency to model them on the one hand on the general hospital and on the other hand on the prison. Architecturally, the mental hospital often shows the same influences.

If the hospital is to become a therapeutic community, as the committee is convinced it must to be successful, it must model its architecture and its plan on that of a community. If it is to support and recreate the sense of individuality in patients, it must not dwarf them by its size and by herding them together in thousands in giant monoblock buildings.

The committee is convinced that it is, in general, undesirable to build new psychiatric hospitals for more than 1,000 patients. It is well known, of course, that many hospitals exist which far exceed this size, and in a later section some suggestions are made of the manner in which the harmful effects of such institutions can be mitigated. It is essential, however, that everything should be done to discourage the building of more hospitals of this type. Indeed, the figure of 1,000 patients which the committee puts forward is, in the opinion of a majority of its members, not put forward as representing the optimum size; it is put forward as a size which should on no account be exceeded. From the point of view of therapeutic efficiency, these members of the committee hold that a better size would be somewhere between 300 and 1,000 beds. The committee is well aware of many arguments put forward in favour of very much larger units. These arguments are frequently based on the supposed reduction in the cost per patient per day obtainable in a larger unit. It appears, however, that the widespread belief in the economy of very large hospitals is probably unfounded.

Recent studies have suggested that from a point of view of financial economy the optimum capacity for hospitals probably lies between 250 and 400 beds. Smaller establishments are expensive because of their lower average percentage of occupants and the difficulty of amortizing technical equipment which is not in full use. Above 400 beds, the cost per bed begins to increase slowly and reaches rather high figures above 800 beds. The reason is probably uncontrollable wastage, lack of responsibility on the part of too large a staff, unnecessary buying, and an industrial type of mechanization which is inevitable in very large hospitals; one must add to these the impossibility of sustained personal contact between the director and hundreds of hospital workers.

Nevertheless, if a careful study of individual items of expense is made by calculating the cost of each function, it shows that certain services can be economically conducted on a much wider basis. The heating plant, general stores, repair and maintenance shops, the laundry, and, in some circumstances, the purchasing services can be more economically conducted for several thousand beds.

From a point of view of pure economy, if a new psychiatric hospital is to be constructed, its capacity should probably not be above 600 beds provided that a co-operative system exists whereby several hospitals, even

when rather widely separated, share common services for certain purchases of non-perishable goods and for services such as laundering.

In addition, if the mental hospital is near a big general hospital, although its administration, finances, and staff should be entirely independent, it can share the heating plant, laundry, and general stores.

Those members of the committee, therefore, who favour from both a therapeutic and an economic point of view the smaller community mental hospital would prefer it to be for between 300 and 1,000 patients. Towards the upper end of this range it will be easier to classify the patients into groups which are homogeneous from the point of the patients' therapeutic needs and their capacity for social adaptation, but it will be much more difficult for the medical director to keep in intimate contact with his staff, the patients, and their relatives.

At the lower end of the scale the hospital with 300 beds ensures this intimate contact but may make difficulties in the classification and grouping of patients unless it is built to accommodate the patients in the small groups which the committee advocates below.

There are other advantages of the small community mental hospital which are of importance in certain circumstances. For instance, in a country of low population density three separate 300-bed hospitals are a much more satisfactory method of providing for a given area the services which the committee advocates than would be a single hospital of 900 beds. In countries where severe shortage of trained staff is a grave problem, the smaller hospitals also have advantages. If, for example, one is forced to accept a ratio of one physician and one trained nurse per 200 patients, a mental hospital of 200 beds with only one physician and one trained nurse will prove a much more effective therapeutic institution than a hospital of 1,000 beds staffed by 5 physicians and 5 trained nurses.

Nevertheless, a minority of the committee's members considers that the smaller hospital creates serious difficulties in making it harder to classify and group patients properly, and to deal with the emergencies that arise through staff sickness, since the staff is too small to allow for the emergency to be dealt with by transferring staff from one section of the hospital to another.

The second criticism which the committee has to make of most existing psychiatric hospitals is that they have been built to last too long. Many countries will be burdened for a long time to come with large obsolete mental hospitals built years ago to fit a conception of the role of the mental hospital which is now completely rejected. It is desirable, therefore, to assume that any new hospital that is built to fit the conception of the therapeutic community which the committee puts forward will itself also be obsolete in many respects in 20 or 30 years' time. The construction

should, therefore, be of a type which makes amortization possible within that period. In addition, the hospital should be planned internally so that it can be adapted easily to new arrangements and functions; the construction of internal walls, for instance, should be of a type which can be inexpensively removed or modified.

