Royal College of Psychiatrists

International Psychiatry

ISSN 1749-3676 (print)
ISSN 1749-3684 (online)

Vol. 3, No. 1, January 2006 *Bulletin of the Board of International Affairs of the Royal College of Psychiatrists*

Contents

Subscriptions

International Psychiatry is published four times a year.

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Annual subscription rates for 2006 (four issues, post free) are £25.00 (US$45.00). Single issues are £8.00 (US$14.40), post free.

Contributions for future issues are welcome – please contact Hamid Ghodse
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Printed in the UK by Henry Ling Limited at the Dorset Press, Dorchester DT1 1HD.

US mailing information
International Psychiatry is published quarterly by the Royal College of Psychiatrists. Subscription price is $45. Second class postage paid at Rahway, NJ. Postmaster send address corrections to *International Psychiatry*, c/o Mercury International, 365 Blair Road, Avenel, New Jersey 07001.

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Internet pharmacies

Hamid Ghodse

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Shopping on the internet has become routine for many people and covers a wide range of products and services. It is therefore unsurprising that, in some countries, medical and pharmaceutical services can also be bought. This has clear advantages in countries such as Australia, where some communities are isolated by huge distances (or other geographical circumstances) but are able to access the internet. However, shopping for psychotropic substances is not quite the same as shopping for toothpaste or televisions. These drugs are subject to strict controls, including the requirement for prescription by a qualified medical practitioner. It is possible to implement systems so that internet shopping for and mail delivery of psychotropic substances conform to regulatory requirements; if this is done, internet pharmacies can be valuable in ensuring an adequate supply of medical provisions to all citizens, wherever they live (US General Accounting Office, 2000). However, these same sales opportunities can easily be exploited by unlicensed internet pharmacies and it is the problems caused by these illicit 'cyber-pharmacies' that are now the cause of grave concern.

Firstly, there are concerns about the quality and cost of the drugs they dispense. Because they are unregulated, there are no guarantees of the quality of the pharmaceuticals that they sell, which may be counterfeits, produced anywhere in the world. Figures from the World Health Organization (2000) suggest that developing countries account for around 77% of all reported cases of counterfeit and substandard drugs. Intuitively, it might be expected that internet pharmacies would be cheaper than conventional, licensed premises because they do not incur the traditional overheads of premises and staff. However, investigations carried out in the United States and in a number of European countries reveal that illicit internet pharmacies are more expensive than licensed ones. Moreover, the costs incurred in shopping from them are unlikely to be refunded by national health systems if the drugs are obtained without prescription (International Narcotics Control Board, 2005).

However, the main concern about internet pharmacies is that they make it very easy to obtain prescription-only medicines without a prescription and there is evidence that they are being used in just this way. Investigations in the United States of illicit internet pharmacies show that the proportion of prescription drug sales within their total sale of pharmaceuticals is significantly higher than for the licensed traditional pharmacy. Indeed, some of the sites explicitly advertise that they provide prescription drugs without prescription or that the dispensing pharmacy will issue the prescription when the internet order is placed. These companies act in full awareness of the illegal nature of their trading, and work on the assumption that, owing to the huge amount of internet traffic and of physical shipments, only a fraction of illegal operations will ever be detected.

Some of the sites explicitly advertise that they provide prescription drugs without prescription or that the dispensing pharmacy will issue the prescription when the internet order is placed.

Even more worrying is the fact that the vast majority of sales of prescription drugs ordered over the internet – sometimes more than 95% – relate to internationally controlled psychotropic substances. This information is confirmed by data analysis and case studies undertaken in European and Asian countries, which have also confirmed that most are sold to people without requiring the prescriptions mandatory for psychotropic medicines (International Narcotics Control Board, 2005). Psychotropic substances such as benzodiazepines, central nervous system stimulants, sedative hypnotics, antidepressants and narcotic drugs are subject to very strict levels of international control, as many of them can have fatal consequences if consumed by patients who have not undergone medical examination. In addition to a range of side-effects, many have a high abuse potential and individuals may become unwittingly dependent on them if they take them without medical supervision. For those who are already dependent, it is possible to maintain their supply very easily because they can obtain their drugs by a simple mouse click. Indeed, drug-dependent individuals may see little need to seek professional help if they can obtain their drugs so easily. Measures put in place in various countries to help drug-dependent individuals are undermined by the ready availability of drugs on the internet and this can have far-reaching consequences for public health. Quite simply, psychiatric conditions and the use of psychotropic medication need professional supervision and there are obvious problems associated with self-medication by those with mental health problems.

The vast majority of sales of prescription drugs ordered over the internet – sometimes more than 95% – relate to internationally controlled psychotropic substances

A specific issue of grave concern is the impact on young people. As the vast majority of internet pharmacies despatch drugs without requiring a valid prescription or, in cases of online doctor consultations, without verifying personal details of the 'patient', there are no checks on the age of their customers. In countries such as the United States, illicit commerce over the internet has been identified as one of the major sources for the misuse of prescription medications among children and adolescents.

It is difficult to gauge the true scale of the internet pharmacy market but several billion doses of medicine are sold in this way. Systematic searches on the internet and evidence collected and analysed by regulatory and law-enforcement authorities indicate that the illicit sale of psychotropic drugs through the internet is a serious global problem, with total profits estimated to be billions of US dollars (International Narcotics Control Board, 2005). At present, most of the customers are in industrialised countries, where there is generally readier internet access. However, the scope of the market is clearly global because ordering over the internet with shipment by mail is, at present, unrestricted, as long as technical access is available. Therefore, there is an immediate risk of expansion to all parts of the world, with consequent exposure of the most vulnerable – individuals and countries – to unrestricted access to psychotropic and narcotic drugs without professional and regulatory supervision.

The solutions will have to be multifaceted, covering monitoring programmes, physician training and public education. Psychiatrists can and should play an important role in all these aspects.

It should be apparent to all that there is an urgent need to develop strategies to tackle these problems. The solutions will have to be multifaceted, covering monitoring programmes, physician training and public education. Psychiatrists can and should play an important role in all these aspects. The pharmaceutical industry, medical community and governments need to work in partnership and look for new initiatives and technologies to identify, investigate and prosecute illicit internet pharmacies.

Consumers need to be made aware that obtaining prescription-only medicines without prescription is illegal and that it can be medically dangerous. Equally, the judiciary will have to accord more importance and adequate penalties to illicit sales of pharmaceuticals, and especially of controlled drugs. However, it should be emphasised that enforcing existing laws in all countries would make a significant contribution to preventing the diversion of psychotropic drugs, and the competent authorities in all countries should therefore seek to identify and rectify weaknesses in their national regulatory systems as well as in their reporting and inspection procedures.

However, global problems usually require global action and the problems associated with internet pharmacies are no exception. Drugs can be ordered from anywhere in the world and shipped to anywhere in the world. Therefore, effective action requires close international cooperation and, above all, the political will of all governments to accord importance to the matter. Specifically, the anonymity conferred by the internet sets new challenges for those investigating the diversion of psychotropic drugs as well as for those responsible for its prevention. However, significant synergies could be achieved in concerted international effort through a wide range of regional and international organisations, such as Interpol, the World Customs Organization, the World Health Organization, the Universal Postal Union and the internet service providers, in addition to the medical and pharmaceutical establishments.

The United Nations International Narcotics Control Board brought the problem of illicit internet pharmacies to attention as early as the 1990s, and it has sought preventive measures. At its 50th session, in 1997, the World Health Assembly adopted a resolution requiring its member states to take action against the uncontrolled sale of pharmaceutical products on the internet. In July 2004, the United Nations Economic and Social Council urged member states to require companies within their national borders to supply internationally controlled psychotropic drugs via the internet only to persons who have met all the medical and legal requirements. It also encouraged the competent authorities to increase public awareness of the risks inherent in obtaining drugs in this way, particularly in relation to the uncertain quality of the products and the disadvantages of having no accompanying medical supervision (International Narcotics Control Board, 1997; United Nations Economic and Social Council, 2004).

The internet is revolutionising lives in the 21st century just as electricity and the telephone changed lives in the last century. As with many innovations, its advantages are accompanied by challenges, and this is undoubtedly true in relation to internet pharmacy. Well regulated, it has the potential to contribute to health service delivery; unregulated, it will be a major hazard to individual and public health. Committing a crime in an electronic environment – 'cyber crime' – is easy. Few resources are required and there is generally little danger of prosecution, because these crimes are notoriously difficult to detect and investigate, often across several jurisdictions. International cooperation is essential to prevent the internet turning into a World Wide Web of psychotropic drug trafficking and crime. Regulatory bodies must restructure themselves into operational and functional networks at a global level if they are to succeed in destroying organisations that are trafficking psychotropics. Professionals and the public should be vigilant about the mental health consequences of illicit pharmacy on the population in general and on those with mental health problems in particular.

Thanks to Mr Koli Kouame, Ms Carmen Selva-Bartolome and Ms Gisela Wieser-Herbeck for their contribution to this article.

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Increasing rates of suicide across cultures

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Suicide, especially among young people, appears to be increasing in prevalence in diverse countries and cultures. The reasons for this worrying trend remain obscure. Here we present commentaries on suicidal trends in three countries.

