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Doctors' behaviour and performance

Hamid Ghodse

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Adverse events have always occurred in healthcare but some high-profile cases over the last few years have led to greater public scrutiny than ever before. Such events may result from problems in clinical practice, products, procedures or systems; attention, however, has focused largely on healthcare workers, and especially on doctors – perhaps in tacit recognition of their leadership role within the field. The performance of doctors – their knowledge, skills, health and behaviour – is firmly in the public eye and therefore on the agenda of their professional organisations and the relevant regulatory bodies.

Patient safety is, and always has been, a fundamental principle of patient care but is now seen as the highest priority. Indeed, it is now acknowledged that health services have the right to know if there have previously been problems or concerns related to an individual doctor's performance or behaviour that could affect patient care. This is a major shift in attitude from the time when doctors' practice and behaviour were rarely challenged, if ever, and has led to new responses from the medical profession and the health service in many countries, including a much more frank discussion and appraisal of the causes of poor performance.

It seems obvious that doctors' health may affect their performance and this subject was discussed in the July 2005 issue of *International Psychiatry* (number 9). However, poor performance can also result from other factors, including the personal characteristics of doctors and the context in which they are working. These factors are often interrelated (National Clinical Assessment Authority, 2004).

As in many other areas, stress is often cited as a major underlying cause of poor performance and studies have shown that stress levels among doctors and other healthcare workers are higher than in the general population, with about 30% of doctors suffering from stress at any one time (Firth-Cozens, 1995; Paice, 2000). This is probably related to the fact that, from undergraduate days onwards, doctors are encouraged and trained to perform a multitude of tasks to a consistently high standard. Admission of tiredness or difficulty in coping can be perceived as failure, which discourages them from disclosing problems; this in turn contributes to an increasing sense of isolation. Long hours of high-intensity work combined with decreased time to sleep also increase stress. Other factors perceived to be responsible for stress are difficulties in maintaining a balance between career and personal life, fear of making mistakes, fear of litigation, difficulties in hierarchical professional relationships and difficulties in dealing with

patients (Firth-Cozens, 1995). Although some groups are considered to be more vulnerable than others, stress among doctors is not restricted to specific specialties or career levels. For instance, doctors within their first year of practice and female doctors tend to exhibit high levels of psychological morbidity (Paice, 2000; Graske, 2003).

Most of the stressful factors which doctors have to handle are common and frequent and, although they may have a significant impact on performance, it is important to consider also the personality characteristics that may affect performance and that may interact adversely with stress. For example, doctors' work culture promotes perfectionism and self-criticism, which are in turn predictors of stress and depression. Together, such factors may affect performance.

A survey of UK postgraduate deans demonstrated that, out of 80 trainee doctors in difficulty who had come to their attention, 34 had presented with 'poor performance'. Of these, substance misuse was the triggering problem in 11 cases and four doctors were described as having personality disorders that led to unacceptable interpersonal conflict (Paice, 2000). Similarly, in a study of doctors referred to the UK's General Medical Council Health Committee from 1980 to 1996, it was found that 12% had personality disorders (Morgan *et al*, 1999): they had deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. Typically, those with personality problems are significantly different from the average individual in a given culture in the way they perceive, think, feel and relate to others.

If it is acknowledged that personality difficulties can contribute to poor performance, it makes sense to consider an individual's personality at the point of entry to training for the profession. Clearly, medical schools have to be careful to maintain equality of opportunity and not to breach applicants' rights, but at the same time many of the problems exhibited by poorly performing doctors have been apparent since medical school days. Firstly, it is worth noting that early childhood experiences are thought to contribute to the choice of becoming a healthcare professional, with emotional neglect in childhood being a notable example. Similarly, there is some evidence to suggest that traumatic childhood experiences such as parental divorce and maternal death are associated with higher stress levels and even increased misuse of substances among doctors (Vaillant *et al*, 1970; Firth-Cozens, 1992).

Developmental conditions such as conduct disorders, personality disorders and Asperger syndrome may

Stress is often cited as a major underlying cause of poor performance ... with about 30% of doctors suffering from stress at any one time

In a study of doctors referred to the UK's General Medical Council Health Committee from 1980 to 1996, it was found that 12% had personality disorders.

be present when students are selected for medical school but only later manifested as sustained abnormalities of social behaviour – unmasked perhaps by the absence of structure in comparison with life at school or in the parental home, rather than by any direct stress of university life. It is true that prospective medical students are subjected to a variety of selection procedures but most medical schools around the world offer little in the way of screening for significant personality and behavioural problems. It is therefore possible, and indeed probable, that vocational medical courses accept young students who may not have developed sufficient personal maturity or strength to deal with the rigours of medical training. It is also true that trainee doctors may have to take on considerable responsibility at a comparatively young age and that many find this difficult.

In recent years there has been a growing emphasis on the importance of doctors having good communication skills and this is now addressed within the medical school curriculum. This is important in terms of communicating not only with patients but also with colleagues. A stressful working environment combined with a communication style that others find difficult frequently leads to problematic working relationships that contribute to impaired performance. Often the individual concerned lacks insight and while colleagues may recognise that someone is difficult to work with they may not be able to pinpoint the specific underlying problem. It is only when an adverse event occurs that everyone acknowledges that damaging interpersonal behaviours may have played a major role. However, for the sake of patient safety, such issues should not be allowed to smoulder indefinitely.

The General Medical Council's guidance *Good Medical Practice* (2001) states that 'all patients are entitled to good standards of practice and care from their doctors. Essential elements of this care are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations'. In *Good Psychiatric Practice*, the Royal College of Psychiatrists (2004) identified a number of core attributes for practitioners, including 'a critical

self-awareness of emotional responses to clinical situations' and 'being aware of the power inherent in the role of doctors and its potentially destructive influence on relationships with colleagues in other disciplines, with patients and with carers, and respecting boundaries'.

It follows that, if there are serious concerns about a doctor's competence and behaviour, there need to be clear routes for assessment. Early recognition of patterns of behaviour which may indicate that a doctor is struggling in work is of paramount importance. However, a strategic approach to prevention will also be important. In a study of over 50 cases referred for poor performance, the National Clinical Assessment Authority (2004) in the UK identified wider, systems issues. These included undergraduate and postgraduate training, workload, team function and handling stress. Studies of this type are invaluable in identifying what contributes to a competent and well performing doctor being derailed from good practice and good delivery of care.

Early recognition of patterns of behaviour which may indicate that a doctor is struggling in work is of paramount importance.

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THEMATIC PAPERS – INTRODUCTION

Recruitment into psychiatry: a medical student perspective

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To ensure a successful future for our profession, we have to attract young enthusiastic doctors to take up residencies in psychiatry, but there have been murmurings of disquiet in recent years that we

are not being as successful as we might, or as we should. We have taken soundings for the theme of this issue: why do too many medical students not consider psychiatry as a career choice? We bring

together perspectives from around the globe: from Israel we have a contribution from Moshe Abramowitz and Daphne Bentov-Gofrit; from Guillem Pailhez and her colleagues we learn of a comparison between Spanish and US students; and from Australia we hear from Bruce Tonge.

The contribution from Israel is full of intriguing detail, concerning as it does heterogeneous populations of medical students with different cultural attitudes to psychiatry. We learn that psychiatry is certainly an attractive option to students in their preclinical years, but the further they are in their training the less appealing the specialty appears. This may reflect the initial intellectual curiosity engendered by disorders of mind, which gradually evolves into cynicism and a belief that there is really no great potential to improve people's lives compared with many other branches of medical practice.

In the United States there seems to have been a small increase in the proportion of freshmen nominating psychiatry as a potential career within the past 5 years or so. Pailhez *et al* consider the quality of medical education and the experience of students in their clinical training to be critical factors. However, we have to make sure that

the placements in which they encounter psychiatric patients are optimal, in terms of the care given, the attitudes of the staff, and the general sense that these are people who can be helped and rehabilitated. It is disturbing to discover in a survey of Spanish students that their teachers were apologetic when teaching psychiatry, and that in general the specialty had low social prestige.

Australia too suffers from low recruitment into the specialty and experiences difficulty in filling training places. Bruce Tonge also draws direct parallels with studies in the United States. Among medical students the specialty was associated with low job satisfaction and was seen as having a very weak scientific foundation – reminiscent of the finding of Pailhez *et al* that many students regard psychiatrists as non-logical thinkers.

Where do these attitudes come from? Do students enter medical school with such prejudices and, if so, how do we change their attitudes? Or is there a perception which grows during training that psychiatrists sit low in the pecking order of medical specialties in academic and therapeutic prestige? We have an enormous amount of work to do to reverse these worrying trends. Let us hope the College can offer guidance.

We learn that psychiatry is certainly an attractive option to students in their preclinical years, but the further they are in their training the less appealing the specialty appears.

THEMATIC PAPERS – RECRUITMENT INTO PSYCHIATRY

The making of a psychiatrist: an Israeli perspective

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When medical school educators – polished veteran doctors – review data on their students' attitudes towards residencies, they remember their own long days in the anatomy dissection room. They recall treating their first teenage patient and comforting a patient seeking solace while succumbing to a fatal illness. They think about why they made their important career choice. Thus the glory days of medical school become a defining and shaping experience for physicians, similar to boot camp for veteran paratroopers.

While cultures differ, medical education seems to differ less, as all doctors have to examine, diagnose and treat. Within this context, the popularity of specific specialties may be based on several factors with local influences. There have been efforts in recent years to quantify the attitudes of medical students using standard questionnaires (Nielsen & Eaton, 1981; Burra *et al*, 1982; Feifel *et al*, 1999). Below we describe the profile of the potential psychiatrist among Israeli medical

students and compare our results with the findings of studies using similar research methods from Western countries with different traditions of psychiatry and medical education.

Medical education in Israel

In Israel there are four medical schools. Approximately 300 medical students are accepted a year. Medical education is heavily subsidised by the government, so the total number of medical students is regulated. Many of those who are not accepted locally choose to study abroad. Those fortunate enough to be accepted in Israel are 2–3 years older on average than their counterparts in the United States, since most men and some women at the age of 18 are drafted into military service. Upon their discharge they are eager to start their schooling and make up for time lost. They then embark on a rigorous 6-year journey of intensive studies: 3 years preclinical and the remainder rotating clerkships through medical

Is there no balm in Gilead; is there no physician there?
(Jeremiah, 8.22)

The results showed that psychiatry is as attractive as gynaecology and internal medicine, more attractive than family medicine, and less attractive than surgery and paediatrics.

Whereas psychiatry received the highest score for 'intellectually challenging' of any residency ... it received low scores for 'the degree to which patients are helped'.

and surgical departments, including a 5-week clinical rotation in psychiatry during the fifth year. Upon completing their formal education they must pass state board examinations and then do a year of internship so as to qualify for a medical licence before starting a residency.

The increase in the percentage of female medical students and doctors is worth noting: 30.2% of all new licences in 1989 were issued to female doctors; that figure grew to 48.6% in 2003 (Israel Ministry of Health Statistics, 2003).

Residency and psychiatric residency in Israel

As a young struggling nation, Israel took pride in its early years in investing energy to build the state and to take positive action in dealing with problems such as the absorption of new immigrants and fighting disease. Acknowledgement of personal difficulties and open discussion of emotions were frowned upon. Thus, psychiatry began to receive recognition only after the 'basic needs' of the country were met. This may account for the fact that a residency in psychiatry in Israel was not considered desirable 25 years ago, to such a degree that a non-governmental, philanthropic agency set up a fund to finance a special pool of psychiatric residencies.

An important contribution to Israeli psychiatry during those years was made by immigrant psychiatrists from Latin America with a traditional psychoanalytic orientation, many of whom still hold senior positions in the academic and clinical world.

However, things have changed in the course of the past 15 years. Close to a million immigrants arrived in Israel from the former USSR during the 1990s, including medical students, doctors and psychiatrists. Between 1989 and 1996, 10 070 licences to practise medicine

were issued, two-thirds of which went to graduates of medical schools in the former Soviet Union. In 2003 the Ministry of Health issued 734 medical licences, of which only 38% went to doctors who had studied in Israeli medical schools (Fig. 1). Immigration has changed the profile of the Israeli psychiatrist, so that any survey of the attitudes of Israeli-trained medical students must take into account the fact that they do not necessarily represent a majority in many residency programmes (Bitterman & Shalev, 2005).