Thirdly, it is desirable that the hospital should be composed of a group of small buildings, rather than a single block. The therapeutic community should take the village as its model. Each unit should be planned for a small group of patients, preferably about 25-30, and it should be assumed that the majority of patients will sleep, eat, and work in comparatively small groups of up to 10 patients. If economic conditions permit, sleeping accommodation should include a fairly high proportion of separate rooms, and much of the remainder should be in small dormitories for 6-8 patients.

For the largest dormitories the committee's aim would be to have groups of 15-20 patients. It is perhaps worth commenting at this point on an interesting change in the use of the different types of sleeping accommodation which is noticeable in some of the more progressive hospitals. In the past it was the general tendency to accommodate the more seriously ill psychiatric patients in single rooms and move them into wards as their condition improved. There is now a tendency in the opposite direction—namely, to arrange for patients to sleep in smaller wards as their condition improves until finally they are given a single room. In this way the sleeping accommodation is adapted to, and accentuates, the patient's returning capacity for individual responsibility.

Ideas on the relationship of day space to sleeping quarters have also changed in recent years. Open wards and the many activities which patients now undertake away from their sleeping accommodation render obsolete the old design whereby day space and sleeping dormitory were part of one locked enclosure.

Although some day-space should be provided in association with the sleeping quarters of each group of patients, most of the day-space of the modern community mental hospital should not be directly associated with the sleeping quarters of any particular group of patients but should be planned and sited so that it can be used for activities available to many members of the community. There is room for much experimentation in the planning of the therapeutic community and for closer collaboration than has so far taken place between psychiatrists and architects. If the committee is correct in its view that the community mental hospital should model itself on the village, rather than on the general hospital, it may well prove that the domestic architect and the town planner have more to offer in such collaboration than has the hospital architect.

In the past, the community mental hospital has often been handicapped by being built a considerable distance from a town and consequently from both civic and medical centres. Ideally, however, it should be situated in the immediate vicinity of the community it is to serve. If this is not done, the failure in communication between the hospital and the relatives of patients leads to great ignorance of the work of the hospital and consequent prejudice. It also creates problems for the staff and accentuates the feeling of inferiority felt by many who work in mental hospitals if they are deprived of the social facilities which are available for the staffs of general hospitals in towns, and in some cases even the transport of their children to schools creates a daily problem.

From the architectural and functional point of view, the buildings should preferably be spaced out in a natural area of woods, gardens, and farm land.

The Expert Committee recommends that WHO should take steps to stimulate interest in the architectural and the planning problems involved in providing an appropriate setting for the role of the community mental hospital as it is set out in this report. Regional seminars for psychiatrists and architects to study this matter would be of great value, and the published proceedings of such a seminar would provide a valuable document for those responsible for the development of psychiatric services in all countries.

WHO could also render a valuable service by stimulating exchanges of views and experience on the subject of mental hospital standards. National standards already exist in some countries, laying down scales on such matters as space per patient and sanitary facilities. In many cases, however, the professional organizations of psychiatrists have played no part in the development of these standards; in other countries it has been the professional associations which have taken the lead in drawing up and propagating standards. Anything that WHO can do to stimulate the exchange of information and experience in this field both between governments and professional groups will be of value. In view of the obvious influence of climatic and social factors it is desirable that such work should be developed initially on a regional basis.

4.1.6 *Administration*

The administrative organization of a mental hospital will to some extent depend on its function. In the earlier part of this report, it was suggested that provision should be made for the treatment and custodial care of the type of patient whose mental illness leads him to become a danger to himself or others or otherwise create a grave social problem in the community in which he lives.

As the hospital develops to fill the wider functions which this report envisages it will need to aim at a level of staffing which provides one physician for every 150 patients, and, should the admissions exceed 300 per year, one extra doctor must be provided for every 100 further admissions.

In a hospital of 800 beds the physicians should include, as well as the medical director, two specialists (with a qualification in psychiatry, if such exists in the country). The remaining physicians work under their direction. The number of the nursing staff will depend to a large extent on the hours worked. If 8-9 hours daily are worked, one nurse will be necessary for each 5-6 patients; for 800 beds, therefore, a total of about 150 male and female nurses will be necessary.

As the functions of the mental hospital develop, the admission rate will increase, and this will involve an increase of medical staff in the ratio mentioned above. Similarly, as certain functions begin to be specialized, more staff will be required. For instance, it will become necessary to increase the ratio of the nursing staff to 1 to every 3 or 4 patients, and an 800-bed hospital will therefore need a total of 200-230 male and female nurses. The setting up of a physical treatment unit will require an extra physician, and there must be additions to the medical staff to enable the extramural activities of the hospital to be developed.