First, Masahito Fushimi and colleagues from Japan draw our attention to the dramatic increase in the number of suicides, especially in Akita Prefecture, where the rate is double the national average. It is extraordinary to read that not only was the highest suicide rate among those of middle age, but the cause of death was usually by hanging, a mode of suicide that is rather unusual outside certain penal institutions in the UK. Economic worries are thought to be an important aetiological influence; they have been exacerbated by the 15 years in which Japan has experienced debt and deflation-ridden economic stagnation. There is also a worrying trend for younger people to engage in suicide pacts made via the internet, a vogue that is now worrying countries in the West as well.

Brazil is a diverse and vibrant country with very different cultures and huge discrepancies in wealth, both within and between regions. The suicide rate is apparently astonishingly low by international comparison, although the country's religious culture may mean that the reported rate is an underestimate. Even so, there has been an increasing risk of suicide over the last two decades, especially among young people. Carolina de Mello-Santos and colleagues discuss this trend, which, in terms of preferred method, is linked especially to the wide availability of firearms (although poisoning and hanging are also common). Increasingly, young single males with low educational attainments and poor economic prospects are the victims.

Finally, Dr N. K. Ndosi provides a fascinating account of suicides in Africa, from the perspective of Tanzania. In Africa, we are told, there are very strong societal prohibitions against suicide, which brings opprobrium on the family of the victim. Despite these attitudes, there is a trend to increasing suicidal behaviour in sub-Saharan Africa, especially among the young, which could be related to increasing urbanisation and the breaking down of traditional cultural structures which militated against the behaviour in former times. We find not only aetiological factors that are culturally relatively specific, such as the oppression of women in patriarchal societies, but also the creeping in of those that were formerly concerns within deprived inner cities in the West, such as heroin addiction. The role to be played by psychiatrists in the primary and secondary prevention of suicide in the diverse cultures discussed in these articles is discussed by all contributors.

It is extraordinary to read that not only was the highest suicide rate among those of middle age, but the cause of death was usually by hanging, a mode of suicide that is rather unusual outside certain penal institutions in the UK.

Suicide in Akita Prefecture, Japan

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In recent years, the number of suicides in Japan has increased dramatically, particularly among middle-aged men. According to the *Brief Report on Suicides in 2001* by the National Police Agency of Japan (NPA, 2002), the number of suicides in Japan was 31 042, and the national suicide rate was 24.4/100 000. Akita is an agricultural prefecture with a population of approximately 1 200 000. According to the Akita Prefectural Police (APP), the number of suicides in Akita Prefecture was 457 (299 males, 158 females) in 2001. Akita Prefecture currently has the highest rate of suicide in Japan. The identification of strategies for suicide prevention is therefore imperative.

Psychological autopsy is useful for obtaining background information regarding suicide victims (Conwell *et al*, 1996; Cheng *et al*, 2000). However, obtaining consent for such studies from the families of the deceased is difficult in Japan. As members of the Akita Prefectural Medical Association (APMA) are thought to have many opportunities to obtain background information on suicides, an investigation of suicides in which members of the APMA are consulted might prove advantageous for accumulating representative data from a large number of cases. The present report describes the results of a questionnaire about suicide that was distributed to members of the APMA

in order to determine the factors underlying suicide in Akita Prefecture.

The survey

Typically, a suicidal individual recruits others on a message board. Subsequently, in a sealed car, they take sleeping pills and light charcoal stoves

Members of the APMA who had attended a suicide case were asked to complete a questionnaire about it. The APMA conducted this investigation from 1 July 2001 to 30 June 2002. The total number of suicides during this period was 138 (102 males, 36 females). A major peak in the number of suicides was observed among individuals in their 50s and 60s, particularly for males. Conversely, female cases increased in number in elderly age-groups compared with male cases. The most common method of suicide was hanging, which was observed in 105 cases (78 males, 27 females). Most suicides (94 cases) were performed at home. The number of suicides according to time of day tended to increase from midnight to early morning and from daytime to evening, which would be when the rest of the family was asleep or absent. Regarding physical disorders, the majority involved chronic diseases (e.g. hypertension). Depressive disorder was the most common psychiatric disorder. Furthermore, character traits which are thought to be strongly associated with depression were common.

The most frequently observed complaints were economic problems. In addition, different age-groups tended to present with different complaints. Specifically, for individuals under 40 years of age, most complaints involved private problems other than health-related ones. For those aged 40–59 years, most complaints involved economic problems. For older adults (those aged over 60 years), most complaints involved health-related problems.

Discussion

For individuals under 40 years of age, most complaints involved private problems other than health-related ones. For those aged 40–59 years, most complaints involved economic problems. For older adults (those aged over 60 years), most complaints involved health-related problems.

In 1998, the number of suicides in Japan increased sharply and the annual number of suicides exceeded 30000, making suicide a significant national problem. Particularly notable was an increase in suicides among middle-aged males.

Recently, in addition to suicide among middle-aged males, suicide pacts among young people who meet via the internet ('internet group suicide' cases) have been reported frequently in Japan, though this was not part of the survey. Typically, a suicidal individual recruits others on a message board. Subsequently, in a sealed car, they take sleeping pills and light charcoal stoves (*rentan*). Death results from carbon monoxide poisoning. In some cases, group members send emails to inform their family or friends just before the final act, or even after, with the message relayed from an automatic mailing system. The common use of charcoal stoves suggests that groups are imitating earlier cases reported by the media.

Statistics from the NPA indicate that when all suicide victims who left a suicide note are classified according to motive, 'health-related problems' represent the leading cause of suicide, followed by 'economic and life-related problems'. Since 1998, the number of cases falling into the latter category has increased substantially, to the extent that this motive is likely to surpass 'health-related problems' as the leading cause of suicide. The NPA reported that, among all suicides in 1998, 6058 were committed because of economic difficulties, which represents an increase of 70.4% from 1997. Furthermore, the 1999 NPA report showed that for 6758 individuals (20.4% of suicides) suicide was a result of economic difficulties, which was up 11.6% from 1998. In addition, the 2000 NPA report showed that concerns over economic difficulties accounted for 6838 suicides (21.4%). These findings clarify a potential relationship between suicide and economic strife (e.g. financial hardships, low income, or unemployment, as a result of the deep and prolonged recession of the Japanese economy). Indeed, the popular press has focused on the correlation between the current economic situation in Japan and suicide rates. According to the APP, the number of suicides in Akita Prefecture that are a result of economic and life-related problems has increased markedly. In 2002, this motive became the leading cause of suicide by surpassing health-related problems (the leading cause until 2001). Similarly, in the present study, economic problems were shown to be most common, followed by health-related problems.

Based on the results of the present study, suicides can be categorised into two groups: one considered to be relatively amenable to medical intervention; and the other considered to be relatively resistant to it. Included in the former group are suicides caused by several psychiatric disorders (depression in particular), while the latter group includes suicides influenced by social situations such as economic problems (e.g. Japan's prolonged recession). As noted in previous studies, early detection and appropriate treatment for depression are obviously crucial for suicide prevention (Rutz *et al*, 1992). However, the majority of middle-aged male suicides are thought to be performed in order to settle economic problems, which reflects current social conditions. In such cases, medical approaches alone may be insufficient for suicide prevention.

The present results do not exclude the possibility that economic problems are a major factor in the recent increase in the number of suicides. However, strategies for managing depression are also considered important.

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Further reading

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Suicide trends and characteristics in Brazil

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Brazil is the largest and most populous country in South America (in 2002 the population was approximately 175 million). Although life expectancy in Brazil has increased, suicide and other forms of injury-related mortality, such as homicide and accident, have increased as a proportion of overall mortality (Oswaldo Cruz Foundation, 1984; Brazil Ministry of Health, 2001). The suicide rate in Brazil (3.0–4.0 per 100000 inhabitants) is not considered high in global terms (World Health Organization, 1999). Nevertheless, it has followed the world tendency towards growth: during 1980–2000, the suicide rate in Brazil increased by 21%. Elderly people present the highest suicide rates in absolute numbers, but the alarming finding in the Brazilian data is that the youth population is increasingly dying by suicide (Mello-Santos *et al*, 2005). This statistic partially confirms a forecast by Diekstra & Guilbinat (1993) that the number of deaths by suicide would dramatically increase over the next decades, mainly in developing countries, including Latin America. In these regions, socio-economic factors (such as an increase in divorce and unemployment and a decrease in religiosity) increase the risk of self-harm. We discuss the reasons for the low suicide rate in Brazil and highlight the socio-economic factors affecting its increase among the youth population in particular.

Low suicide rate in Brazil: fact or artefact?

It is important to determine whether there was an actual increase in suicide rates in Brazil or whether it represents only a methodological artefact arising from the improvement in data collection at national level. The tendency for not all deaths to be notified in Brazil is common to other Latin American countries as well; the problem is compounded by the authorities' disregard (Grossi & Vassan, 2002). The Brazilian Mortality Information System, operated by the Ministry of Health, may be capable of tracing only about 80% of total deaths in Brazil, since 20% of deaths are not registered (Mello-Jorge *et al*, 1997).