Attitudes and career preferences among Israeli-trained medical students

Our objective was to gain a better understanding of the attitudes and career preferences of Israeli medical students and to compare the results with research from the USA and Australia that had used similar methods (Abramowitz & Bentov-Gofrit, 2005). It was also our intention to gain insight into the learning process from the students' perspective. To achieve these goals, a 23-item questionnaire was administered anonymously to 181 Israeli medical students in their preclinical years at the medical school of the Hebrew University in Jerusalem. The study population consisted of students in three consecutive preclinical years. The response rate was 70%. The results were analysed to find whether there were any statistically significant differences between students who considered psychiatry as a 'chosen' career or a 'strong possibility' for their career and those who did not.

Demographic analysis showed one significant difference between students who considered psychiatry residency and those who did not: students who considered psychiatry were all Jewish, although 7% of the responders were non-Jewish ($P = 0.011$). It is worth noting that roughly 10% of the medical student population in Jerusalem is Arab.

The results showed that psychiatry is as attractive as gynaecology and internal medicine, more attractive than family medicine, and less attractive than surgery and paediatrics.

When examining the aspects most important to medical students in their future career, they responded in favour of 'intellectually challenging' and 'the degree to which patients are helped' – results similar to American and Australian studies using the same questionnaire (Feifel *et al*, 1999; Malhi *et al*, 2002). Whereas psychiatry received the highest score for 'intellectually challenging' of any residency in Israel and Australia, it received low scores for 'the degree to which patients are helped' in all three countries.

Compared with the studies in the USA and Australia, the results of our study showed that more students considered psychiatry as an option, and fewer students disliked the field. The Israeli study also showed that 32.8% of local medical students in the preclinical years considered residency in psychiatry, compared with only 7.7% in the US and 15.9% in Australia (Fig. 2).

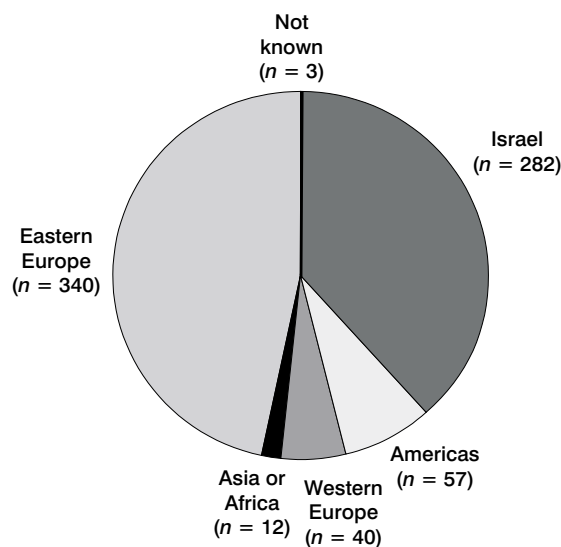


Fig. 1. Number of licences issued in Israel, 2003, according to location of doctors' medical studies (total $n = 734$).

Why is psychiatric training more attractive to Israeli medical students?

In comparison with European countries, the ratio of psychiatrists per 100 000 population in Israel is favourable, at 13.7 (see Fig. 3). Perhaps it has to do with the long tradition of psychiatry as a 'Jewish' profession. This may be a myth, but none the less in our study no non-Jewish students preferred psychiatry. This raises the possibility that the greater appeal of psychiatry among the Israeli sample has to do with the compatibility of the perceived nature of psychiatric practice and the collective Jewish ethos (e.g. a tradition of valuing 'cerebral' pursuits).

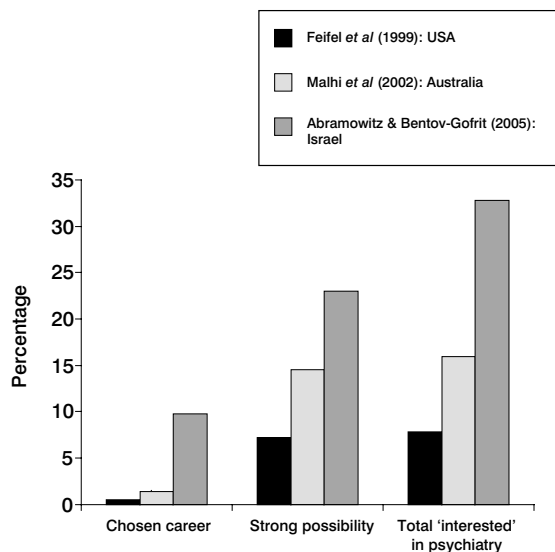


Fig. 2. Comparison of the popularity of a psychiatric residency between Israeli ($n = 181$), Australian ($n = 655$) and North American medical students ($n = 223$). Total 'interested' in psychiatry is the sum of the percentages who had 'chosen' psychiatry as a career and those who gave it as a 'strong possibility'.

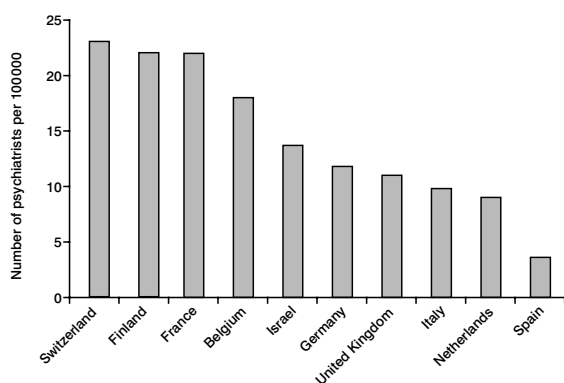


Fig. 3. Number of psychiatrists per 100 000 population in different European countries. Data from Mental Health Atlas 2005: A Project of the Department of Mental Health and Substance Abuse, Geneva: World Health Organization. See <http://cvdinofbase.ca/mh-atlas/index.htm>.

It would seem that the apparent popularity of psychiatry in the preclinical years among Israeli students has much to do with local and cultural factors, including those referred to by Sierles *et al* (2003) as 'extrinsic' factors (e.g. national trends and the average age of the preclinical student).

Finally, the aforementioned increasing number of female graduates may account for some of the popularity of psychiatry, as they tend to give high ratings for the importance of 'controllable lifestyle' (less time-consuming schedule, the option of private practice, etc.).

Despite the relatively high percentage of preclinical medical students who consider psychiatry as an option, only approximately 6% eventually enter residency in the field (Israel Ministry of Health Statistics, 2003). Where do we lose those students? Are we allowing the 'good' ones to get away, to fields such as neurology and brain science on the one hand or to family practice on the other? Our research group is presently involved in a cohort study of students, following them through the clinical years and through the rotation in psychiatry. Preliminary results show that in the clinical years there is a dramatic fall in the popularity of psychiatry.

Conclusions

We began by asking whether the local Israeli population of medical students has anything in common with students abroad. It would seem that psychiatry has a universal image problem among students, who see it as an intellectually stimulating and interesting residency but devoid of any real potential to improve patients' lives. This can be seen as an encouraging finding, as such problems can be remedied. Role modelling, academic promotion of psychiatrists, exposing students to successful treatment outcomes and an admissions policy open to excellence in the humanities are steps that can be taken to improve this image (Weissman *et al*, 1994).

In summary, do we expect the familiar image of the empathic and wise psychiatrist, though at times perhaps neurotic or eccentric – described by Zimny & Sata (1986) and others some 20 years ago – to fade away and make room for a more 'hi-tech', goal-oriented professional? Which prototype attracts the better students?

Our view, based on the recent research in Israel and elsewhere, is that modern psychiatry is arguably the only specialty in which students feel that they can combine the two prototypes. It would seem that future psychiatrists will intuitively seek the experience of wholeness and integration in treating patients and favourably respond to being taught in this fashion. Perhaps in this respect our students may have much in common with students in many countries worldwide.

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Despite the relatively high percentage of preclinical medical students who consider psychiatry as an option, only approximately 6% eventually enter residency in the field.... Where do we lose those students?

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THEMATIC PAPERS – RECRUITMENT INTO PSYCHIATRY

Attitudes to psychiatry: a comparison of Spanish and US medical students

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The present tendency in daily practice towards managed care has changed psychiatric training, and now students may consider psychiatrists as mere psychopharmacologists.

There is a growing concern in many countries over the low recruitment into psychiatry among medical graduates. This has led to studies that aim: (1) to study the attitudes of medical students towards psychiatry, (2) to determine factors that influence such attitudes, (3) to assess the possible causes of this low recruitment and (4) to try to change students' views of psychiatry during their medical education to improve recruitment.

In the United States a negative attitude towards psychiatry or the psychiatrist's role has been observed among medical students at the start of their freshman year (Feifel *et al*, 1999); however, on completion of their psychiatric training it seems that the opinions of students are now improving (Balon *et al*, 1999) in comparison with attitudes that were prevalent 25 years ago (Nielsen & Eaton, 1981).

Over the past 20 years studies in the United States (Nielsen & Eaton, 1981; Balon *et al*, 1999; Sierles *et al*, 2003a,b) and in the United Kingdom (Brockington & Mumford, 2002) have reported that the percentage of students choosing psychiatry as their future specialty has decreased steadily, although other evidence suggests a small increase recently among US students, from 3.5% in 1999 to 4.5% in 2003 (National Resident Matching Program, 2003). The recent increase may be due to a change in opinions towards the field, although this may represent only a partial explanation (Balon *et al*, 1999).

Factors that affect the proportion of students contemplating a career in psychiatry have been divided into extrinsic (e.g. national trends, geographical region) and intrinsic factors (e.g. the quality of psychiatric education). In the USA it seems that local and regional extrinsic factors were not associated with an increase in the proportion of students choosing psychiatry (Sierles *et al*, 2003a). This emphasises that the quality of educational programmes could be one of the most important influences on students' attitudes to psychiatry. Experiences such as students' contact with psychiatric patients (Singh *et al*, 1998), the quality of training (Lee *et al*, 1995) and the prestige of the local psychiatric department (Sierles, 1982) emerge as influential aspects of psychiatric education. Sierles *et al* (2003b) have discussed concerns about future recruitment into the psychiatric profession in the United States. One of these concerns is the graduating seniors' suboptimal satisfaction with their psychiatry clerkships. Another is that clerkship directors in psychiatry, when compared with those in other specialties, tend to perceive more that managed care reduces the quality of clinical medical education. The present tendency in daily practice towards managed care has changed psychiatric training, and now students may consider psychiatrists as mere psychopharmacologists. Thus the profession may not fulfil students' expectations that psychiatry would be more oriented towards psychotherapy (Balon *et al*, 1999).

Attitudes to psychiatry

In order to gain a broader view of the process of recruitment, we compared the attitudes to psychiatry of Spanish and US medical students (Pailhez *et al*, 2005). We chose these groups because a comparison between two different countries with different teaching approaches to psychiatry could help us gain a broader perspective on the complex process of recruitment. We recorded the opinions of 151 students who had completed psychiatry at the end of their fourth year. Our survey was based on responses to a 33-item questionnaire, using a cross-sectional design. Data on US students were obtained from the study by Balon *et al* (1999), whose questionnaire explored the attitudes of medical students towards psychiatry in six areas: (1) overall merits of psychiatry, (2) efficacy, (3) role definition and functioning of psychiatrists, (4) possible abuse and social criticism, (5) career and personal reward and (6) factors specific to the medical school.

We found that many Spanish students felt that psychiatry was not an expanding frontier of medicine. However, Spanish students regarded psychiatry as more scientific and precise than other specialties (72.9% of the Spanish sample endorsed this view, compared with 56.1% of the US sample).

More Spanish than US students agreed that a psychiatric consultation could be useful for medical or surgical patients. However, about a third of Spanish students (37.1%) said that most psychiatrists are not logical thinkers, compared with 17.9% of the US sample. Furthermore, the Spanish students were largely of the opinion that psychiatrists have no more authority and influence than other mental health professionals; that they are too apologetic when teaching psychiatry; and that psychiatrists abuse their legal power to hospitalise patients against their will. Finally, Spanish students expressed a greater preference than did US students for a style of psychiatric practice that was both more biological and more attentive to the patient's psychological problems.