Whether the hospital is in its earlier stage of development or has progressed to fill the wider role described in this report, an administrative director will be necessary, but he should be subordinate to the medical director. Unless this is so, conflict between administrative expediency and psychiatric principles will be difficult to avoid. The medical director will be unable to undertake the psychiatric task which section 4.1.4 above outlines unless he carries the ultimate responsibility for all aspects of the therapeutic community.

Many hospitals already exist which are far bigger than the size recommended in this report. The committee is convinced that if these hospitals are treated as single units they cannot provide the standards of psychiatric treatment and care which the smaller hospital is able to give. There is, however, one way in which some of their disadvantages can be reduced—namely, by dividing them into parallel and independent services for from 400 to 700 patients, each with its own medical director and its own medical staff. Such a service should be complete in that it includes patients of both sexes and of all clinical types. It should have its own admission facilities, its own treatment facilities, and its own occupational and other group activities. The central common services which all share are restricted to those indicated in section 4.1.5 above, such as heating, and purchasing of certain types of supplies. Certain members of the committee can speak from personal experience of the great improvement that results

from reorganizing a large hospital in this way. All health authorities should give consideration to this means of reducing the handicaps which many of the existing large hospitals otherwise inevitably impose on the practice of the modern conception of psychiatry which the committee has previously outlined.

4.2 Home Care

Sufficient use has not been made in many countries of the possibilities of boarding out patients with suitable families. For many years in certain countries a large number of psychotic defective patients have been boarded out with farmers in rural areas and, indeed, with householders in towns and villages throughout the country. In general, families providing care should come from farming communities, owners of small concerns, and relatives of the staff of the hospital rather than industrial workers, shopkeepers, or intellectuals. Subsistence money should be paid, the sum varying with the ability of the patient to work; it is highly advisable to give some cash to the patient for this work in order to encourage him and promote self-respect. In some districts where boarding out has become a feature of the life a great deal of tolerance has been developed towards mental patients and their problems with the result that they are socially useful and able to work, whereas in a less tolerant community they would be regarded as complete invalids. The patients chosen for this kind of care are those whose illness is chronic but whose behaviour is not likely to be violent or otherwise intolerable to the community. Boarding out serves a double purpose: first, the care of chronic but undisturbed patients outside the community mental hospital can help to relieve the pressure on the hospital's beds and at the same time to promote healthy characteristics of the patient in a normal environment and under normal conditions of life; and secondly, a patient's transition to complete freedom and normal work is facilitated by a period of family care. Patients boarded out must be regularly visited—at least once a month—by the outpatient service of the institution, i.e., by the doctor and the social worker or psychiatric nurse.

There is also a need to extend the domiciliary care of patients in their own homes. With the extension of education on psychiatric topics, more and more relatives have developed sufficient insight to be able to tolerate the patient in home surroundings, provided they are given help, and the fullest advantage should be taken of these changing attitudes. It is not always advisable to admit the patient to hospital if his family is prepared to maintain him in the close emotional relationships of the home. This can only be successful if the family is helped by advice from a psychiatrist and preferably also by periodical visits from a social worker or psychiatric

nurse to explain the patient's behaviour and advise the relatives how they should respond.

4.3 Institutions for Aged Patients

There is a place in the community mental health service for residential institutions for the elderly demented patients who are not difficult to nurse and have some ability to work. Such an institution could be planned for 100 male and 100 female patients. It should be under the supervision of the medical superintendent of the mental hospital with which it is associated, and it is desirable that it should also be associated with arrangements for family care. It should not be run as an isolated institution.

4.4 Psychiatric Wards in General Hospitals

In much modern writing on the subject it is taken as axiomatic that psychiatric wards in general hospitals are the most desirable form of provision for psychiatric medical care. The committee cannot accept this view as axiomatic. It is true that in a teaching hospital this may be considered the most convenient method of making clinical material available to students; but, as the committee has emphasized, the psychiatric hospital does not do its job best by imitating the general hospital. Too often the psychiatric wards of a general hospital are forced by the expectations of the hospital authorities to conform to a pattern which is harmful to their purpose. Patients are expected to be in bed and nurses are expected to be engaged in activities which resemble general nursing. The satisfactions of neurological diagnosis are enhanced by the prestige in the general hospital of clear-cut physical pathology, to the detriment of interest in the average psychiatric patient whose case does not exhibit such features; and it is difficult to obtain recognition of the overwhelming importance in psychiatry of the factors described in section 4.1.1 (page 17).