Some peculiarities of the Brazilian health system may have affected the national statistics. One methodological problem of registering death is the difficulty of distinguishing suicide from other violent deaths, such as homicide and accident. Frequently, coroners do not record the basic cause of death on the death certificate, but instead explain only the nature of the lesion. In Brazil, suicide cases are registered according to the classifications in the 'external causes' section of ICD–10 (World Health Organization, 1992), which classifies lethal events not arising from biological diseases as: those resulting from violence, those resulting from fatal accidents, and suicide. This procedure hampers the gathering of conclusive data on the nature of the death, such as the non-accidental cases (e.g. exogenous intoxication in the case of alcohol-related car accidents). Brazilian authorities are more concerned with the registering of accidents and homicides than with the accuracy of suicide statistics, as homicide is the largest single cause of death in Brazil. During 1980–2002, the homicide rate in Brazil more than doubled, from 11.4 per 100000 population to 28.4 (Gawryszewski & Mercy, 2004).

Relatives and even the authorities often conceal the suicide for fear of judicial disputes or retaliation. There is a social prejudice against suicide and this results in non-disclosure (Mello-Jorge, 1988; Souza, 1991).

On the other hand, obtaining access to the means of suicide is easy in Brazil. The sale of psychotropics on the black market, the non-regulated and illegal carrying of guns, the ambiguous policy in relation to alcoholism, and the sale of caustic soda and rat poison in supermarkets are some examples. These

Elderly people present the highest suicide rates in absolute numbers, but the alarming finding in the Brazilian data is that the youth population is increasingly dying by suicide.

Brazilian authorities are more concerned with the registering of accidents and homicides than with the accuracy of suicide statistics, as homicide is the largest single cause of death in Brazil.

are the major means of attempting suicide. Pesticides are commonly used in rural areas. The recent disarmament campaign, the withdrawal of inflammable products from supermarket shelves, a prohibition of the sale of some types of rat poison and stricter pesticide sales regulations reflect increasing concern. However, the Brazilian government still has not adequately tackled the recent increase in suicide rates through control of the means of suicide.

Suicide among Brazilian youth: the role of socio-economic factors

Recent data indicate that Brazilian youths are dying more from violent causes than from biological ones.

The significant increase in suicide among Brazilian youths (those aged 15–24 years) is in line with a world tendency, in which the majority of suicides occur in the population aged 5–44 years (Bertolote & Fleischmann, 2002). From 1980 to 2000, the suicide rate in this age-group increased 1000% in Brazil. Female suicide within the same age-group increased only 400%, while the male increase was about 2000% (Mello-Santos *et al*, 2005). Our own data for the city of São Paulo, the largest and most important Brazilian city, can be used to illustrate the national findings: from 1996 to 2000, 66% of all suicides were by persons aged 5–44 years. Recent data indicate that Brazilian youths are dying more from violent causes than from biological ones. In nine Brazilian capitals surveyed, Souza *et al* (2002) noted a 27.6% increase between 1979 and 1998 in deaths due to external causes among individuals aged 15–24 years. Suicide was ranked sixth among the external causes.

The analysis of the young people who have died by suicide reveals a population in crisis. The common characteristics are being male, single and a non-specialised worker with low educational attainment (Souza *et al*, 2002). These factors, together with the highly competitive market economy, limited employment opportunities and low governmental incentives, further combined with professional and economic instability, make the young population vulnerable. Accordingly, these factors are related to feelings of hopelessness among the younger generation, which encourages their suicidal behaviour. However, more studies are necessary to clarify the relationship between socio-economic factors and suicide among Brazilian youths.

Suicide methods and gender

The male:female ratio for suicide is 3:1, which is consistent with the findings of international studies…. However, this ratio is reversed when we study suicide attempts: women are three times more inclined to attempt suicide than men.

The male:female ratio for suicide is 3:1, which is consistent with the findings of international studies (Bertolote & Fleischmann, 2002). However, this ratio is reversed when we study suicide attempts: women are three times more inclined to attempt suicide than men (Teixeira & Villar Luis, 1997).

The difference in gender also reflects the lethality of the methods chosen. Women opt for poisoning or overdose, whereas men look to violent and more lethal methods, such as hanging and the use of firearms (Teixeira & Villar Luis, 1997) – the two most common methods in Brazil (Souza *et al*, 2002; Grossi & Vassan, 2002). In Brazil, two important suicide methods, mainly used by women, should be mentioned: the use of methyl alcohol for self-immolation (Marchesan *et al*, 1997; Souza *et al*, 1998) and the ingestion of carbamate (a rat poison) (Lima & Reis, 1995). Men die by suicide typically because they seek a drastic solution to a personal problem; women generally attempt suicide in an attempt to improve adverse conditions (Teixeira & Villar Luis, 1997).

Information on family problems, religiosity and divorce are not available in the routinely collected data for suicide.

Conclusion

Even though their reliability can be questioned, the Brazilian data on suicide rates allow the identification of risk groups among the general population. The increase in the youth suicide rate is a worldwide phenomenon, not exclusive to Brazil. In spite of the low suicide rates among Brazilian youths, its steady increase over the last two decades is a reason for concern. The young population, who have few opportunities, are vulnerable to socio-economic factors. Preventive strategies directed at this population should be implemented in order to reverse this trend. Intervention studies with high-risk populations are tasks for Brazilian researchers and a challenge for the public health authorities.

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Perspectives on suicide in Africa

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Suicide is a serious worldwide health problem, particularly among youths. It is defined as the intentional act of killing oneself. Analytically, the suicidal act entails: the wish to kill, the wish to be killed and the wish to die. People who die by suicide know what they are doing and are aware of the consequences of their actions. A completed suicidal act is a complex phenomenon associated with psychological, biological and social factors. It follows severe exhaustion under a continuing assault of stressors when the suicidal individual is no longer able to cope with and to restore homeostasis. In order to categorise a case as a suicide, legal authorities demand unequivocal evidence of intent.

Common determinants of suicide

In many traditional African cultures people fear death by suicide and it is one of the strongest taboos. In East Africa suicide is a terrible event for family and close friends (Swift, 1977, p. 118). Rates of suicides were considered to be low in Africa as a result of both a paucity of depressive conditions and frequent communal clashes that diverted aggression away from the self and towards others (Elliott, 2001). This view is no longer tenable, however. Depression in Africans is not readily recognised, as it tends to present with somatisation, rather than feelings of guilt and self-reproach, unlike in Western cultures (Morgan, 1979).

Although there is rather little information on the causes of suicide in sub-Saharan Africa, there are indicators that the rates are rising, particularly among young people, and that the majority of cases result from overwhelming social factors (Lister & Wilson, 1990; Nwosu & Odesamni, 2001; Ndosi *et al*, 2004).

Rapid urbanisation in Africa is undermining the prevailing networks for social support and causing the social alienation of individuals. The ensuing diverse psychosocial pathologies increasingly predispose people to suicide (Ndosi, 2005). Young people experience more stress in relation to their as yet unmet expectations and demands from their governments. When emotionally overwhelmed, in the absence of people to confide in, they tend to develop suicidal thoughts.

Continuing poverty among Africans threatens the very fabric of existence. Some 340 million Africans live on less than US$1 per day (Heggenhougen & Lugalla, 2005, pp. 291–300). Extreme poverty destabilises lives, crushes self-esteem and creates despair, and this can lead to self-harm. Poverty marginalises, stigmatises and erodes human decency and leads to dependence and powerlessness. Unemployment and underemployment (as petty traders or lowly paid workers) subject young adults to hardships which enhance ruminations of self-destruction.

The gender identity of the majority of sub-Saharan women is deeply embedded in a cultural context of male dominance. Many women are thus pushed into defeat and helplessness, which makes them vulnerable. Conjugal relationships are fraught with jealousies, grief, feelings of abandonment and fear of contracting sexually transmitted diseases (Kabeer, 1993). Culturally, men have the right to discipline their wives, and wife-beating is widespread. Anger, shame and despair attain overwhelming levels, and suicide can be an expression of intolerable distress.

Despite the paucity of data, clinical observations indicate that a considerable proportion of young females who have become pregnant unexpectedly attempt and complete suicide when they are abandoned by their male partners (Ndosi & Waziri, 1997; Ndosi *et al*, 2004).

In clinical practice, about 90% of people who die by suicide suffer from an underlying psychiatric disorder (Ndosi *et al*, 2004). The risk of patients with a mental illness killing themselves is 3–12 times greater than that of people without psychiatric illness. In particular, the lack of dependable social support for those with schizophrenia can make them feel lonely and unwanted. They continue to suffer from the stigma attached to mental illness in their communities,

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and nearly a tenth of these patients complete suicide (Ndosi *et al*, 2004). The risk is higher among patients with poor adherence to medication, especially during the first 4 weeks after hospital discharge.

Young people with a personality disorder and from broken homes, who are often homeless or forced to reside in squats, tend to react impulsively with suicidal behaviour when overburdened by stress in their environments. Some of these youngsters misuse drugs and lead chaotic lifestyles. They often accumulate financial debts as a result of their addiction, which triggers severe interpersonal conflicts and emotional outbursts that culminate in self-harm. Heroin misuse among young males in urban sub-Saharan settings is on the increase. The risk of suicide among heroin misusers has been estimated to be 20 times that in the general population (Ndosi *et al*, 2004).

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Clinical observation indicates that alcohol dependence in sub-Saharan countries has lately increased considerably, and alcoholism has been noted to be the second most common psychiatric disorder among individuals who complete suicide. In a third of suicides in Dar es Salaam, alcohol was found to be an associated factor (Ndosi *et al*, 2004).