Regarding career choice, Spanish students tended to believe that psychiatry has low social prestige. However, they seemed to be subject to fewer additional external pressures when making their choice of specialty than were students in the United States; these pressures included the opinion of their family (14.9% in Spain versus 25.3% in the United States), friends (20.4% in Spain versus 33.0% in the United States) and fellow students (34.0% in Spain versus 41.5% in the United States).

Spanish students had a worse opinion of the quality of psychiatry teaching (48.3% of students in Spain believed it to be good, compared with 73.8% in the United States). (These questions referred to both the quality of the theoretical lessons and the psychiatry rotation.) They also described receiving less encouragement to enter psychiatry as a profession than did students in the United States (49.6% in Spain versus 69.1% in the United States), but reported more respect for psychiatry

among non-psychiatric staff (71.7% in Spain versus 54.5% in the United States).

Recruitment

In general, Spanish students' views of psychiatry were positive, as were those of the US students in the study by Balon *et al* (1999). However, comparisons revealed differences in responses to some questions relating to the bio-psychosocial concept of illness, salary, social pressure and respect from non-psychiatric staff. The number of students choosing psychiatry as their future career was 6% in our study. This percentage is higher than the 4.5% currently reported in the United States.

Some US authors have tried to elucidate the possible causes of low recruitment: first, there is a large influence of biological psychiatry in the specialty nowadays; second, there are lower income prospects compared with other specialties; third, psychiatry, psychology, social work and primary care medicine overlap in the treatment of patients (Sierles & Taylor, 1995; Balon *et al*, 1999). Other causes of negative attitudes could be the negative social pressure exerted by colleagues and non-psychiatric staff in the medical schools (Nielsen & Eaton, 1981), or the inability of psychiatry to change society through medicine (Balon *et al*, 1999). Approximately 14% more Spanish students than US students felt that psychiatry is too biological (32.6% in Spain versus 18.5% in the United States) and that, on average, psychiatrists make as much money as most other doctors (62.4% in Spain versus 48.7% in the United States). More believed that their friends (66.0% in Spain versus 58.4% in the United States) and non-psychiatric staff (71.7% in Spain versus 54.5% in the United States) would respect their decision to become a psychiatrist. These factors affect recruitment in a very complex way, and the explanations of the difference in attitudes of Spanish and US students are speculative. In the United States students do not seem to have the same reasons as Spanish students for negative attitudes to psychiatry in these specific respects.

The uptake of a residency position in Spain is determined by an official examination; the overall number of positions is determined by the Ministry of Health. Only those students who complete the 4 years of residency after the entrance examination get the specialist degree. Over the last decade, the Ministry of Health has increased the number of psychiatry positions by 33%. In the year 2002/03, out of a total of 5496 medical residency positions, 2.9% were in psychiatry, making it the eighth most available specialty. Despite this increase in the number of positions, 51.7% of the students from our study with an interest in psychiatry after their fourth year of medical school could not enter the specialty.

In this respect, the recruitment process has not presented particular difficulties for the training of psychiatrists in Spain. The number of positions offered yearly by the Ministry of Health depends on the capacity of the accredited training centres, the national budget

Spanish students were largely of the opinion that psychiatrists have no more authority and influence than other mental health professionals; that they are too apologetic when teaching psychiatry; and that psychiatrists abuse their legal power to hospitalise patients against their will.

Paradoxically, when students' opinions are more critical, recruitment in both Spain and the United States seems to rise, probably because being more critical leads to a better understanding and stronger desire to choose the specialty.

available and social demand. Therefore, in contrast with US students, who are guaranteed a psychiatry position, Spanish medical students may regard psychiatry as a more worthwhile specialty because of the competition for training places.

From the 1950s to the mid-1970s, studies in the United States showed that students considered psychiatry more unscientific and imprecise and to have less prestige than nowadays. However, recruitment then was at its highest (Castelnuovo-Tedesco, 1967; Zimet & Held, 1975). Students seemed to make their choice while being very aware of the specialty's weak points. Paradoxically, when students' opinions are more critical, recruitment in both Spain and the United States seems to rise, probably because being more critical leads to a better understanding and stronger desire to choose the specialty. Or could it be that recruitment has nothing to do with attitudes to psychiatry after all?

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THEMATIC PAPERS – RECRUITMENT INTO PSYCHIATRY

Some Australian reflections on problems with recruitment into the profession of psychiatry

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Both studies found that psychiatry was regarded overall as the least attractive career option in the field of medicine and that the students held negative and prejudicial views about the practice of psychiatry and its patients.

Psychiatry has probably always been the least attractive of the medical specialties. The choice of psychiatry as a career has been consistently low in the English-speaking world over the past 50 years (*British Medical Journal*, 1973; Feifel *et al*, 1999; Brockington & Mumford, 2002). Over the past decade there has probably been a further decline in the proportion of medical graduates choosing to train in psychiatry (Sierles & Taylor, 1995; Feifel *et al*, 1999).

The situation in Australia: an international comparison

In Australia over the past several years it has been increasingly difficult to fill available psychiatry training

positions. A critical factor in recruitment is the attitude medical students develop towards psychiatry as a specialty and as a possible career choice.

In 2003 an Australian study was published regarding the attitudes of 655 new medical students towards psychiatry as a career choice (Malhi *et al*, 2003). This study replicated the findings of a study of 221 new students attending three medical colleges in the south-west United States (Feifel *et al*, 1999). Both studies found that psychiatry was regarded overall as the least attractive career option in the field of medicine and that the students held negative and prejudicial views about the practice of psychiatry and its patients.

The Australian study gathered questionnaire information from 655, of a possible 1032, first-year medical students attending a mix of six undergraduate-entry

($n = 452$) and graduate-entry ($n = 203$) medical schools (Malhi *et al*, 2003). The questionnaire from the US study, with minor modification, was used in the Australian study. Student attitudes were compared regarding careers in medicine, surgery, paediatrics, general practice, obstetrics and gynaecology and psychiatry.

The Australian findings point to a number of student perceptions which probably contribute to the unattractiveness of psychiatry as a profession:

- *Financial reward.* Psychiatry rated slightly ahead of general practice but behind the other specialties.
- *Job satisfaction and enjoyable work.* Psychiatry was rated the lowest of all specialties.
- *Lifestyle.* Obstetrics and gynaecology and surgery were rated lower than psychiatry. The US students rated lifestyle as significantly more attractive than the Australian students.
- *Interest and intellectual challenge.* Psychiatry rated ahead of obstetrics and gynaecology and general practice.
- *Scientific foundation and drawing on all aspects of medicine.* Psychiatry rated the lowest.
- *Effective and helpful treatments.* Psychiatry was viewed as having the least effective treatments.
- *Prestige and association with colleagues.* Psychiatry was rated the lowest. The students also considered that psychiatry would be held in the lowest regard by their families and other students but considered that other physicians might rank general practice lower than psychiatry.

In spite of these attitudes, 15.9% of the Australian students indicated that the choice of psychiatry as a career was 'a strong possibility', which must be regarded as something for the profession to build on during the medical course. In the US study only 7.7% of the students nominated a career in psychiatry as at least 'a strong possibility'.

Improving recruitment

These findings paint a pessimistic picture for recruitment but also point to strategies for improving the attractiveness of psychiatry. Competitive increases in the financial remuneration of psychiatrists in both the public and private health sectors in Australia are central to better recruitment. This requires a political decision, not just about the budget allocated to mental health services but also about the necessary numbers of psychiatrists per head of population.

Recruitment is unlikely to improve unless working conditions and job satisfaction improve. Patients in public mental health services are seriously mentally ill, often with a complex of psychosis, personality disorder and substance misuse problems. The Australian medical students expressed concern that psychiatrists experienced personal danger and emotional stress in their

work environment. Flexible employment conditions which provide the possibility of a variety of clinical roles, options to undertake some research or teaching and adequate support for professional development may help to improve job satisfaction.

The recognition by medical students that psychiatry is interesting and intellectually challenging is a perception to build upon. The challenge to curriculum design is to ensure that students learn about:

- the exciting and rapidly expanding scientific basis of psychiatry
- the relative effectiveness and range of treatments of psychopathology
- the richness of a bio-psychosocial model in understanding human development, behaviour, health and illness
- the enthusiasm of psychiatrists for their work.

Although competitive high achievement, usually in mathematics and the sciences, determines entry into undergraduate and graduate medical courses in Australia, all courses have interview or other selection processes which favour students with better communication and interpersonal skills. Psychiatry staff also teach about the psychological system in the classes on clinical skills and professional attitudes that are now components of all medical courses in Australia.

The pervasive negative community attitudes and stigma towards individuals with mental illness extend to psychiatrists and other mental health professionals (Sartorius, 1998). This community apprehension about mental illness is likely to colour medical students' and even other medical practitioners' perceptions of psychiatrists.

Public mental health promotion campaigns and efforts over the past decade by government agencies and professional organisations in Australia have focused on reducing the stigma and community fear of mental illness. The continuation of vigorous efforts to reduce the stigma associated with mental illness coupled with further advances regarding brain function and the treatment of psychopathology are likely to improve attitudes towards psychiatry and improve recruitment.

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Introduction

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The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributors. Please contact Shekhar Saxena (email: saxenas@who.int).

This issue of *International Psychiatry* presents three country profiles, from Iran, Lithuania and Australia. The one from Iran traces the care of people with a mental illness through history and summarises the current mental health services and training in the country. The experience of Iran illustrates how basic mental health services can be provided to a population with the scarce resources that are available in a developing country. The profile from Lithuania shows how the availability of

professionals and resources does not by itself translate into effective services in the absence of an adequate and progressive policy framework. The profile from Australia, on the other hand, provides a contrasting picture: of the provision of optimal care with a high level of resources available. This profile, along with another on Australia and New Zealand on pages 19–21 of this issue, illustrates the continuing challenges of providing mental healthcare in countries with a well developed mental health system.

COUNTRY PROFILE

Psychiatry in Iran

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In the middle ages, when in the West people with a mental illness were typically punished and tortured as witches or were looked upon as being possessed, the main approach to their care in the Islamic world, including Iran, generally involved kindness and some form of counselling, combined with herbal, aroma and music therapy and custody in special asylums.

The Islamic Republic of Iran is located in the Middle East between the Caspian Sea and the Persian Gulf. Iran's total land area is 1 648 000 km². Its total population in 2003 was about 68 920 000 (UNICEF, 2003). The population growth rate is 1.41%. Of the total population, 60.4% live in urban and 39.6% in rural areas (Yasamy *et al*, 2001).

Health indicators

Life expectancy at birth in the year 2002 was estimated to be 66.5 years for males and 71.7 years for females (World Health Organization, 2003). The mortality rate for infants (under 1 year) was 33 per 1000 live births in the year 2003 (UNICEF, 2003). Iran has a rather young population: roughly 40% are under 15 years and only 4.5% are aged 65 years or more (Iran Centre of Statistics, 2003).

The rate of suicide is estimated to be 6.2 per 100 000 per year in both males and females.

History of psychiatry in Iran

In Iran, the history of psychiatry is as old as the history of medicine. In the middle ages, when in the West people with a mental illness were typically punished and tortured

as witches or were looked upon as being possessed, the main approach to their care in the Islamic world, including Iran, generally involved kindness and some form of counselling, combined with herbal, aroma and music therapy and custody in special asylums.

Rhazes (Muhammad ibn Zakariya al-Razi, 865–925) and Avicenna (Abu Ali Ibn Sina, 980–1037), two great Iranian physicians and philosophers, in their writings described such mental disorders as melancholia, mania and delirious states. They also prescribed psychotherapy for their patients and described the effects of emotions on the cardiovascular system.

Modern psychiatry in Iran begins with the foundation of Tehran University in 1934. In 1937 the department of psychiatry at the medical school began teaching students. The first teachers at the department were mainly French-educated, among them the late Professor Abdolhossein Mirsepassi and Professor Hossein Rezai, who were pioneers of psychiatry in Iran.