Psychiatric wards of general hospitals sometimes have another characteristic which may prove very detrimental to the community mental hospital if they are the only portal of entry for patients into the latter. In such a case the general hospital may treat and return to society a high proportion of psychiatric patients capable of early recovery and send to the community mental hospital only those patients who are grossly disturbed, chronic, or of apparently bad prognosis. There is no more certain way of turning the community mental hospital into a "madhouse" and depriving it of its role of a therapeutic community. It would be wrong to suggest that these problems cannot be avoided, but in order to be avoided they must be recognized, and some of the advocates of psychiatric sections in general hospitals do not seem to be aware of their existence.

The problems are most likely to be avoided if the psychiatric staff of the community mental hospital is also responsible for the psychiatric wards in any general hospitals in the community, in order that the two activities may be run in close association so that neither functions to the detriment of the other.

4.5 Special Hospitals

Some authorities have advocated the specialization of psychiatric hospitals according to clinical type or social capacity. Others advocate the provision of special institutions for neurotics, for the acutely ill, and for chronic cases. Special institutions have also been created for epileptics, alcoholics, etc. Such a practice may have advantages, but its disadvantages probably outweigh them. The more highly specialized an institution, the more difficult it is to staff, and also the more patients are segregated with their own kind. Segregation implies reduction of social contacts and is therefore opposed to sociotherapy, envisaged as a re-education technique through those contacts. The patients whose sociability is least affected form a natural link between those who are normal and the most asocial patients. By removing them from the general psychiatric hospital for treatment elsewhere one creates a gulf between the most seriously sick patients and society; their chances of recovery are diminished, and their isolation consolidated. This conception seems to be based on a confusion between therapy and adaptation.

Adaptation is favoured by reduction and specialization of social contacts. Therapy, on the other hand, aims at developing social capacity as much as possible in order to permit rehabilitation to the highest possible level. In order to develop social capacity in the patient he must be offered a wide range of levels to which he can gradually attain. If the social contacts of the patient are specialized within the hospital, he is being adapted to the hospital, which is contrary to our aim.

* * *

This report could not cover in any comprehensive manner the whole organization of a mental health service, but, nevertheless, three main aspects of the problem need to be mentioned.

First, this report presupposes legislation on the care of psychiatric illness which is based on modern psychiatric knowledge. Few countries, however, have such legislation. In many countries, voluntary admissions to mental hospitals are not provided for by law. Similarly, the commitment procedures whereby patients unwilling to accept treatment are sent to hospital are archaic. There are in some countries also obstructions to the provision of good psychiatric treatment arising from obsolete laws which

may, for instance, prevent females from nursing male patients or may prevent social contact between male and female patients. WHO could do much to encourage the adoption of modern legislation in this field by a comparative study of the existing laws and an appraisal of current tendencies in the most modern legislation. From such a study it would be possible to suggest general principles and also comparative data which could be discussed in detail by the committee at its next meeting and on which recommendations could be made which would be of value to governments considering the introduction of new legislation.

The second point which should be mentioned in connexion with the organization of the community mental health services is that the pattern of development described in section 3 of this report is a description of the manner in which, historically, the more progressive community mental hospitals have gradually expanded their functions to cover a wider role in the community. The mental hospital was for a long time the only means of psychiatric treatment and is even now often the principal means. The development of techniques and the evolution of ideas on mental illness have, however, led to a diversification of the means of prevention, treatment, and assistance, which are centred no longer on the hospital but on the medico-social team. Psychiatric services can therefore be regarded from two rather different points of view :

(a) the classical : the psychiatric hospital increasing its scope and extending into the community via its extramural activities ;

(b) the modern : the medico-social team responsible for all the mental health problems of the community and considering the psychiatric hospital as one of many tools for carrying out its work.

Although the first view-point is likely to be evident in the earlier stages of development of community services, some members of the committee feel that the sooner the second type of organization can be adopted the better, where it is appropriate to the pattern of social organization of the country concerned. In that way, all aspects of mental health work can be integrated to form a technical whole rather than being confined to, or extended from, the architectural unit of the mental hospital. This can enable the services to develop flexibly according to the needs of the moment and prevent one activity's being conducted in a way that is detrimental to another.

The final point concerns the question of organization at the national level. Overall planning and co-ordination are essential. The committee wishes to re-emphasize what has already been said in its first report—namely, that mental health work should be the concern of a division in the Ministry of Health, or other equivalent government department,

under the direction of a physician with training and experience in this field. Without such central representation it will prove very difficult to stimulate the development of mental health work throughout the country on the lines which the committee recommends, and such developments as take place will tend to be uneven in quality and view-point and poorly integrated with each other.

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