Patients with HIV infection have been found to be 35–40 times more likely to kill themselves than HIV-negative persons (Rajs & Fugelstad, 1992). Studies conducted in four African cities have shown an increased rate of suicidal ideation, suicidal attempts and completed suicide in individuals with HIV and AIDS (Buve *et al*, 2001). Among suicides in Dar es Salaam, the rate of HIV seropositivity was found to be at least twice that in the normal population. The suicide risk among poor HIV-positive persons tends to be higher if the HIV infection is advanced and accompanied by disabling illness.

The prevalence of epilepsy in poor African countries is notably high. People with the condition have a fivefold higher risk of killing themselves. This risk may be very much higher still in those with temporal lobe epilepsy.

Usual methods of suicide

Methods selected to complete suicide vary with age and availability, and are influenced by cultural values and social policy. Males outnumber females in violent methods of self-destruction. Culturally, African men are expected to summon stiffer resolve in difficult life situations. They show greater intent in their suicidal acts, which typically involve hanging, slashing or stabbing and gunshots, whereas females predominantly opt for poisoning. Uneducated and unemployed people in rural areas use hanging more frequently than the better educated, who prefer firearms more often. Insecticides, rodent poisons, organophosphates, DDT, kerosene and cheap chemicals are frequently used in cases of fatal self-poisoning in rural farming populations.

It is not surprising that rates of deliberate overdose in recent years appear to be increasing, as a result of the ready availability (over the counter) of therapeutic drugs (Mbatiya, 1997). The drugs commonly used include chloroquine (especially in malaria-prone regions), antibiotics, aspirin, paracetemol, psychotropic drugs, dilute sulphuric acid, antiseptic solutions and deworming medicaments.

Prevention

Strategies to prevent suicide need to employ traditional approaches that focus on community-based and clinical interventions. They should include restricting access to lethal means, providing services to high-risk groups and making medical services rapidly available. A suicidal patient needs emergency evaluation and help. Underlying psychiatric disorders have to be treated aggressively. Severe mental symptoms of depression, psychosis, aggression, impulsive acts and suicidal behaviour, when the capacity to cope is overstrained without reliable social support, call for hospital admission. Prevention of suicide includes precautions such as removing lethal drugs or firearms and dangerous objects from patients. Attempted suicide is one of the strongest indicators of suicide. The circumstances under which a suicide attempt was made and the choice of means can give some clue as to the seriousness of the risk.

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Sweden

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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).

With an area of 450 000 km², Sweden is one of the largest countries in Western Europe. It is 1500 km from north to south. It has nearly 9 million inhabitants (20 per km²). It is a constitutional, hereditary monarchy with a parliamentary government. Sweden is highly dependent on international trade to maintain its high productivity and good living standards. Many public services are provided by Sweden's 289 municipalities and 21 county councils. Municipal responsibilities include schools, child care and care of the elderly, as well as social support for people with a chronic mental illness. The county councils are mainly responsible for healthcare, including psychiatric care, and public transport at the regional level. Sweden is characterised by an even distribution of incomes and wealth. This is partly a result of the comparatively large role of the public sector.

The healthcare system

Sweden's healthcare system is governed through the three levels of government – central, county and municipality. Central government is responsible for legislation within the healthcare system, higher education (universities), research funding, the health insurance system, and general and directed subsidies to the counties and municipalities to help them carry out different public service measures. The 21 counties are responsible for specialised healthcare activities, which include hospitals and primary healthcare (general practitioners) and the medical professionals working there. The 290 municipalities are responsible for social services for elderly persons and those with a disability, including a mental disability. This includes not only social support but also medical nursing.

The public healthcare system is financed by taxes raised at all three levels of government. A minor part of healthcare is carried out on a private basis (mostly short-term treatment). Private care is most common in the big cities and is rare in rural regions. The management of the care and social services provided for people with mental disorders is handled by the counties and the municipalities.

In 2001 the total expenditure on medical care in Sweden was €19.1 billion, which represented 8.0% of gross domestic product (GDP). After allowing for income from patient fees and so on, the net cost to government was €12.1 billion.

Mental healthcare has achieved political prioritisation over the last 20 years, on the one hand through a national action plan for the development of healthcare and on the other by the introduction of a national mental health coordinator, combined with directed subsidies from the government for the development of mental healthcare.

Mental health services

Net expenditure on psychiatric care is €1.4 billion per year. The psychiatric treatment prevalence of adult persons is about 2–3% of the total population per year. In the bigger cities the treatment prevalence is higher (e.g. 4–5% in Stockholm).

Psychiatric care is divided between four different types of organisation: general psychiatry (for those aged 18 years or more); child and adolescent psychiatry; forensic psychiatry; and psychiatry of persons with drug misuse.

Hospital beds

In 1967 the mental hospitals were transferred from the state to the counties. At that time there were in total some 35 000 psychiatric beds (4 beds/1000 inhabitants), of which about 70% were in mental hospitals. Thereafter they began to close, and since the mid-1990s Sweden has had no beds in mental hospitals. Today there are about 4000 psychiatric beds (0.5 beds/1000 inhabitants), all of them in psychiatric wards in general hospitals (except 350 in forensic high-security hospitals).

In-patient care

The number of in-patients continues to decline. The proportion of beds occupied by persons under compulsory and forensic care was higher in 2005 than previously (Table 1). The reduction in bed numbers has been made possible through the out-patient care centres and the commitment of the municipalities to the psychiatric reforms of 1995 (see below). But there has been a re-institutionalisation. The beds in the former psychiatric hospitals have now to a certain degree been replaced by nursing homes and supported housing managed by the municipalities.

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Social services

The social services are responsible for the care of people with a disability, which includes people with a long-term mental illness. Expenditure on social services was €13.2 billion in 2000, or 5.7% of GDP. Unfortunately it is impossible to separate costs for

Table 1 Number of in-patients in Sweden, based on data from a single-day census

Form of care	1991		1994		1997		2005	
	Men	Women	Men	Women	Men	Women	Men	Women
Voluntary	4270	4659	3218	3396	1884	2141	2228 (total)	
Compulsory	1003	919	557	551	522	409	394	461
Forensic	731	106	677	58	699	71	809	126
Total	6004	5684	4452	4005	3105	2671	4022 (total)	

Source: National Board of Health and Welfare, Sweden (2005).

Today there are about 45 000 people with a chronic mental illness (0.7% of the total adult population) yearly in the care of social services or psychiatric care organisations. This is about a quarter of all patients in psychiatric treatment.

mental healthcare within social services from other costs. In 2002 there were some 8000 people with mental disabilities in 850 sheltered homes for whom the social services were responsible.

The social services also have responsibility for long-term care and economic support for persons with substance misuse disorders. In the year 2000 some 21 000 people aged 21 years or more were in receipt of such services, at a total cost of €406 million.

Development of psychiatric care

Community Mental Healthcare Reform, 1995

An evaluation of the sectorised organisation of psychiatric care showed, among other things, that patients with a long-term mental illness, for example those with schizophrenia, in a number of respects were not receiving satisfactory care. Their needs for medical treatment were mostly being met, but other needs (e.g. social support) were not. The responsibility for interventions regarding these needs was given to the social service agencies, with the Swedish Social Services Act of 1982. However, a parliamentary commission of 1992, the Committee on Psychiatric Care, concluded that social services were still largely inadequate and were not being provided in a satisfactory manner. Therefore, the mandate upon municipal social services was clarified through the Community Mental Healthcare Reform, which came into effect on 1 January 1995. The reform is directed towards individuals with severe and long-standing mental illness.

The aim of the reform was to take back into the local community people undergoing long-term treatment in psychiatric hospitals and nursing homes and to force social service agencies and psychiatric units to cooperate in their care for these people. The reform also clarified that social services had the primary responsibility to support anyone with a chronic mental illness in the community with housing, daily activities and rehabilitation.

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Legislation concerning psychiatry

The Swedish Disability Act 1994 aims to provide support and services for people with disabilities of various kinds, including psychiatric disorders. The law states a number of specific forms of assistance that these people can receive, including counselling and support, personal assistance, housing with special services, contact persons and companions. The Act is 'complementary' in that it cannot entail any curtailment of assistance to which the individual is entitled under other legislation. Moreover, it is civil rights legislation, and decisions can therefore be appealed against in the administrative courts. As of 2002, 2700 persons with a mental disability were in receipt of benefits under the Disability Act.

The Healthcare Act 1982 regulates the treatment of persons in need of medical or psychiatric treatment, whether by nurses in sheltered homes within social services or by specialised psychiatric care in these homes or in clinics.

The Social Services Act 2001 obliges the municipal social services to conduct outreach activities among persons with psychiatric disabilities. Social services are also obliged to plan their assistance programmes for these people in collaboration with the psychiatric care organisation and other social bodies and organisations.

The Municipal Financial Responsibility Act 1995 makes it incumbent upon the municipalities to pay for the care of patients who, after three consecutive months of in-patient treatment by a psychiatrist, have been deemed as fully medically treated within the psychiatric in-patient system but who are still being cared for in hospital because they cannot be transferred into community-based independent living or sheltered housing. One of the aims of this municipal financial responsibility is to stimulate the development of new forms of housing within the community for people with a mental disability who have been in long-term institutional care.