There had been some asylums for the custody of psychiatric patients since the 19th century in Tehran and other major cities of Iran; these were mainly managed by the municipalities, and were mostly in an unfavourable condition. Roozbeh Hospital was founded in 1946 as the first modern psychiatric teaching hospital in Iran. This hospital has since trained many generations of

psychiatrists and still is the leading centre in psychiatric education, treatment and research (Kermani, 1966).

Prevalence of psychiatric disorders

Various studies have estimated the point prevalence of all psychiatric disorders to be in a range from 11.9% (Bash & Bash-Liechti, 1969) to 41.1% (Motamedi *et al*, 1998). In a recent study about a fifth of interviewees (25.9% of the women and 14.9% of the men) were rated as likely 'cases'. Symptoms of depression and anxiety were more prevalent than somatisation and social dysfunction. The rates of learning disability, epilepsy and psychosis were 1.4%, 1.2% and 0.6%, respectively (Noorbala *et al*, 2004).

Substance misuse in Iran

Opium and its natural and synthetic components (especially heroin) are the most widely used substances in Iran, although other substances, notably cannabis, amphetamine-like drugs and to a lesser extent cocaine, seem to be used increasingly, especially by adolescents.

An estimated 2.8% of the Iranian population over the age of 15 years used opiates in 2001 (International Narcotics Control Strategy, 2003).

One study found that 93% of opiate addicts in Iran were male, with a mean age of 33.6 years, and 1.4% were HIV positive (Yasamy *et al*, 2001).

Methadone maintenance and HIV prevention programmes are expanding, although HIV infection in the prison population is a serious problem (Hashemi Mohammad Abad & London, 2003).

Healthcare beliefs

Despite a significant decrease in discrimination and stigmatisation in recent years, it seems that attitudes towards mental health remain a major challenge in Iran. In a recent (unpublished) study of the families of 300 patients with schizophrenia, major depressive disorder and bipolar disorder, 49%, 30% and 51% of these respective groups reported stigma and humiliation (further details from the first author on request).

As in many other developing countries, emotional problems are frequently expressed in somatic form. Beliefs that illness may be caused by a person with the 'evil eye' (i.e. who can harm others merely by looking at them) or an imbalance in 'hot/cold' temperaments or foods are common and coexist with more medical concepts (Sadeghi, 2003).

In general, there is less verbalisation of emotions, especially depression and anxiety. Feelings of guilt are seldom expressed spontaneously. Hypochondriasis and somatic complaints are frequent (Sartorius *et al*, 1983).

Traditional healers still have a major role. One study found that 16% of patients had visited traditional healers and used alternative medicine before their first psychiatric visit (Omidvari *et al*, 2001).

Mental health facilities

There are currently 8950 psychiatric beds distributed among 23 psychiatric and general hospitals, and 825 psychiatrists are practising throughout the country, of whom 30 are child psychiatrists (National Research Centre of Medical Sciences, 2003; Ministry of Health and Medical Education, 2003).

The therapeutic modalities in Iran are mainly pharmacotherapy (the most widely used), psychotherapy and electroconvulsive therapy (ECT). Although many newer psychotherapeutic drugs are available in Iran they are generally too expensive for the average patient. Psychiatric rehabilitation facilities in general are scanty and insufficient.

Psychiatric non-governmental organisations in Iran

The Iranian Psychiatric Association was founded in 1966 and is a member of the World Psychiatric Association (WPA). The Child and Adolescent Psychiatric Association was founded in 2001.

There are also other non-governmental organisations (NGOs) active in mental health, including the Association for the Support of Schizophrenic Patients and Narcotic Anonymous (NA), a self-support group for ex-addicts.

Education

Undergraduate

The duration of general medical training in Iran is 6–7 years. Medical students have a 1-month course in psychiatry, which covers theoretical aspects, and a 1-month internship during which psychiatric history taking and interviewing skills are taught.

Postgraduate

Postgraduate psychiatric training is a 3-year course covering the theoretical and practical aspects of psychiatry, including in-patient and out-patient adult psychiatry, psychiatric emergencies, psychotherapy (especially cognitive-behavioural and/or analytical approaches), consultation-liaison psychiatry, child psychiatry and rotations in forensic psychiatry and neurology. Every psychiatric resident has to conduct a supervised research project during his/her training as a prerequisite for participation in written and oral board certification examinations set by the National Board Examiners' Committee.

The only sub-specialty training is child and adolescent psychiatry, which is a 2-year course.

Research

The publication of papers in international journals has seen considerable growth during recent years: from about four in 1973 to more than 90 in 2001. However, because none of the 23 mental health journals published

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in Iran are indexed in international databases, the output of Iranian researchers in branches of medicine related to mental health is less than may appear to be the case.

Mental health promotion and policies

The National Programme of Mental Health, which seeks to integrate mental healthcare within primary healthcare, was started in 1989 as a pilot study in two rural areas (Yasamy & Bagheri Yazdi, 2004). In 1995 it was jointly evaluated by the World Health Organization and the Tehran Psychiatric Institute. The programme was recognised as one of the most successful in the region (Murthy, 2002).

The aim is to establish a hierarchical, pyramid-like referral system. At the base of the pyramid there are health workers known as *Behvarz*, who are mainly local residents of each primary healthcare area; they are trained to recognise, refer and follow psychiatric cases to the higher level, which comprises rural health centres (Fenton, 1998). Currently, 21.7% of the urban population and 82.8% of the rural population is covered by the National Programme of Mental Health (Yasamy et al, 2001).

Future of psychiatry in Iran (opportunities and threats)

The advancement of psychiatric education and the promotion of mental health policies in the past decade have profoundly affected psychiatric services. At present, it seems that there are enough psychiatrists in major cities throughout the country, and most psychotropic medications are available in Iran. All psychiatric hospitals are equipped with modern ECT machines.

On the other hand, non-biological treatments are not extensively available, being mainly limited to four or five major cities in the country. Iran lacks a practical and comprehensive mental health act. Limited coverage of mental health expenses by insurance companies has affected psychiatric care in both the private and the governmental sectors. Despite a dramatic increase in recent years, the mental health budget still remains highly

insufficient. The Mental Health Bureau of the Ministry of Health and the Iranian Psychiatric Association have been struggling to increase the budget.

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At the base of the pyramid there are health workers known as *Behvarz*, who are mainly local residents of each primary healthcare area; they are trained to recognise, refer and follow psychiatric cases to the higher level, which comprises rural health centres.

Non-biological treatments are not extensively available, being mainly limited to four or five major cities in the country.

COUNTRY PROFILE

Mental health in Lithuania

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Lithuania is a country with an approximate area of 65 000 km². Its population is 3.422 million, and the gender ratio (expressed as men per 100 women) is 87. The proportion of the population under the age of 15 years is 18%, and the proportion above the age of 60 years is 20%. The

literacy rate is 99.6% for both men and women. The country is in the higher middle-income group (by World Bank 2004 criteria).

The health budget represents 6% of the country's gross domestic product. The per capita total expenditure on health is \$478 (international \$) and the

per capita government expenditure on health is \$337. Life expectancy at birth is 66.2 years for males and 77.6 years for females. Healthy life expectancy at birth is 59 years for males and 68 years for females (World Health Organization, 2005).

Cultural context

Lithuania has undergone a marked transition in its economic, social and cultural life. After economic decline in the 1990s, the economy started to grow significantly after 2000. Similar trends can be observed in the dynamics of public health indicators: they reached their worst in 1994; after that a gradual improvement in the indicators of mortality and general morbidity was observed. However, high levels of social pathology remain (including violence, suicides, alcohol misuse and other self-destructive behaviours); this is combined with a stigmatising approach by the general population towards people with a mental disturbance and other vulnerable groups. Lithuania is among the countries with the highest rates of suicide in Europe, and indeed the world (42–44 per 100 000 per year during the last 10 years), with middle-aged rural males the group at highest risk (among whom the rates of suicide exceed 100 per 100 000). According to a World Health Organization (2002) report, youth homicide rates in Lithuania (5.4 cases per 100 000 of the population aged 10–29 years) and other Baltic countries are several times higher than those in 'old' member states of the European Union (EU) and Central European countries, but none the less are three times lower than those in Russia. Recently the problem of bullying in schools has been recognised as a serious issue (it appears that more than half of all schoolchildren in Lithuania are involved in bullying).

Psychiatric services

Analysis of existing data about financial and human resources invested in the mental healthcare system has raised questions for policy makers about the effectiveness of the traditional investments. Lithuania, like other countries of Eastern Europe, does not have a problem with a lack of psychiatrists and psychiatric services. The largest proportion of physical and human capital is concentrated in psychiatric institutions, with large numbers of beds, psychiatrists and increasing funding for reimbursement for the new generation of psychotropic medications. However, the other components of care are lacking, such as community-based housing, psychosocial and vocational rehabilitation, psychotherapy, community-based child mental health services, and supportive services for families at risk. The political will is needed to develop these as priorities and as alternatives to the powerful system of residential institutions and psychiatric hospitals.

In 1997 a new network of municipal out-patient psychiatric services (municipal mental health centres) was launched; the total number of such centres throughout the country was 64 in 2004. It was a very

important first step in the development of community-based services and mental health promotion. However, the composition of staff in the centres is too 'medicalised': the 617 staff members in 2002, for example, comprised 32% psychiatrists, 33% nursing staff, 22% social workers and 13% psychologists. The annual general cost of reimbursement of psychotropic medications prescribed by psychiatrists attached to these municipal mental health centres is two times higher than the sum of the running costs of all the mental health centres (including salaries for mental health teams and other staff).

The number of beds in psychiatric hospitals has steadily decreased, from 5380 in 1991 to 2996 in 2003. However, this has been achieved to a certain extent through the transfer of patients with a chronic mental illness from psychiatric hospitals (which are under the Ministry of Health and funded from obligatory health insurance funds) to psychiatric long-stay care institutions (which fall under the system of social welfare). In these centralised large residential institutions (of which there are over 20 throughout the country) the number of clients is more than 6000. The new network of municipal mental health centres (mentioned above) is not currently able to start the process of de-institutionalisation, and there are waiting lists for placement in residential institutions, in the absence of alternative community-based services.

Another gap which was identified during an analysis of resources and processes is a lack of sustainable and effective activities in the field of mental health promotion and the prevention of mental disorders. There are many new initiatives by municipal authorities and non-governmental organisations (NGOs) in the field of mental health promotion and prevention; however, these lack a tradition of measuring their effectiveness and sustainability of funding. Also, general practitioners (GPs) are not involved in mental health issues, partly because it was planned that the municipal mental health centres would take care of all people who are in need of out-patient mental healthcare. Now it is becoming obvious that GPs need to be involved as gatekeepers in primary mental healthcare, as the municipal mental health centres are receiving too many referrals of common cases.

These findings may be useful for the development of modern mental health policies in the countries of Eastern and Central Europe, which were deprived for decades of the possibility of introducing evidence-based mental health policies and services.

During an analysis of the performance of the national mental healthcare system, it became clear that existing policies and programmes do not include economic or social outcomes, which should be monitored as criteria by which to measure the effectiveness of resources and processes (services). However, there are some indicator targets which the Lithuanian Health Programme and the State Programme on Prevention of Mental Disorders have been planning to reach, for example to reduce the suicide rate to 25 per 100 000 and to reduce morbidity from alcoholic psychosis to 10 per

Lithuania is among the countries with the highest rates of suicide in Europe, and indeed the world ... with middle-aged rural males the group at highest risk (among whom the rates of suicide exceed 100 per 100 000).

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It is difficult to compete for national and international research funds against fields like cardiology, oncology, rheumatology and other traditional priorities in health research, which have separate state-funded research institutes from Soviet times.

An improvement is required in the governance of the systems in order to make mental health systems accountable and effective and to enable them to meet the needs of patients.

100 000 by 2005. It is obvious now that these goals have not been reached; neither has a primary goal of the State Programme on Prevention of Mental Disorders: 'to create an effective community-level network of social psychiatric structures by including NGOs in service provision'.