Problem areas

There are three groups for whom care provision in Sweden is at present problematic:

- patients with a chronic mental illness

- those aged 18–25 years
- those with a dual diagnosis of personality disorders and substance misuse.

Patients with a chronic mental illness

These persons belong mainly to the diagnostic categories of the psychoses and most (75–80%) have schizophrenic disorders. The Community Mental Healthcare Reform has meant that about 80% of these people live in the community, with support mostly from social services. The predominant problem is the degree of cooperation between social services and the psychiatric care organisations, which both have some responsibility for people with schizophrenia. Central government is trying to force the counties (psychiatric care) and the municipalities (social services) to create a joint organisation for the care and social support of these people. This has been legally possible since 1 July 2003.

Younger patients

The treatment prevalence of persons within psychiatric care has increased notably in recent years, mostly in out-patient services. In Stockholm county (in which one in five of the Swedish population resides) this number increased by 33% between 1997 and 2001 (from 45 000 persons to 60 000, or from 3.5% of the adult population to 4.5%). The increase is, however, most marked for people aged 18–25 years. Substance misuse is common in this group. A large part of psychiatric out-patient resources are directed to this problem but there has been no systematic effort to provide services directed to the psychiatric problems of 'young adult' persons. One solution would be to merge child psychiatry with adult psychiatry services. These care organisations at present mostly operate entirely independently.

People with personality disorders and substance misuse (dual diagnosis)

This category of psychiatric disorder has come to public prominence recently because of a few high-profile cases, notably one which involved the murder of Sweden's foreign minister, Anna Lind. Investigations showed that these persons often have a long history of treatment, have had early contact with social services and from a young age have engaged in criminal behaviour. A government inquiry has been launched to investigate how medical/psychiatric treatment and social services can be better coordinated for these people.

Suicide

Sweden has traditionally had a reputation as a country with a high suicide rate, but after marked increases in the 1960s and 1970s the rate steadily fell after 1979 (Table 2). The suicide rate for 2000, 19.0 per 100,000 population aged 15 years and over, was the lowest since the current classificatory system was introduced in 1969, and Sweden is now part of the middle group among European countries. Furthermore, the age differences in suicide fatalities are, from an international perspective, relatively small. In line with the general decrease, suicide rates for both men and women fell in the 20 years up to 2001, when certain suicide rates increased from the rather low levels in 2000. Public health specialists became concerned that this increase could announce a change in trend towards rising suicide rates. Figures for 2002 published by the National Board of Health and Welfare indicate a decrease in the female suicide rate in 2001/02, accompanied by a marginal increase in the male rate.

The reduced suicide rate has not been as evident among younger groups, however; in parallel, in international comparisons, the oldest age-group has a relatively low suicide rate.

Recruitment trends

According to statistics from the National Board of Health and Welfare, in 2002 there were 1700 doctors with a specialist qualification in psychiatry. Of these, 1400 were actively engaged in healthcare. The number of new psychiatrists who had received their training in Sweden increased over the period 1996–99 but the number fell thereafter (see Figure 1).

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Table 2 Numbers of suicides and suicide rates per 100 000 (men and women, aged 15 years and over), by age-group, for selected years 1980–2002

Year	15–24 years		25–44 years		45–64 years		65 years and over		Total	
	n	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate
1980	174	15.4	805	34.4	790	42.3	468	34.4	2237	33.4
1985	158	13.5	749	31.1	664	36.6	495	34.0	2066	30.2
1990	153	13.1	638	26.2	676	35.2	513	33.6	1980	28.1
1995	131	12.1	568	23.4	663	31.3	444	28.8	1806	25.2
2000	106	10.3	416	17.1	483	21.4	375	24.5	1380	19.0
2001	110	10.6	445	18.3	601	26.3	390	25.5	1546	21.2
2002	146	13.9	418	17.2	586	25.3	335	21.8	1485	20.3

Source: Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health, 2005.

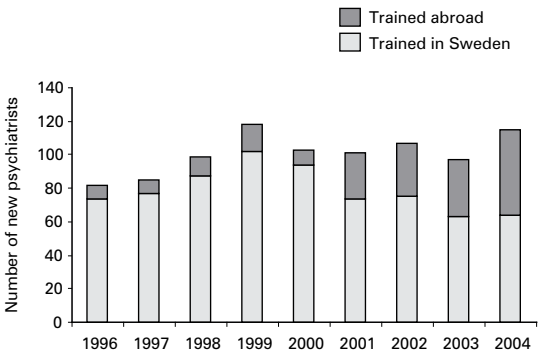

Figure 1. Total number of specialty licences in psychiatry distributed to doctors trained in Sweden or abroad, 1996–2004. Source: National Board of Health and Welfare, NPS database.

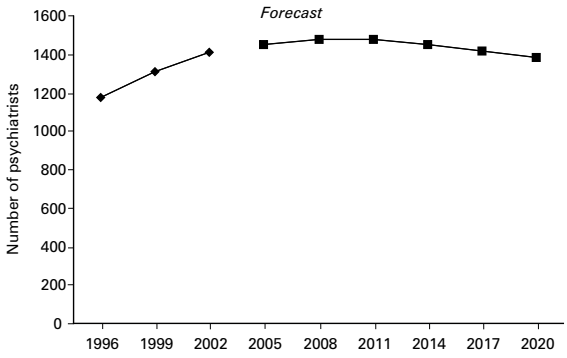

Figure 2. Total number of psychiatrists in the healthcare system, 1996–2002 and forecast for 2005–20. Source: National Board of Health and Welfare, NPS database.

The number of psychiatrists employed in the public healthcare system care is forecast to rise to 2010. Thereafter the number will be stabilised at around 1500, and then fall again so that by 2020 it is expected to be at the same level as in 2001 (Figure 2).

According to a 2004 nationwide inquiry by the National Board of Health and Welfare directed at the county councils, there was some optimism regarding their ability to recruite new professionals, not only psychiatrists but also nurses and psychologists.

COUNTRY PROFILE

Mental health in Finland

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The recession of the 1990s, the subsequent changes in the labour market, job insecurity and persistent long-term unemployment are all part of the national context for increasing mental ill health.

The prevalence of mental illnesses in Finland generally reflects global trends, with a clear increase in the occurrence of depression and anxiety. At any time, between 4% and 9% of the population of 5.2 million suffer from major depressive disorders. Some 10–20% of the population experience depression during their lifetime. Bipolar depressive disorders affect 1–2% and schizophrenia 0.5–1.5% of the population. The prevalence of alcoholism is 4–8%.

The incidence of depression has increased over the past 15 years, in part reflecting better diagnostic practices and more widespread antidepressant treatment but also the altered living and psychosocial environment. Depression has been a growing cause of sickness absenteeism and work disability pensions – although the overall level of work disability has dropped.

Stress and burnout are common among employees, and are experienced in some form by over 50% of the workforce. The recession of the 1990s, the subsequent changes in the labour market, job insecurity and persistent long-term unemployment are all part of the national context for increasing mental ill health, although mental health trends parallel those of other countries. There is also concern about the growing extent of psychosocial problems among children and young people.

Policy, programmes and preventive work

Finland deployed the first comprehensive national suicide prevention programme between 1986 and 1996. There have since been several other national programmes to develop preventive and early intervention measures in mental health. They include the National Depression Programme, Mental Health in Primary Services, and the Meaningful Life, Early Interaction and the Effective Family programmes.

A mental health policy was initially formulated in 1993. It focused on advocacy, promotion, prevention, treatment and rehabilitation. Part of the mental health policy has been the de-institutionalisation of psychiatric care. A substance misuse policy was initially formulated in 1997.

The Ministry of Social Affairs and Health produced quality guidelines for mental health services in 2001 and is working on quality guidelines for supportive housing for people with mental health problems. The government has also adopted a Drug Policy Action Programme for 2004–07. The national Alcohol Programme was launched in 2004. Comprehensive quality guidelines for health promotion at the local level are in preparation, linked with the updating of the Primary Healthcare Act.

National strategies such as the Health 2015 public health programme and the government's Goal and Action Plan for Social Welfare and Healthcare 2004–07 stress mental health and mental health promotion. Both policy strategies also highlight the need to improve mental health among young people and children.

Ongoing programmes (e.g. in occupational health) to encourage people to extend their working lives emphasise better intervention to safeguard mental health.

Two interlinked national projects, the National Healthcare Project and the National Development Project for Social Services, make mental health and the improvement of mental health services integral to the development of the health and welfare systems.

Prevention to forestall mental ill health is crucial to programmes to develop child welfare. Efforts are under way to boost cooperation between schools, day care centres and healthcare services for the prevention of mental health problems among children and young people, and for identifying problems and providing help at an early stage.

Mental health services

The healthcare system in Finland is decentralised. It is organised at local level within the country's 432 municipalities spread over five provinces. Some municipalities contain very small and scattered populations. The country has 21 hospital districts and specialised healthcare is provided at this level.

Municipalities are responsible for organising out-patient mental healthcare and rehabilitation through the primary healthcare system provided at health centres and through social services. Specialised mental healthcare comprises in-patient services arranged through hospital districts, as well as out-patient services provided by hospital districts and health centres.

As municipalities have taken a greater share of the responsibility for arranging health services, the role of primary healthcare in organising mental health services has increased.

Since the early 1990s there has been a major shift away from institutional in-patient care for psychiatric patients towards out-patient community care. In 1980, there were 4.2 beds for psychiatric patients per 1000 inhabitants. By 1994, the ratio was 1.3 per 1000 inhabitants. Correspondingly, out-patient visits rose from 520 000 in 1980 to 1 290 000 in 1997.

A challenge for mental healthcare is to reduce regional disparities in quality and availability of services and ensure comprehensive mental health planning at local level. Programmes seek to develop supportive out-patient services for long-term patients, with more supported housing, day centres, support staff and guided leisure activities, and improved support for carers.

Rehabilitation

Occupational healthcare focuses on vocational rehabilitation in addition to preventive work. The Social Insurance Institution and labour authorities have responsibility for organising vocational rehabilitation. The Ministry of Social Affairs and Health has focused on the need for increased support for rehabilitation services. An active approach to rehabilitation in general, and that relating to mental health problems in particular, is a characteristic of Finnish health policy.

The report of an expert group appointed by the Ministry of Social Affairs and Health (Lehto *et al*, 2005) highlighted various needs in the area of rehabilitation that are being addressed in current work. They include:

- the crucial role of psychotherapy and the need to link it to other activities promoting functional capacity and social interaction
- an emphasis on rehabilitation services, and especially vocational rehabilitation, for example by increasing the training and skills of rehabilitation professionals
- cooperation between occupational health services, workplaces and rehabilitation providers.

Organisations

In addition to local authorities, numerous non-governmental organisations play a central role in providing mental health services and rehabilitation. The largest include:

- the Finnish Association for Mental Health
- the Finnish Central Association for Mental Health
- the VATES Foundation (which promotes the employment of people with disabilities)
- the Rehabilitation Foundation.

The main state authorities and related agencies dealing with mental health are:

- the Ministry of Social Affairs and Health
- the National Research and Development Centre for Welfare and Health (STAKES)
- the Finnish Institute for Occupational Health
- the Ministry of Labour.

Mental health also features in the activities of other branches of government, including the Ministry of Education, Ministry of Defence and the development programmes of the Ministry for Foreign Affairs.

Changing profile

Psychiatric care in Finland has been transformed over the last quarter of a century, from a system focused on in-patient institutional care and treatment, when Finland had one of the highest ratios of hospital beds to population in Europe, to one essentially based on community services. Finland's deep economic recession in the 1990s (the most dramatic ever seen in an industrialised country) disrupted the smooth transition to community-based care. Resources were cut and the tight financial situation of the municipalities meant that greater priority was given to somatic, general health services.

Now, additional allocations to mental health services have been granted by the government to

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support the development of the sector, for example in the context of the National Healthcare Project and the National Development Project for Social Services.

Despite the autonomy of municipalities in arranging services, a large number of municipalities have adopted central government recommendations on mental health and interventions promoting mental health for children. Efforts are under way to tackle regional disparities in service availability.

At the same time, population ageing and the need to encourage a longer working life have raised the profile of good mental health as integral to people's capacity to lead active and rewarding lives.

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COUNTRY PROFILE

French psychiatry

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Until very recently France was ranked second in the world in terms of the per capita provision of psychiatrists (nearly four times higher than that in the UK, for example), with, at its peak, about 13 500 psychiatrists for a general population of some 60 million.… There is also a marked geographical disparity: the population density of psychiatrists is 10 times higher in Paris than in the north-east of the country.

French psychiatry is currently facing a period of profound change, as many of what were considered its most specific characteristics and traditions have been called into question. It is therefore difficult to draw a profile of French psychiatry, because it has to take into account a radical splitting between, on the one hand, what is still the common profile of most French psychiatrists and, on the other, the new model imposed by stakeholders and policy makers who want French psychiatry to take on a more Anglo-Saxon profile, with evidence-based practice coming to the fore, for instance.

Staffing

In this context workforce issues are becoming a major concern for French psychiatrists. Until very recently France was ranked second in the world in terms of the per capita provision of psychiatrists (nearly four times higher than that in the UK, for example), with, at its peak, about 13 500 psychiatrists for a general population of some 60 million. Nevertheless, around 20% of public hospital positions remain vacant, which reflects a growing preference for private practice. There is also a marked geographical disparity: the population density of psychiatrists is 10 times higher in Paris than in the north-east of the country.

Most stakeholders wish to correct the French figure for psychiatrist density. There is a trend to reduce the number of all types of doctor to the European average, but psychiatry is particularly affected in this regard, and since 1990 the number of psychiatry students has dropped by 37%. Accordingly, the number of psychiatrists will be 40% lower in 2020. If there is no significant increase in the number of psychiatric students, or if psychiatrists' freedom to choose their type of practice is maintained, the present disparity in the provision of psychiatric resources will be exacerbated, and a large part of the French population will have very limited access to psychiatric services.

The same disparity also exists for allied professions: France has 58 000 nurses working in psychiatry. Their number is set to decrease with the recent termination of a specific psychiatric nursing diploma. There are also 35 000 psychologists and psychoanalysts, but for historical reasons they are still not officially considered health professionals (the idea was opposed by both medical and psychological organisations for ideological or economic reasons). The psychologist's role in both the public health sector and private practice is limited, because it is not recognised by the national social security system.

Education

In France, psychiatric specialisation follows a 4-year national diploma programme, which is open to students who have passed the 6-year general medicine programme. Access to medical schools is very tightly regulated. These training programmes are offered by at least one public university in each of the country's 12 regions. At the end of the programme for general medicine the number of positions available for each specialty is decided nationally; for psychiatry (including child and adolescent psychiatry) this number has been recently increased slightly, to 200. Medical students choose their specialisation in accordance with their rank in a national competitive examination at the end of the programme for general medicine.

The specialisation programme includes 4 years of residency training in psychiatric wards with at least 1 year in child psychiatry for future general psychiatrists and 1 year of general psychiatry for future child psychiatrists. Each student has to take a number of 'education units'; most are optional and particular to each university, but some are compulsory, including diagnosis and treatment using different techniques and theories. At most universities this allows prominence to be given to psychotherapeutic techniques and theory, especially psychodynamics and

psychoanalysis. However, there is no specific training in any of the psychotherapeutic techniques, the specifics of training being left to each student to choose, through non-governmental scientific associations. Most of the psychiatric wards receiving residents give them supervision for their psychiatric practice rather than specific training in a particular psychotherapeutic technique. There is currently a debate concerning which psychotherapeutic techniques should be included within undergraduate training, and which of the scientific associations should be involved in it. The strength and diversity of French psychoanalytic movements (Freudian and Lacanian) add to the complexity of the problem.

Mental health policy and programmes

French psychiatry is also facing a crisis over the organisation of its public mental health services. This organisation is still very much based on *le secteur*, the division of the country in *géo-démographique zones* of 60 000–80 000 inhabitants for general psychiatry, and of 150 000–200 000 inhabitants for child and adolescent psychiatry. Within each sector a multi-disciplinary team is in charge of all the mental health needs of the population, from prevention through to rehabilitation and different treatment modalities (from ambulatory consultation to in-patient units or day care), under the direction of a psychiatrist. Private hospitals in psychiatry are not very numerous compared with other developed countries. They are generally used for less severe or less acute disorders and for patients of higher socio-economic status, even if in most cases they do not cost patients more because the national social security system reimburses much of the expense.

This sectoral model is valued by most public psychiatrists, who see it as well adapted to the treatment of patients with a psychosis, especially in reducing the burden of chronic psychosis. It has allowed the modernisation of hospital treatment, which was once limited to old asylums.

The problem is that the public service is required to take charge of an ever-growing range of problems, many of them worsened by the disengagement of social agencies with the end of the welfare state model. As a consequence, most of the *secteurs* are no longer able to give adequate attention to many psychiatric patients, either because of waiting lists for ambulatory early treatments or because of a drastic shortage of psychiatric beds (a reduction of 41% between 1987 and 1997, with the mean length of hospital stay dropping from 86 days in 1989 to 52 days in 1997). There has been a corresponding decrease in the medical supervision of psychiatric in-patient units and an increasing use of compulsory and urgent hospital admissions because they are becoming the only way to obtain a bed in overbooked public hospitals.

The future of the sectoral system is therefore being debated and new trends are emerging to try to improve its functioning:

- complementarities between the sectors need to be recognised to take into account the specific psychiatric needs of, for example, the homeless, elderly, emergencies, adolescents and young adults, and infants
- network strategies are needed for specific pathologies (sexual delinquency, schizophrenia, bipolarity, eating disorders, suicidality, etc.)
- rehabilitation programmes are required for the patient with chronic impairment in collaboration with specific social non-psychiatric public or private agencies
- better links with users and their associations are needed.

Legal issues

The French Mental Health Act gives priority to medical considerations and a limited role for judicial power in respect of compulsory hospitalisation. When things are working properly, priority is given to the psychiatric aspect of the hospitalisation needs of the patient. With the reduction in hospital resources and the growing need to protect users from medical abuse, this model has to be revised, at least in some respects. The Health Democracy Law passed in 2002 increased the power of users and of users' associations, and has given them the right to be informed and to have free access to their medical files.