Psychiatric training and education

The system of training in psychiatry and other mental health and allied professions is undergoing changes towards harmonisation with EU standards. After 6 years of undergraduate medical education and 1 year of general internship, graduates of medical schools (there are medical faculties at Vilnius University and at Kaunas Medical University) may choose 4 years' residency in two psychiatric specialties – general psychiatry and child and adolescent psychiatry. Courses of continuing medical education are also available in these medical schools. Training courses in psychotherapy are available for both medical doctors and psychologists. Social work is developing as a new specialty.

Research

Research in the field of psychiatry and mental health is not very well developed, mainly because of a lack of research capacity and the absence of research institutions in these fields. It is difficult to compete for national and international research funds against fields like cardiology, oncology, rheumatology and other traditional priorities in health research, which have separate state-funded research institutes from Soviet times. Most of the research in the field of psychiatry and mental health is carried out at Vilnius University and Kaunas Medical University, by PhD doctoral fellows and teaching faculty. Recently PhD theses have been defended on subjects such as eating disorders, autistic spectrum disorders, depression and suicide. In 2004 the first epidemiological study in Lithuania in the field of mental health was completed – the prevalence of child mental health problems was evaluated by a joint research team at Vilnius University with the use of validated instruments. The first attempts at the evidence-based assessment of mental health systems have been provided by the research team in Vilnius University. The problems of research capacity in the field of mental health and unsustained funding remain unsolved.

The future

Completion of a 'country profile' (Puras *et al*, 2004) was a very important exercise in the country, which is

looking forward to developing and implementing an evidence-based mental health policy and improving both the performance of the mental health system and indicators of population mental health. The country profile revealed a phenomenon common to most Eastern European countries, whereby statistical accounts keep the tradition of presenting processes as outcomes, while the modern assessment of outcomes of services, programmes and policies is lacking. This tradition of monitoring the amount of processes as if they were outcomes creates a vicious circle in which a system of services that do not meet the modern requirements of a public mental health approach and the needs of patients becomes a serious obstacle to the formulation, development and implementation of new mental health policies.

Analysis of the findings from the country profile identified the gaps in the existing mental healthcare system and raised the question of the need for a national evidence-based mental health policy. After a World Health Organization ministerial conference on mental health, the Lithuanian Minister of Health appointed the Committee for Mental Health, which has prepared a draft of a new mental health policy. This draft new mental health policy is currently being debated.

In conclusion, there is an obvious need to establish a modern culture of evaluation, independent assessment and research within the mental health sector in the countries of Central and Eastern Europe (Jenkins *et al*, 2001). These countries fall into two groups economically, with some (e.g. the Baltic states) seeing an improving economy but others experiencing greater economic difficulties. It is the case, however, that both groups have problems in the field of mental health. In this context there is a need for responsible, transparent and evidence-based decisions over the allocation of resources. An improvement is required in the governance of the systems in order to make mental health systems accountable and effective and to enable them to meet the needs of patients. Lithuania could be a good candidate as a demonstration country, with its improving economy and quality of life, in the development of modern mental health services as an alternative to the traditional system of centralised psychiatric institutions.

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Australian psychiatry: coming of age?

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Australia, a vast continent of 7 700 000 km² (including the island state of Tasmania), is roughly the size of Western Europe or mainland USA, but with a population of only 20.2 million (2004 estimate), mainly concentrated in coastal areas.

Australia's official language is English and its largest religion is Christianity (76.4%). Of the current population 92% are Caucasian, 7% Asian and 1% 'other' in origin, including 350 000 who claim Aboriginal descent. Australia's population growth once relied largely on migration from Britain, and to a lesser extent Ireland, but after the Second World War it was broadened by refugees and others from many other parts of Europe. Since the 1970s there has been more substantial migration from Asia. While refugees continue to be taken in and supported, Australia takes a tough stance on unauthorised arrivals, including prolonged detention, which is beginning to be softened due to growing public concern.

The Commonwealth (national) government is responsible for general policy directions in health, disability, education, employment and so on. The state governments retain responsibility for organising all their own health services and facilities, including mental health services. Consequently, such provision is diverse. Further, Australia has developed a substantial private medical sector, now funded nationally by taxpayers through the Health Insurance Commission, as well as via private health insurance schemes.

Epidemiology

A national cross-sectional community survey of mental health and well-being (Andrews *et al*, 1999; Jablensky *et al*, 1999) was conducted via lay surveyors from the Australian Bureau of Statistics. It revealed that 17.7% of adult Australians met criteria for the common anxiety, affective and/or substance use disorders. More than 20% were likely to have a diagnosable and treatable mental disorder when psychotic, cognitive and personality disorders were included. Only 38% of individuals with a mental disorder (more women than men) sought professional help, which is concerning, and in most cases this was from a general practitioner rather than from a specialist mental health professional. Half as many Australians have a long-term mental disorder as have a long-term physical disorder, with physical disability being more common in the elderly and mental disability being more prevalent in young adults.

Psychotic disorder was found to be associated with a higher prevalence of severe physical illnesses and a

much lower access to appropriate medical and surgical interventions (Lawrence *et al*, 2001).

The funding for a new national community survey, which may well have a longitudinal component, was announced by the federal government in July 2005.

Policy developments and shift in service provision

A National Mental Health Policy was first endorsed by all Australian health ministers and published in 1992. It has been elaborated upon in two further National Mental Plans. These will be the subject of a forthcoming paper in *International Psychiatry*. Together they have sought to promote mental health, increase the quality and responsiveness of services, and to forge a consistent approach to mental health service system reform among Australian states and territories. They also represent a shift over more than a decade to community re-provision from former reliance on psychiatric hospitals. This has occurred with a slight growth in the number of acute beds, mainly in general hospitals, and a 63% decrease in long-stay hospital beds, and partial compensation in the growth of supervised community residential placements, crisis and assertive community treatment teams.

Mental health legislation

Although each state and territory has its own Mental Health Act, a template model Mental Health Act upholding the rights and responsibilities of people with mental illness was developed centrally in the early 1990s (as part of the First National Mental Health Strategy). A Rights Analysis Instrument was subsequently developed by the Federal Attorney-General's Department, which is now used to calibrate all state and territory mental health legislation with the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991; Whiteford & Buckingham, 2005).

Workforce and training

There were an average of 87.5/100 000 full-time equivalent professional staff employed in specialist mental health services by 2001–02, including 9.7/100 000 medical, 57.1/100 000 nursing and 20.7/100 000 allied health workers (Department of Health and Family Services, 2004). This represents a 100% growth in professional staffing over the previous decade.

Only 38% of individuals with a mental disorder (more women than men) sought professional help, which is concerning, and in most cases this was from a general practitioner rather than from a specialist mental health professional.

Case management is generally shared between nursing and allied health professions, as Australian standards and guidelines do not support the development of a generic case manager role, either by merging professions or on a non-professional basis.

In 1999 more than 20% of the health burden in Australia was attributable to mental disorders, yet only 5% of the national health budget was spent on mental health.

Australian public mental health services are largely staffed by interdisciplinary teams of at least five fully professional disciplines: psychiatry; psychiatric nursing; psychology (particularly clinical psychology); occupational therapy; and social work. Variably, depending on location, teams may also include rehabilitation or vocational counselors or instructors, and indigenous and transcultural mental health workers. Increasingly, paid consumer and carer advocates, consultants or teams are being employed in such services. Case management is generally shared between nursing and allied health professions, as Australian standards and guidelines do not support the development of a generic case manager role, either by merging professions or on a non-professional basis (Rosen *et al*, 1995; Gianfrancesco *et al*, 1996; Rosen & Teesson, 2001; National Mental Health Strategy, 2003; Rosen, 2005).

Following a medical course of 4 years (graduate) to 5 or 6 years (undergraduate) and 2–3 years of rotating hospital resident posts, trainee psychiatrists undergo a 5-year (or more) training period that combines apprenticeship and coursework. This now includes advanced training in a sub-specialty over the last 2 years, which may be child and adolescent psychiatry, adult psychiatry, aged-care psychiatry, consultation–liaison psychiatry, psychotherapy and so on, and which results in the trainee becoming a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP – on which see Boyce & Crossland in this issue).

Nurses are trained on university general nursing courses for 3 years and then may attain postgraduate certificates while working in their chosen specialty (e.g. mental health nursing).

Allied professionals usually have a bachelor degree in their chosen profession, often taking 4 years, but they are being increasingly encouraged to proceed to masters or doctorate level, particularly in psychology.

There are over 2000 psychiatrists; although only around 20% were in public practice (Henderson, 2000), this proportion is growing (it grew by 37% over the decade to 2002) and the number of psychiatrists in private practice has been shrinking by 2–3% per year since 1997 (Whiteford & Buckingham, 2005). Boyce & Crossland in this issue indicate that 40% of Australian psychiatrists now work in the public sector and 60% in the private sector. The apparent difference is explained by the probable increasing proportion of Australian psychiatrists now doing a combination of public and private practice. The RANZCP Workforce Study 2005 revealed that 23% of Australian psychiatrists work solely in public practice, 41% solely in private practice and 36% in both. Comparison with an earlier survey (Australian Medical Workforce Advisory Committee, 1999) indicates a slow decrease in the number of psychiatrists working predominantly in private practice and a slow increase in the numbers of psychiatrists working predominantly in public practice.

The clinical staffing levels in public mental health services (Department of Health and Family Services, 2004) totalled nearly 18 000 by 2002, having grown by 15% since 1992–93, and consisted of 62% nursing, 22% allied health, 10% medical professionals and 6% others.

There is currently a shortage in psychiatry of registrars and nurses, as in other Australian health disciplines.

Resourcing

In 1999 more than 20% of the health burden in Australia was attributable to mental disorders, yet only 5% of the national health budget was spent on mental health (Andrews *et al*, 1999). This proportion of expenditure grew only marginally, to 6.5%, in 2001–02 as derived from *World Health Reports* (Rosen *et al*, 2004). Total expenditure on mental health services in 2001–02 was A\$3.09 billion, of which 58.2% was spent by the states on the public mental health system, 37.1% was spent by the commonwealth government mainly on pharmaceutical subsidies, general practitioner and private psychiatrist rebates, and 4.7% by private health funds, mainly for private hospital services (Department of Health and Family Services, 2004).

Research

Particular, sometimes outstanding contributions have been and are being made by Australians to psychiatric research in many areas, as listed by Henderson (2000): the phenomenology and treatment of both the depressive and the anxiety disorders; abnormal illness behaviour and somatisation disorder; illness prevention and health promotion; the epidemiology of mental disorders and the social environment; the epidemiology of mental disorders in late life; the neurobiology of schizophrenia; early intervention in the psychoses; mental health service system research; the mental health of indigenous peoples; alcohol and drug misuse; post-traumatic stress disorder; and psychiatry and ethics. To these I would add research in: mental health literacy, stigma and mental health first aid; telepsychiatry and related strategies for rural/remote areas; classification, phenomenology and treatment of depression; consultation–liaison psychiatry; the psychological health of asylum seekers in detention, of refugees and of traumatised populations; medico-legal provision; psychosocial (including family) interventions; crisis and assertive community case management and residential alternatives to in-patient care; interdisciplinary roles, teams and leadership; outcome measurement; and consumer and carer participation in services.

Conferences and forums

Each mental health professional grouping runs its own annual congress or conference, and there are many national and international special interest meetings.

There is a strong independent movement, the Mental Health Services Conference of Australia and New Zealand (www.themhs.org) (Andrews, 2005), which is co-owned by all mental health professions, managers and consumer/carer networks, which promotes joint conferences, binational debates and forums, and mental health service achievement awards for local integrated services, early intervention, comorbidities,

rural and remote services, indigenous and transcultural mental health services, consumer and carer service initiatives, mass media representations of mental illness and services (print and electronic). The MHS conference begins with separate indigenous, consumer, carer leadership and provider training forums, with all these constituencies coming together for the last 3 days.

Conclusion

Mental health reforms in Australia have resulted in considerable achievements (see forthcoming paper in *International Psychiatry*). However, after 5 years of real growth of integrated community and local hospital mental health services from 1992 to 1997, many community-based psychiatric services are now being increasingly starved of resources, and others were never adequately developed. This plus increasing presentations involving severe comorbidity with substance misuse, particularly in males, has put severe pressure on emergency departments, acute in-patient units and consultation–liaison teams. Private sector resources are not rationally distributed and public health administrations siphon mental health budgets continually. Australia still compares poorly with other Western countries in terms of the proportion of its gross domestic product and health budgets spent on mental health (Rosen *et al*, 2004). So although on paper the Australian National Mental Health Policy has been world class, its implementation has proven patchy and fragile. We now need to lift our game, and call for a consistent independent umpire, a National Mental Health Commission or equivalent.