Nevertheless, since 1992, under a new law governing compulsory hospitalisation (the French Mental Health Act of 1990, which replaced La Loi de 1838, written under the influence of Esquirol) involuntary hospitalisations have nearly doubled (even if these still represent no more than 13% of hospitalisations in psychiatry). At the same time, the number of mentally ill prisoners has never been so high, partly because of a growing tendency to limit the use of sentence reductions for psychiatric reasons.

To deal with both these problems and increasing public concern, special units for dangerous patients were recently developed, changing the type of relationship between psychiatric wards and penal institutions for these patients.

Scientific issues

Most French research and publications in psychiatry are based on clinical studies. Standardised research studies based on evidence-based methods are still relatively rare. For this reason French psychiatric literature has a low international impact factor. Linguistic considerations may account for some of this under-representation but most of it arises for both theoretical and material reasons.

The French psychiatric tradition values a global, humanistic approach rather than a symptom-focused

The public service is required to take charge of an ever-growing range of problems, many of them worsened by the disengagement of social agencies with the end of the welfare state model. As a consequence, most of the *secteurs* are no longer able to give adequate attention to many psychiatric patients, either because of waiting lists for ambulatory early treatments or because of a drastic shortage in the number of psychiatric beds.

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one. It rejects theoretical reductionism and, as a consequence, is hesitant to adopt the methodological reductionism required by standardised evidence-based approaches. Many French psychiatrists consider that this type of approach is an artefact and does not account for psychiatric subjective reality. The same sort of ambivalence appears when one looks at nosographic issues: most French psychiatrists consider DSM–IV to be a purely research classification that is inadequate for clinical work, and which therefore serves to increase the split between research and clinical reality.

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French psychiatry is relatively under-resourced in terms of research. There is no specific research institute in psychiatry comparable to the Institute of Psychiatry in London. There are twice as many researchers at the Institute of Psychiatry as there are in all of France, despite the density of psychiatrists being, nationally, four times higher.

Epidemiological and outcome studies as well as aetiological research are thus relatively rare in all psychiatric fields. However, things are changing, with young psychiatrists placing a growing value on publication in international journals with a high impact factor (i.e. in English-language journals) for academic advancement. Genetic and cognitive work on schizophrenia, autism, eating disorders, bipolar disorders and borderline personality disorders is currently emerging but has yet to be published.

The abundant French-language literature contains valuable theoretical and clinical work on infant and adolescent mental health, bridges with social sciences, attachment and separation theory, developmental approaches in work with children and adolescents, the therapeutic alliance and community treatments. Much of this work adopts a psychodynamic perspective and refers to psychoanalytic or phenomenological psychopathology. Current leading topics are psychodynamic and cognitive approaches to schizophrenia and borderline personality disorders, and psychodynamic and systemic approaches to addiction, eating disorders and infant–mother interactions.

Professional organisations

Another specific feature of French psychiatry is that there is a division between psychiatric scientific organisations and the professional 'syndicate' bodies. Another uncommon feature is the number of these organisations. French psychiatry has nearly 40 active scientific associations and six specific syndicates. Syndicates are related to different types of practice, whereas the scientific associations were established on the basis of theoretical differences or are closely linked with one of the syndicates. The associations are of unequal importance: some have fewer than 100 members, whereas the larger ones have nearer 2000; some are of historical or symbolic value, but others are directly dependent on a syndicate; some issue a journal whereas others do not; some have only an annual scientific meeting, whereas others have monthly business or scientific meetings. None the less, all of them are federated on an equal basis in the French Federation of Psychiatry (FFP), which was created 10 years ago to try to overcome the weakness of such divided psychiatric scientific representation. International representation is still quite scattered, however. Six of the French scientific associations are members of the World Psychiatric Association (WPA) – the French Association of Psychiatry, the Psychiatric Evolution Society, the Medico-Psychological Society, the French Association of Psychiatrists of Private Practice, the Psychiatric Information Society (public sector psychiatrists) and the French Society of Expression Psychopathology – but it has been impossible to unify this representation under the FFP banner, and French psychiatrists are still rather under-represented in the WPA, as they are in most international and even European psychiatric societies.

SPECIAL PAPER

Earthquake in Pakistan and Kashmir: suggested plan for psychological trauma relief work

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On the morning of 8 October 2005, Pakistan and Pakistani-controlled Kashmir were hit by an earthquake that measured 7.6 on the Richter scale. Within 5 seconds, almost all buildings in two major cities of the north were destroyed: the capital of Pakistani-controlled Kashmir, Muzaffarabad, and Balakot, a picturesque mountain city. This was about 9 a.m. Children were in classrooms and mothers were doing household chores. Many men were in the fields. Therefore, when houses

and buildings collapsed, thousands of young children and women were killed, as a result of falling roofs and walls. All government buildings, universities and colleges were destroyed and thousands of students died. In one town there were no children left alive: a generation had been wiped out. In two schools alone people were trying to retrieve 600 bodies of young girls. The earthquake hit hardest in difficult mountainous terrain. Even under normal conditions, four-wheel-drive vehicles are required to travel in this area; after the earthquake, landslides had blocked access to large villages. Many small villages were buried.

This whole area, according to the last census, had 3.6 million inhabitants, living in 530 000 households. The rural population was 3.3 million and the urban population just over 300 000. Muzaffarabad had a population of 904 000 in 125 000 households.

It is the 3.3 million rural people who suffered the most. It was difficult to get to them for days. Pakistan did not have enough air transport vehicles to meet the need and asked for international help.

Mass and severe trauma has multiple personal, social and future dimensions which affect social and political stability, in both the short and the long term. These affect communities in many ways and devastate individuals.

Pakistan has had three great traumatic events in the past. Two were direct tragedies, traumatising Pakistan's large rural population. One was a mass social upheaval, the effects of which are still felt in all aspects of Pakistani social life (this is aside from the creation of Pakistan, which was characterised by mass migration, ethnic cleansing and massacres of refugees on the border of India and Pakistan in 1947). These three events in the 1970s were: the flood in (then) East Pakistan, in 1970; a huge earthquake in northern areas in 1973; and the 3 million Afghan refugees who entered Pakistan, traumatised and devastated by Russian invasion and atrocities in their home country.

Such tragedies pose enormous challenges for mental heathcare, but disasters may sometimes be opportunities to develop greatly needed community-based mental health services in under-resourced regions. It therefore becomes imperative to use the available resources to get services in place.

The current earthquake has many dimensions, some of which are as follows:

- the effect on children, traumatised and left alone, numb with shock
- the effect on adults, left alone, grief stricken, numb with trauma
- the specific concern about young, adolescent and adult women (women are particularly at risk)
- young and working-age men in need of meaning and purpose (which the trajedy has taken away)
- migrants in search of safety and food (who have effects on the host community; in the short term crime, drugs and prostitution; in the long term there may be a need to tackle resentment)
- how to avoid the tent cities for survivors becoming ghettoes
- vocational and occupational identity crises.

The situation in Pakistan is dire owing to the limited resources. The response therefore needs to be imaginative. Victims need to be treated for emotional and psychological trauma, but this can be done by relatives, friends, teachers and their own community professionals. This has to be a long-term process of community support.

Reports have suggested that there are more than 70 000 dead and 60 000 seriously injured. As whole remote villages perished without a trace, the true totals may never be known. The numbers of dead and injured are estimated to be at least four times these figures once final statistics are gathered. There are those who are damaged and injured emotionally, after seeing horrible death and destruction. They are not yet counted. These could number hundreds of thousands or more.

The management of disasters like this needs to be tailored to local requirements (World Health Organization, 2003; Van Ommeren *et al*, 2005; Saraceno, 2005). To address the massive needs and very limited professional resources (as happens in many developing countries), many innovative approaches will have to be considered (Singh & D'Souza, 2005; World Health Organization, 2005).

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Treatment clinics

Treatment clinics should be run on an individual and group basis, initially under the supervision of registered professionals but in collaboration and participation with local communities (see below). These should be culturally sensitive yet emotionally empowering (e.g. female professionals for female victims, whenever appropriate).

Training programmes

Experience from other countries, and especially after the tsunami, suggests that self-help and community involvement matter more to people than formal help from trained professionals. The former are more meaningful than the latter, as they are culturally appropriate and empathic. Training is required for community volunteers and community leaders to deliver this help. Those who are less emotionally damaged can provide help to their own community and they then can become helpers rather than victims.

The following groups need to be involved:

- family practitioners, social workers and community workers, to be trained in the management of trauma-related psychological distress
- primary and secondary school, college and university teachers, to be trained in short-term trauma

Experience from other countries and especially after the tsunami suggests that self-help and community involvement matter more to people than formal help from trained professionals.

treatment and management in short training courses
- volunteers, trained on brief trauma management courses
- multidisciplinary professionals, to conduct the training.

The training should be modular and based on manuals.

Another important issue is the place of religion, spirituality and religious rituals in enhancing resilience, coping and rebuilding through acceptance and finding some meaning even in suffering and loss. There have been many examples of when type of feeling being empowering.

Governmental liaison – new lives, new cities

Expert liaison with the government of Pakistan and Kashmir needs to be initiated over social development in view of the emotional state of the communities affected. There needs to be proactive advice on social drift: the risks of drug addiction and misuse, crime, prostitution and so on (numbed victims who are untreated can become involved in self-destructive and socially destructive activities).