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After 5 years of real growth of integrated community and local hospital mental health services from 1992 to 1997, many community-based psychiatric services are now being increasingly starved of resources, and others were never adequately developed.

SPECIAL PAPER

Fifteen-year follow-up of conversion disorder

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The terms ‘conversion’, ‘hysteria’ and ‘conversion hysteria’ were used interchangeably to describe a condition characterised by a single somatised symptom, often pseudo-neurological in nature. DSM–III (American Psychiatric Association, 1980) expanded the concept of conversion to generalised symptoms involving loss or alteration of physical functioning suggestive of a physical disorder, along with a clinical indication that the conversion was an

expression of psychological conflict or need. The type of symptom or deficit should be specified as: with motor symptom or deficit, with sensory symptom or deficit, with seizure or convulsions, or with mixed presentation (Kaplan & Sadock, 2004).

Lifetime prevalence in the general population has been estimated at between 11 and 300 cases per 100 000. The prevalence is 5–14% of general hospital patients, 1–3% of out-patient psychiatric referrals and

In early studies, general medical aetiologies were later found in a quarter to a third of persons initially diagnosed with conversion symptoms.

The study reported here was an investigation into the psychiatric comorbidity present after 15 years among patients previously identified as having conversion disorder.

5–25% of psychiatric out-patients (Kaplan & Sadock, 2004). A higher prevalence is found in females than in males, with a female:male ratio ranging from 2:1 to 10:1.

Approximately 25% of emotionally normal post-partum and medically ill women report conversion symptoms during their lives. Lower socio-economic status is associated with higher prevalence rates, and this is evident in a comparison of developing with developed countries; the prevalence may be as high as 31% in some developing nations (Uguz & Toros, 2003).

Limited data suggest that conversion disorder is found more frequently in relatives of individuals with the disorder. Case series show an increased risk in monozygotic twins but not in dizygotic twins. Non-genetic familial factors such as incestuous sexual abuse in childhood may be associated with an increased risk of conversion disorder. The disorder may prove to be the only mechanism for communication that remains available to the child or adolescent (Lancman *et al*, 1994).

Age at onset is generally from late childhood to early adulthood; conversion disorder rarely occurs in children younger than 10 years. There is little information on psychiatric comorbidity in conversion disorder (Tomasson *et al*, 1991).

Factors complicating the diagnosis of conversion disorder include the presence of a coexisting physical illness, as the two conditions are not mutually exclusive: patients with incapacitating and frightening physical illnesses may appear to exaggerate symptoms. At the same time, patients with actual neurological illnesses may also exhibit conversion symptoms. More than a third of individuals with conversion symptoms have a current or prior neurological condition. In early studies, general medical aetiologies were later found in a quarter to a third of persons initially diagnosed with conversion symptoms (Lancman *et al*, 1994).

Conversion disorder has a favourable outcome in children and adolescents (Pehlivanurk & Unal, 2002). Mace & Trimble (1996) reported that the prognosis for chronic symptoms remains poor, but subsequent rediagnosis of neurological disease is less frequent than commonly supposed.

Another study showed that the outcome of non-epileptic seizure was poor. Depressive symptoms, suicidal ideation and suicide attempts were commonly found in these patients (Ettinger *et al*, 1999). One study reported a possible relationship of conversion disorder to affective illness (Kapfhammer *et al*, 1992).

The study reported here was an investigation into the psychiatric comorbidity present after 15 years among patients previously identified as having conversion disorder.

Methods

The study was conducted in the out-patient department of Sir Ganga Ram Hospital and Free Psychiatric Clinic, Ahbab Hospital, Ravi Road, Lahore. Over 2 years (1986–88) 137 patients were diagnosed with

conversion disorder by a consultant psychiatrist on the basis of DSM–III criteria. Patients of both genders were included; those suffering from organic or other psychiatric illness were excluded. The patients' age, gender, marital status and family psychiatric history were noted. In 2003, that is 15 years later, 107 of these patients were reassessed on the basis of DSM–IV criteria (American Psychiatric Association, 1994) (30 patients were lost to follow-up) on the same variables and for the presence of psychiatric comorbidity, by a rater who was masked to the initial diagnosis.

Results

Out of the sample of 107 patients, 89 (83%) were female and 18 (17%) were male. The mean age of the sample at the original assessment was 23.2 ± 4.3 years. At that time, 62 (58%) were married and 45 (42%) were unmarried; 78 (73%) had a family history of psychiatric disorder.

At follow-up, 21 patients (20%) still had conversion disorder and 4 (5%) patients were reported to have epilepsy (among them three patients with partial complex seizures and one with tonic–clonic seizures). One patient had an arteriovenous malformation and two patients had vascular headache. In this study 20 (19%) patients had comorbid major depressive disorder; 59 (55%) patients did not fulfil the criteria of DSM–IV for any disorder.

Discussion

Attempts have been made over the past century to abolish and then to reinstate the condition by using different labels, and conversion hysteria continues to attract controversy (Ron, 1994; Webster, 1996, p. 5).

Crimlisk *et al* (1998) reported a high level of psychiatric comorbidity in patients with conversion disorder in their investigation of psychiatric/neurological morbidity and indicators of prognosis among 73 patients with unexplained motor symptoms. The present study used a similar research design and produced comparable findings.

Another study (Spierings *et al*, 1998), conducted in The Netherlands, reported that 62% patients with conversion disorder had a history of organic illness, whereas only 5% patients had an organic disease at follow-up. The present study produced similar findings at 15-year follow-up.

A study conducted in New York in 1996 found that depressive symptoms, suicidal ideation and suicide attempts were common in patients with conversion disorder (Ettinger *et al*, 1999). The present study did not record suicidal ideation and suicide attempts but the results regarding depressive symptoms are similar to those of the New York study.

Scheidt *et al* (1992) also reported the presence of depressive symptoms at follow-up in a third of their sample with psychogenic tremor ($n = 17$). In addition, physical illness was also present during the

follow-up. The present study found that 19% of patients with conversion disorder also had depression, but it did not examine physical illness. The results of the two studies regarding depressive disorder are similar.

Finally, Lancman *et al* (1994) examined the presence of comorbidity among patients with conversion disorder and reported that 48% of the sample were taking anticonvulsants. The results of the present study regarding comorbidity of epilepsy with conversion disorder are in line with these findings.

Conclusions

Conversion disorder is more common in married women with a family history of psychiatric disorder. High levels of psychiatric comorbidity exist with conversion disorder. Emphasis must be given to the better use of neurodiagnostic tools for the evaluation and the management of comorbidity. Further studies are required to explore this aspect.

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Attempts have been made over the past century to abolish and then to reinstate the condition by using different labels, and conversion hysteria continues to attract controversy.

ASSOCIATIONS AND COLLABORATIONS

The Royal Australian and New Zealand College of Psychiatrists

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The vision of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) is of 'a fellowship of psychiatrists working with and for the general community to achieve the best attainable quality of psychiatric care and mental health'. It is the principal organisation representing the specialty of psychiatry in Australia and New Zealand; it currently has around 2600 Fellows, who account for approximately 85% of psychiatrists in Australia and 50% of psychiatrists in New Zealand. The RANZCP sets the curriculum, accredits training and training programmes, and assesses trainee psychiatrists. In addition, it administers a continuing professional development programme for practising

psychiatrists, has a role in policy development, publishes two scientific journals – the *Australian and New Zealand Journal of Psychiatry* and *Australasian Psychiatry* – and holds an annual scientific congress.

Organisation and history

General Council is the governing body of the RANZCP. Its core functions are served by four boards: the Fellowships Board, the Board of Practice Standards, the Board of Professional and Community Relations, and the Board of Research. Each board oversees committees. Sub-specialties of psychiatry are represented through faculties (the Faculty of Child and Adolescent

Website <http://www.ranzcp.org/publicarea/public.asp>

The educational remit of the RANZCP extends beyond election to Fellowship. Its programme for continuing professional development provides a pathway for psychiatrists to review and develop professional practice and abilities, with the objective that the profession delivers the highest quality of psychiatric service.

Psychiatry, the Faculty of Psychiatry of Old Age), sections (Section of Consultation–Liaison Psychiatry, Section of Forensic Psychiatry, Section of Psychotherapy, Section of Social and Cultural Psychiatry, Section of Addiction Psychiatry, Section of Neuropsychiatry) and special interest groups. The RANZCP has branches in New Zealand and in each Australian state and the Australian Capital Territory.

The RANZCP began life in 1946 as the Australasian Association of Psychiatrists. There were 67 foundation members, all practising psychiatrists. The Association's inception closely followed the Second World War; the war may have been influential in its establishment, having led to an increase in the recognition of, and demand for, psychiatric treatment. Membership was limited to those with both medical and psychiatric qualifications: at this stage the Association had no role in the process by which people could enter the profession and did not admit trainees. Some of its other activities, however, remain the same today: publication (in those days of the *Australasian Psychiatric Quarterly*) and an annual conference. The Association became the Australian and New Zealand College of Psychiatrists in 1963, acquiring the 'Royal' prefix in 1977. The College's remit expanded to include a role in education and it became the gateway for doctors to become specialists in psychiatry (Rubenstein & Rubenstein, 1996).

Becoming a Fellow: the RANZCP's training programme

The RANZCP programme for postgraduate training in psychiatry is based on an apprenticeship model. Trainee psychiatrists must complete a minimum of 5 years' full-time (or equivalent part-time) training in psychiatric practice. To register with the RANZCP as a trainee, applicants must:

- have satisfactorily completed at least 2 years' full-time equivalent general medical training
- hold current registration as a medical practitioner in Australia, New Zealand or other approved country, state, territory or dependency
- be in good standing with the relevant medical registration board or equivalent approved body

- be selected to enter an approved basic training programme
- be appointed to an approved training post.

Basic training takes 3 years. The first year concentrates on the acquisition of knowledge and skills in phenomenology, interviewing, clinical assessment and the principles of management planning. The second and third years place an emphasis on the development of knowledge and skills in clinical management and teamwork. Assessment of basic training is via two case histories, and written and clinical examinations.

Advanced training involves 2 years' full-time equivalent supervised experience in clinical psychiatry or in an approved advanced training programme, and completion of core advanced training experiences. Self-directed learning and the processes used in continuing medical education are important for advanced training. On successful completion of all training requirements, trainees are eligible for election to Fellowship of the College.

The educational remit of the RANZCP extends beyond election to Fellowship. Its programme for continuing professional development provides a pathway for psychiatrists to review and develop professional practice and abilities, with the objective that the profession delivers the highest quality of psychiatric service.

Providing strategic leadership and support in mental health policy

In Australia and New Zealand, as in many other countries, recognition of mental health issues has increased in recent years. Table 1 gives an overview of psychiatry in Australia and New Zealand.

The RANZCP aims to inform and influence mental health policy by offering credible, objective and clinically informed advice and initiatives. It works in partnership with governments, consumer organisations, and other medical organisations. It publishes position statements and other guidelines on psychosocial issues in response to current events and for the information of its members and the wider public.

In both countries there is an under-supply of psychiatrists, and the shortage is particularly acute in rural

Table 1. An overview of psychiatry in Australia and New Zealand

Australia	New Zealand
Population 20 million; majority of European descent, 2.2% Aboriginal and Torres Strait Islanders	Population 4 million; majority of European descent, 15% Maori, 7% Pacific Islanders
Total health budget (2002) A\$66.6 billion	Total health budget (2001–02) NZ\$6918 million
Mental health budget (2002) A\$3.9 billion	Mental health budget (2001–02) NZ\$692 million
12.1 psychiatrists per 100 000 population	4.3 psychiatrists per 100 000 population
60% of psychiatrists work mainly in private practice, the other 40% mainly in the public system	The majority of psychiatrists work in the public system

Sources: Australian Bureau of Statistics, Statistics New Zealand, Australian Institute of Health and Welfare, New Zealand Mental Health Commission.

and remote areas. The RANZCP recognises that workforce shortages and difficulties in recruitment are significant and constitute a major challenge to service provision, and is attempting to improve recruitment into the profession.

Strengthening the psychiatric workforce involves clarification of the role of the psychiatrist. The RANZCP supports the role of the psychiatrist as a specialist treatment provider, and as a consultant and clinical leader within a multidisciplinary team.

With a shortage of psychiatrists, and with much mental healthcare in the primary sector, the RANZCP has formed partnerships with the Royal Australian College of General Practitioners, the Australian Divisions of General Practice, consumer groups and the Australian government to develop a range of practical and systemic measures to improve liaison between psychiatry and general practice. Among these is the development of structures to allow psychiatrists to work in a consultant capacity, whereby general practitioners may refer their patients to a psychiatrist for an assessment and receive a management plan from the psychiatrist. This new practice will be supported by cross-discipline training workshops.

In a specialty which treats complex, multifactorial disorders, evidence-based principles are important in ensuring effective treatment. The RANZCP has recently published clinical practice guidelines on six common psychiatric conditions:

- schizophrenia
- bipolar disorder
- depression
- anorexia nervosa
- panic disorder and agoraphobia
- self-harm.

These guidelines stem from an earlier RANZCP project, carried out between 1981 and 1991, which produced ten evidence-based clinical practice guidelines for the common mental disorders – the first set of guidelines to be developed for any specialty. Comprehensive guidelines for clinicians are published in the *Australian and New Zealand Journal of Psychiatry* (Boyce *et al*, 2003), and versions for consumers and carers are available from the College's website or in booklet form. The RANZCP, with the assistance of funding from the Australian and New Zealand governments, is currently beginning the process of implementing these guidelines.

Improvements in mental health systems can be made only with the participation of those who use mental health services. Aware of this, the RANZCP invites consumer and carer representatives to sit on its Board of Professional and Community Relations, and is currently developing a broader policy of community engagement to inform the core areas of College business.

Looking ahead: community, workforce and international affairs

The RANZCP will build upon its existing practice to establish a programme of greater community participation, to use the lived experience of people with mental illness to inform the College's work, such as the training of psychiatrists, and in the ongoing professional development of RANZCP Fellows. Through engaging the community, the College hopes to make research partnerships to inform policy development and to advocate for improved and more accessible mental health services and psychiatric care.

The RANZCP aims to meet the challenge of mental health workforce shortages by improving recruitment into the profession. In addition, its training programme will broaden and support skills development in multidisciplinary practice, complex care coordination, specialised psychosocial interventions and leadership. Acquiring a basic understanding of, and respect for, the range of mental health disciplines is crucial during training and a key to ongoing professional collaboration. The College has also begun a programme to support psychiatrists trained overseas.

An important future focus for the RANZCP will be to establish and maintain collaborative working relationships internationally, particularly across the Asia-Pacific region. The College seeks to create closer links with neighbouring organisations and enhance public mental health promotion strategies in the region. To this end, an Office of International Relations is being established within the Office of the President and the Chief Executive Office to review strategic directions, respond to international issues, oversee international projects and build international relations.

The RANZCP will be hosting the World Psychiatric Association (WPA) World Congress in Australia in 2007. The WPA Congress is held annually and is one of the largest psychiatric meetings, attracting over 5000 participants from around the world. The RANZCP, in partnership with the WPA, has proposed a WPA Asia-Australasia Partnership Initiative for Mental Health to develop collaborations with membership societies in Asian countries and promote a programme for education and training to advance the best practices of clinical psychiatry. Such education and training aim to help member societies to improve and extend mental health service delivery to their citizens.

References

- Boyce, P., Ellis, P. & Penrose-Wall, J. (2003) Introduction to the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines series. *Australian and New Zealand Journal of Psychiatry*, **37**, 637–640.
- Rubenstein, W. D. & Rubenstein, H. L. (1996) *Menders of the Mind: A History of the Royal Australian and New Zealand College of Psychiatrists, 1946–1996*. Melbourne: Oxford University Press.

In both countries there is an under-supply of psychiatrists, and the shortage is particularly acute in rural and remote areas. The RANZCP recognises that workforce shortages and difficulties in recruitment are significant and constitute a major challenge to service provision, and is attempting to improve recruitment into the profession.

Royal Australian and New Zealand College of Psychiatrists.
Clinical Practice Guidelines for Consumers and Carers. Updated 21 March 2005:
<http://www.ranzcp.org/publicarea/cpg.asp>

News and notes

For contributions to this column, please contact Brian Martindale FRCPsych, Early Intervention in Psychosis Service, South Tyne and Wearside NHS Mental Health Trust, Monkwearmouth Hospital, Newcastle Road, Sunderland SR5 1NB, email: Brian.Martindale@stw.nhs.uk

The Board of International Affairs and the College meeting in Edinburgh, June 2005

This was the first annual meeting of the College following the formal creation of the College's six International Divisions and the elections of their chairpersons. Four of the divisions gave symposia to the meeting and next year in Glasgow there will be an opportunity for all six to do so. In addition, the Board of International Affairs (BIA) organised the important session described immediately below in the core programme of the College.

Recruitment and migration of psychiatrists from developing countries

This is an ethical issue and represents a conflict between social responsibility and individual freedom of choice. The active recruitment of psychiatrists has been of concern to the BIA and others for a good while and the January 2005 issue of *International Psychiatry* (number 7) had several articles on the topic. At the session we had three excellent speakers and therefore were able to get a range of views.

Professor Santosh Chaturverdi spoke from the experience of having been an International Fellow from India who has returned to his country. Particularly helpful was his account of the steep pyramidal system and bureaucratic structures that restrict access to psychiatric training in India to a very small proportion of those who wish to undertake it. At this level, the UK is not draining India's psychiatric resources; in fact, the UK is training many who would never have the chance to train as psychiatrists in India. At the qualified level, Professor Chaturverdi spoke of the considerable benefits to him and his home institution in Bangalore from his experience of having been a Fellow in the UK. He implied that without such exchanges there is little stimulus to develop and change practice. He also spoke of family benefits, such as his capacity to educate his children well as a result of his period as a Fellow, during which his income was dramatically increased. He did not discuss the problems stemming from those trained psychiatrists who leave developing countries and do not return.

Professor Srinivasa Murthy has worked most of his life in South Asia but is now the Regional Mental Health Officer for the World Health Organization's Eastern Mediterranean Region. He stated that foreign recruitment affects not only service provision but also local training, research and professional support for voluntary

organisations. He raised important questions about the moral responsibility of the College and the stance it could take. He gave statistics that focused especially on Africa, with its huge disease burden and shortage of skilled professionals (25% of the world's health burden and 1.3% of the skilled health force); some countries have less than one-fifth of the number of psychiatrists per head of population than even India. While deploring active recruitment, he also suggested a number of alternative solutions to the dependency on psychiatrists for mental health problems such as alcoholism, dementia, self-harm and the mental health consequences of disasters. These included psychiatric involvement in facilitating responses by the community, by families, by teachers and by primary healthcare personnel, as well as self-care.

Professor Norman Sartorius, former Director of the World Health Organization's Mental Health Division and past President of the World Psychiatric Association (WPA) and of the Association of European Psychiatrists, emphasised the draining of the specialty's intellectual power base in developing countries and the sapping of a community's morale through the loss of health staff, especially when oppressive regimes are in power. He gave an excellent historical context of the current trends and made a number of suggestions as to how situations could be ameliorated.

It was most satisfying to hear that the new Presidents of the College and the WPA were in agreement that they would work collaboratively in their period of office to produce international guidelines and perhaps an ethical code in this important area.

Psychiatry in its international diversity – the College's International Divisions programme

The programme this year particularly aimed to capture the diversity of psychiatric practice in the Divisions and the challenges faced by those who develop services, as well as practitioners. The following is just a snapshot of a very full day of interesting presentations that highlights the common problem of resource limitations and also summarises some developments that begin to meet the challenges.

The Pan-American Division

Nigel Bark, chair of the Pan-American Division, gave an overview of the cultural heritage in the Americas and highlighted differences in the kinds of interventions given to members of different cultures, such as the greater use of traditional neuroleptics by Black Americans and more

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particularly their use in higher doses. He also highlighted the lack of adequate medical interventions for the large number of uninsured persons in the USA, the inequalities for rural populations and the need for more up-to-date studies of mental health issues among immigrants.

Dr Maria-Elena Medina-Mora from the National Institute of Psychiatry, Mexico City, gave the results of an epidemiological survey showing the high incidence of psychiatric disturbances, although a relatively low rate of some of the more severe illnesses. Particularly important was the evidence that only a very small proportion of people with a psychiatric illness access services – only a third making any use of them at all.

Dr Stephen Kisely from Dalhousie University in Nova Scotia gave a most useful report on an epidemiological study from linked databases showing that in spite of the principle of universal access to healthcare, patients in lower socio-economic groups and those with psychiatric illness had a considerably higher mortality from physical disorders and that this included patients with psychiatric disorder treated in primary care and by outpatient services. The findings also indicated a reduced rate of use of investigations for physical problems in psychiatric patients.

In the absence of the third speaker we were fortunate to have Dr Khaled Mufti from Pakistan, who spoke of the serious mental health problems in refugees from Afghanistan, of whom 60% suffer from post-traumatic stress disorder and a large number from depression and substance misuse. The paper was accompanied by a disturbing video that recorded the kind of traumas to which the Afghans were exposed. Lack of access to treatment resources was again highlighted.

The African Division

Dr Femi Olugbile gave the findings from a survey of 250 street children in different parts of Lagos, Nigeria. The survey indicated the need to characterise street children better if attempts at their rehabilitation are to succeed. A particular finding was the large number of 'area boys': young males who have dropped out of education and are involved in petty crime, have a high level of poly-substance misuse and have little contact with their families. Another significant group are vagrant people with a psychosis. He discussed the implications for state policies and for professional services.

Professor Tuviah Zabow from the University of Cape Town is the newly elected Chair of the African Division. He focused on the special needs of people with a learning disability in South Africa and the history of their needs being neglected, or their being passed to other agencies. He outlined the progress being made by multi-agency task forces looking at different aspects of their needs, including those with dual diagnoses, the overcoming of stigma, training and research needs, and the need to keep in focus ethical issues such as sterilisation.

Dr Fred Owiti from Nairobi, Kenya, reported on a 6-year survey of mental health disturbance in 1200 persons who were arrested for violent crimes and referred for a mental health opinion. A large number

were unemployed, a third were vagrant and violent crime exceeded property crime. There have been important changes in the Kenyan Mental Health Law that have improved cooperation between the courts and the mental health services.

The Middle Eastern Division

Dr Fuad Antum from the Lebanon gave a clear account of the diverse religious and cultural influences in the Lebanon and their interaction with mental health issues. Of particular interest was the relation between different cultures and stigma, and the extent of belief systems in supernatural powers and the varying attitudes to death.

Professor Said Azim of Giza in Egypt gave a similarly informative talk about the different and changing attitudes to sexuality, love and passion in various Middle Eastern cultures. He covered variations in attitudes to monogamy and polygamy, virginity, circumcision, masturbation and homosexuality, and the differences between religious beliefs and traditions in some of these areas. He highlighted the need for much better education of doctors so that they could better attend to relevant aspects that came to their attention.

Dr Sherif Atallah, from Cairo in Egypt, gave a most interesting talk about issues related to private psychiatric practice in Egypt. He highlighted the lack of information and discussion about the many issues. Nearly all psychiatrists in Egypt spend some time in private practice; the need to earn a better income is a primary motivator. His survey indicated the high level of stress involved, the risk of burn-out, the isolation of professionals and the pressures from families for 'cure', which may lead to more aggressive therapies being used. He raised a number of important issues, such as when to refer to a colleague, complex dependency issues and the different role of the family to that in Western cultures and the relative lack of experience and use of psychological therapies.

The South Asian Division

Professor Haroon Ahmed from Pakistan is the chair of the Division and he gave a very open account of the difficulties encountered in contemporary psychiatric practice. Mental illness is widely believed to result from possession states or is looked upon simply as 'madness'. In the former there remains a tendency to believe that the possession is the result of the activities of another person and to seek spiritual treatments, which can be expensive and delay medical intervention. A worrying feature of South Asian psychiatry is the low rate of referrals from family and other doctors, and related to this the very low rates of diagnosis of the many presentations of depression relating to social stressors. Interventions are nearly always confined to pharmaceutical ones. Overall, continuing medical education is not at all prominent, and there are concerns about the domination and influence of the pharmaceutical industry. There is ready access to neuroleptics without the need for prescription. There are very few facilities catering for the mental health needs of children. He is hopeful that

A worrying feature of South Asian psychiatry is the low rate of referrals from family and other doctors, and related to this the very low rates of diagnosis of the many presentations of depression relating to social stressors.

the development of a South Asia Division Committee will provide some leadership and guidelines for future progress and improve communication and education.

Dr Mohammed Mullick from Bangladesh gave a very helpful overview of demographic features. He made us aware of the extent of the unmet need of adults and children for mental health services and informed us of some local differences from the West, such as the earlier onset of dementing illnesses and the better prognosis of schizophrenia (resulting from the acceptance of families), the high rate of depression presenting in somatic forms and the frequent religious content of obsessive–compulsive disorder. He gave clear ideas as to how the few psychiatrists (1 per 2 million population and only 1 child psychiatrist) needed to function, especially in relation to primary care, and he also had hopes that the Division would lend considerable support and assistance to psychiatrists in the region.

Professor Nalaka Mendis of Colombo, Sri Lanka, focused on overcoming the lack of psychiatric training at medical school and in general practice by a new programme, initiated in 1995, through which medical students are sensitised to a wide range of relevant subjects and evaluated through continuous assessment in their competence to manage patients in whom psychosocial aspects are important components of their disease. The intention is that these areas will feature in at least 3 years of the undergraduate course. The effect of this training is a far better attitude on the part of graduates of all disciplines to the psychological aspects of patients' problems.

Leaders of national and European psychiatric organisations

In April 2005 the leaders of national and European psychiatric organisations had their sixth meeting, in Munich, before the conference of the Association of European Psychiatrists (AEP). These European leadership meetings address key issues of the profession and are shaping a European identity for psychiatry.

This year's meeting was on leadership and organisational functions of psychiatric societies. Dr Anders Milton, head of National Psychiatric Services

Coordination in Sweden, addressed the meeting. He focused especially on the need for psychiatrists to lead in coordinating the systems of care between the different mental health professional groups, ensuring that responsibilities are clearly defined and coordinated so as to maximise care and minimise dangers.

The workgroups that discussed the day's themes agreed that most psychiatrists needed more training to help professional societies develop their organisational capacities and competence and for psychiatrists to take leadership roles. The workgroups highlighted a number of areas where organisational competency was needed.

The meeting took place 3 months after the Helsinki Europe-wide Ministerial Conference on Mental Health, and Dr Matt Muijen summarised the outcomes. (Details are available at the website <http://www.euro.who.int/mentalhealth2005>.) The resolutions provide a number of opportunities for psychiatric organisations and their leaders to take important initiatives that related to the theme of the day.

The meeting resolved the following:

- The Helsinki Declaration should be translated into all national languages.
- All national psychiatric organisations and governments are recommended to adopt the document formally.
- Constructive comment should be made by all psychiatric organisations on the local adaptation and local implementation of plans. Decisions should be made in consultation with national mental health boards.
- The Europe-wide psychiatric organisations – the European Union of Medical Specialists (UEMS), AEP, the WPA and the European Task Force should adopt the Helsinki Principles and act in partnership with the World Health Organization to deliver the aims of the implementation plan.
- Psychiatric organisations should encourage local and national media to cover their governments' acceptance of the Helsinki agreement.
- Symposia focusing on the declaration should be conducted in European conferences in the next 2 years, focusing especially on an exploration of common values and progress with the Declaration.

Tsunami and an international perspective on psychiatry

Sir: I have just read the opening editorial in the April 2005 issue of *International Psychiatry* (no. 8) regarding the tsunami that struck at the end of last year, and wanted to relay my thanks for a well written piece. I was actually in Chennai, India, when the tsunami struck and so was able to get involved with some of the relief and rehabilitation work.

I am very interested in international psychiatry and consequently read *International Psychiatry* when I get the time. Research and capacity building in the field of global mental health is so undervalued it is good to see an organisation proactively addressing these deficits.

Arun Gopal

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email: arun_gopal@med.unc.edu*

The APA and the new Pan-American Division of the College

Sir: In the elegant, well upholstered and well named lounge/director's room of the Ritz-Carlton Hotel in Atlanta, the Pan-American International Division of the Royal College of Psychiatrists – proudly representing the 37 countries of the Americas – held its inaugural meeting: a reception hosted by the Chair of the Division (Nigel Bark, and his wife, Helen) for members, fellows and guests attending the annual meeting of the American Psychiatric Association (APA), with a large delegation of College officers and staff, including Hamid Ghodse, who has led the drive to form International Divisions, Richard Williams representing the College President and many others.

This actually was the 27th year since the North American 'Society', 'Chapter' and later 'Group' started having receptions at the APA. For the last 4 years we have also held symposia with speakers from the other International Divisions. This year, paralleling the theme

of the APA meeting, the symposium was on 'A World View of Medical and Psychiatric Comorbidity', covering history (Nasser Loza, Egypt), mortality (Frank Njenga and Pius Kigamwa, Kenya), the somatic presentation of depression (Khalid Mufti, Pakistan), outcomes (Stephen Kisely, Canada) and substance misuse (Maria Medina-Mora, Mexico), with John Cox (past President of the College and Secretary of the World Psychiatric Association) summing up.

Nigel Bark

*Chair of the Pan-American Division,
Royal College of Psychiatrists*

International meeting in Coventry

Sir: The Midlands Psychiatric Research Group organised its annual international meeting in Coventry on 2–4 June 2005. This educational event was arranged in collaboration with the World Psychiatric Association (WPA) and the World Association for Psychosocial Rehabilitation (WAPR). The scientific programme included speakers from the USA, Greece, India and Pakistan, along with experts from the UK who presented an update in different fields of mental health.

The participation of Professor Hamid Ghodse and Dr Brian Martindale from the Board of International Affairs of the College reflected the keen interest of the College in establishing links with international psychiatry.

The meeting provided all the UK participants with an opportunity to have updates in a number of mental health areas with overseas colleagues and also generated a lot of interest in future collaborative work with different countries. It urged the College to continue taking the lead in promoting such links, such as the establishment of its International Divisions. In this way members of the College can contribute significantly to the promotion of mental health services around the globe.

Afzal Javed

Deputy Registrar, Royal College of Psychiatrists

Correspondence is welcome on any of the articles or issues raised in *International Psychiatry*. Letters of no more than 500 words should be sent to the Editor, Hamid Ghodse, email: hghodse@sghms.ac.uk

Forthcoming international events

6–8 October 2005

V European Congress on Mental Health in Mental Retardation: Integrating Research and Practice
Barcelona, Spain.
Contact: Dr Luis Salvador-Carulla.
Email: luis.salvador@telefonica.net
Website: www.aeecrm.com

20–21 October 2005

4th European Conference on Violence in Clinical Psychiatry
Good clinical, evidence-based practice for understanding and managing aggressive and violent behaviour
Otto Wagner Hospital, Vienna, Austria.
Email: conference.management@freeler.nl
Website: www.oudconsultancy.nl

20–23 October 2005

Fourth International Congress on Vascular Dementia
Porto, Portugal.
Contact: Kenes International – Global Congress Organisers and Association Management Services, 17 Rue du Cendrier, PO Box 1726, CH-1211 Geneva 1, Switzerland.
Email: vascular@kenes.com
Website: www.kenes.com/vascular

30 October–2 November 2005

Strengthening Bonds Opening Horizons. Psychiatry and its bonds as a medical specialty
WPA Regional Meeting, Mexican Psychiatric Association
Los Cabos, Mexico.
Contact: Dr Luis E. Rivero Almanzor.
Email: aspsiqm@prodigy.net.mx

3–6 November 2005

55th Annual Meeting of the Canadian Psychiatric Association
Vancouver, British Columbia, Canada.
Email: asaunders@cpa-apc.org
Website: www.cpa-apc.org

12–13 November 2005

1st Asia-Pacific Conference on Trauma Psychology: Life Adversities and Challenges
Chinese University of Hong Kong.
Email: trauma@psy.cuhk.edu.hk

15–18 November 2005

XIV Russian Congress of Psychiatry
WPA co-sponsored conference with the Russian Society of Psychiatry.
Email: krasnov@mtu-net.ru

16–20 November 2005

WPA Regional Meeting and XIX Congreso Nacional de la Asociación Psiquiátrica Mexicana
Los Cabos, Mexico.
Contact: Dr Luis E. Rivero Almanzor.
Email: aspsiqm@prodigy.net.mx

17–20 November 2005

2nd Congress of the International Society on Brain and Behaviour
Thessaloniki, Greece.
Website: www.psychiatry.gr/intro_brain2_eng.html

25–26 November 2005

Second Workshop of Franciacorta. New Developments on Diagnosis and Treatment of Mood Disorders
WPA Section on Private Practice.
Provaglio d'Iseo, Brescia, Italy.
Contact: Dr Giuseppe Tavormina.
Email: president@censtupsi.org
Website: www.censtupsi.org

25–27 November 2005

Second International Mental Health and Cultural Psychiatry Conference
WPA co-sponsored conference with the Indo-Australasian Psychiatric Association, Australasian South Asian Psychiatry Forum.
Sydney, Australia.
Email: RDSOUZA1@bigpond.net.au

2–4 December 2005

First Conference of the South Asian Association for Regional Cooperation (SAARC) Psychiatric Federation
WPA co-sponsored conference.
Agra, India.
Contact: Dr Roy Abraham Kallivayalil.
Email: ktm_roykalli@sancharnet.in; ucg@sancharnet.in; uttam_garg@yahoo.com

6–8 December 2005

3rd International Conference on Psychiatry: Mental Health in Developing Countries: Challenges and Prospects
Dhaka, Bangladesh.
Email: bap@agni.com
Website: www.icp2005.info

3–6 March 2006

Affective Disorders: Integrated Approaches Across the Lifespan
WPA co-sponsored conference with the International Society for Affective Disorders.
Lisbon, Portugal.
Website: www.isad.org.uk

4–8 March 2006

14th European Congress of Psychiatry: 'New perspectives on treatment in psychiatry'
Association of European Psychiatrists (AEP)
Nice, France.
Email: aep2006@kenes.com
Website: www.aep.lu; www.kenes.com/aep2006

6–10 March 2006

14th European Congress of Psychiatry
Association of European Psychiatrists.
Website: www.aep.lu

30 March–1 April 2006

15th Annual Meeting of the International Association for Forensic Psychotherapy: Perspectives on Crime and Punishment
St Catherine's College, Oxford, UK.
Email: 2006reg@forensicpsychotherapy.com

20–23 April 2006

WPA thematic conference (Zone 8) Lopez Ibor Foundation
Madrid, Spain.
Contact: Dr Juan J. Lopez Ibor, Jr.
Email: jji@lopez-ibor.com

16–20 May 2006

2nd Kyoto Conference: The interfaces between psychology, psychotherapy, analysis and Buddhism
Email: dalemthers@yahoo.co.uk; miller@norwich.edu

13–16 June 2006

15th ISPS Congress (International Society for the Psychological Treatments of Schizophrenia and other psychoses)
Madrid, Spain.
Contact: Dr Manuel Gonzales de Chavez.
Email: mgchavez@teleline.es
Website: http://www.ispsmadrid2006.com/

14–17 June 2006

Prevention and Treatment of Psychiatric Disorders
13th European Symposium of the Epidemiology and Social Psychiatry Section of the Association of European Psychiatrists (AEP).
Bordeaux, France.
Email: contact@aep-epidemiology2006.fr
Website: www.aep-epidemiology2006.fr

10–13 July 2006

Royal College of Psychiatrists' Annual Meeting
Glasgow, UK.
Email: conference@rcpsych.ac.uk
Website: www.rcpsych.ac.uk/2006