It is important that new ghettoes are not established in the planned tent cities, that these are only temporary measures and that communities are retained in their structure according to their culture. Graves of parents and ancestors are strong bonds for most people in that area. There is strong attachment to the memory of one's parents in Pakistan and Kashmir. Artificially created communities always develop social problems.

Mentoring and protecting

It is important that those who help are also protected by mentoring. If they are to develop into self-help communities and local volunteers are to be trained, then they will be in need of constant help. That should be ensured.

To develop as community helpers, the respect and participation of communities are essential. In such times, people need to become protectors of each other, to develop into purposeful individuals and communities.

With such measures in place, services may be able to provide hope to victims and also help local mental health services.

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SPECIAL PAPER

Senior Volunteers Programme: a visit to Zambia

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The Board of International Affairs of the Royal College of Psychiatrists initiated the Senior Volunteers Programme in 2004 following discussion at the Board and planning in a subgroup over the preceding year. The aim was to match requests from other countries for specific psychiatric teaching with the services of senior psychiatrists in Britain. The College has acted as intermediary, inviting requests from countries, Members and Fellows overseas, and setting up a database of psychiatrists offering a range of skills. The concept is simple but all the skill and hard work lies in the detail!

When preparations for the Senior Volunteer Programme were nearly complete, the planning group wished to carry out a pilot scheme using a volunteer. Mr John Mayeya, Mental Health Specialist of the Central Board of Health, Zambia, with Professor Alan Haworth, an Honorary Fellow of the College and Professor of Psychiatry in Lusaka, invited us to contribute to undergraduate teaching in the Medical School of the University of Zambia, participate in the training programme for mental health clinical officers and have seminars and clinical exchange with junior doctors in psychiatry. We were also invited to discuss mental health services and postgraduate psychiatric education.

Of the 12 million population of Zambia, 50% are aged 15 or younger. Lusaka, the capital, is home to 3 million, most of whom live in single-room dwellings with minimal amenities.

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3 million, most of whom live in single-room dwellings with minimal amenities. The HIV/AIDS epidemic affects most aspects of everyday life, and virtually every family. The annual death rate from AIDS is still increasing, but we were told that the rate of new infections had peaked and was beginning to decline. Zambia is one of the poorest countries on the poorest continent, and this is everywhere apparent in Lusaka, including mental health services. It was not uncommon to have to buy the petrol before the taxi could take us to the hospital. It is also the most overtly Christian country we have visited, with a penchant for the more energetic Pentecostal denominations, and a church on almost every corner.

Mental health services are mostly delivered through primary care; specialist services are very limited. Patients requiring admission tend to be admitted to local general hospitals. The only specialist mental health facility in the country is Chainama Hills Hospital, on the edge of Lusaka. There are only two trained psychiatrists in the country (as many have left to work elsewhere), and when we were there four other doctors worked in psychiatry in the hospital. Chainama is desperately overcrowded and under-funded, and provision for patients is considerably below an acceptable level. Ward staff, nursing and medical, were kind and caring but struggling under impossible conditions. The numbers of all mental health professional staff are grossly inadequate – doctors, nurses, mental health clinical officers (who could be the linchpin of the whole service) and social workers; other professions are non-existent. Three of the reasons for low staffing, we were told, are:

- the haemorrhage of trained nurses and doctors out of the country, especially to Britain
- the loss of highly trained and experienced professional staff from the public sector to non-governmental organisations working in Zambia
- advice from the World Health Organization a few years ago that mental health clinical officers should not be recruited directly from school-leavers.

The medical undergraduates were a delight to teach – bright, very interested in psychiatry and keen to use their new knowledge. Unfortunately, as the psychiatric training they receive is largely hospital based, the state of the hospital and the stigma of mental illness discourage most students from working in psychiatry after qualification. The mental health clinical officers were a superb group of dedicated people, with common sense and an enthusiasm for the subject. If only there were an adequate number they could make an enormous contribution to the country; among other roles, they could to a greater extent filter admissions to Chainama, and so lessen the grossly excessive demands currently being made.

There is no formal postgraduate training in psychiatry in Zambia. Medical graduates entering the specialty have to go abroad for further training, and they rarely return. There are 4-year training programmes in medicine, surgery, obstetrics and paediatrics, but not in psychiatry. Equivalent postgraduate training and qualification in psychiatry are essential for the future development of mental health services in Zambia (such programmes already exist in Kenya and Tanzania).

We were in Zambia for most of November 2004. Andrew Sims concentrated on psychiatric teaching on the wards and in the classrooms at Chainama, and in the out-patient department at University Teaching Hospital, Lusaka, as well as giving a few more general lectures. Ruth Sims, as a consultant child psychiatrist, was similarly involved in teaching medical students and in the work at Chainama; she also visited several community facilities for needy children and families.

There are only two trained psychiatrists in the country (as many have left to work elsewhere).

Was our visit worthwhile?

From the Zambian point of view, you would have to ask them. For us it was a wonderful experience that we shall always remember. Our grousing, blame culture in Britain could learn a lot from the happiness and fortitude of ordinary Zambians. The problems are huge, but there are also many courageous, charitable people helping in different ways. We felt greatly enriched, and also personally challenged, by our time there.

What could the Royal College of Psychiatrists do for Zambia?

The College could help enormously in postgraduate education, if this was requested from Zambia. The detail would need to be worked out and any scheme coordinated, but the College's experience of planning and delivering training and the probable availability of short-term teachers not requiring remuneration could help start an invaluable programme.

Our grousing, blame culture in Britain could learn a lot from the happiness and fortitude of ordinary Zambians.

Obviously, national poverty is a major reason for poor amenities being provided for people with a mental illness. In our opinion, however, stigma is an even greater cause. Zambia needs an organisation for doctors interested in psychiatry to combat stigma at home and to link up with psychiatric societies internationally. It also needs its mental health non-governmental organisations to be strengthened. The College, through its members, could possibly make a contribution to both.

Finance made available and wisely spent could help to initiate the regeneration of mental health services. The College could use its charitable status to set up an account specifically for improving mental healthcare abroad through donations from members, and Zambia could justifiably benefit from this.

Beyond numbers: the NHS International Fellowship Programme in Psychiatry

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The issue of recruiting in an under-resourced developing country, where skilled and trained professionals are in short supply but where demand is huge, has exposed the duplicity with which many developed countries interact with developing countries.

The recent controversy surrounding the National Health Service (NHS) International Fellowship Programme (IFP) for consultant psychiatrists (Patel, 2003) has raised a number of important issues. In particular, the issue of recruiting in an under-resourced developing country, where skilled and trained professionals are in short supply but where demand is huge, has exposed the duplicity with which many developed countries interact with developing countries. Although countries such as the UK are forever talking about strengthening the research and training capacity of these countries, they have no qualms about taking trained professionals for their own needs (Goldberg, 2003). Holsgrove (2005) has defended the IFP and tried to counter many of the arguments raised by those opposing it (Patel, 2003; Khan, 2004; Ndeiti *et al*, 2004).

Pakistan

The justification so far put forward by proponents of the IFP seems to be devoid of the reality that exists in many developing countries. Take the example of Pakistan, a South Asian developing country with a population of approximately 150 million. The country has one of the lowest rates of literacy (35%) in South Asia, has more than a third of its population living below the poverty line and health indicators that make sorry reading. All this is compounded by a precarious political system, a weak economy, rampant corruption and poor governance.

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The mental health situation is even worse than the general one. Community-based prevalence studies for common mental disorders give very high rates (25–66% for women; 10–44% for men) (Mumford *et al*, 2000). These figures are higher even than those of other developing countries with a similar socio-economic background. When severe mental illnesses (approximately 1–2% prevalence), drug addiction (totalling some 3 million), children with psychiatric morbidity and mental retardation, and countless others with 'psychosomatic' illnesses are included in the total, the scale of the burden of mental health problems in Pakistan becomes apparent.

How can this be addressed? Resources are severely lacking. Health spending is less than 1% of the gross national product. Mental health does not even have a separate budget. There are few psychiatric facilities in the country and few mental health professionals. There are negligible numbers of psychologists, mental health nurses or occupational therapists. Properly trained and qualified psychiatrists number only about 100–150. The reasons for this are partly historical (psychiatry is an unpopular specialty with a reputation for difficult postgraduate examinations), partly situational (there are very few training posts in the country) and partly ideological (few Pakistani psychiatrists abroad want to return).

Six psychiatrists too many

Psychiatrists, however, are a critical factor in driving the development of mental health services in the country. A few are now being trained in the UK, with generous financial packages and easy passage, by the NHS. Both Goldberg (2003) and Holsgrove (2005) make much of the fact that, of the 124 on the IFP, 'only six are from Pakistan' (Holsgrove, 2005). Can a country like Pakistan, with its abysmal mental health indicators, afford to lose even one psychiatrist? These are the best of the locally trained psychiatrists, desperately needed for the country's fledgling mental health system.

Stringent scrutiny?

Holsgrove (2005) has termed Khan's (2004) raising of issues around the IFS 'misleading'. He, in line with Goldberg (2003), argues that every application is 'stringently scrutinised' and only those that meet the 'College's high standards are recommended for Specialist Training Authority (STA) registration'. My personal contact with some of the selected candidates shows otherwise. I will restrict myself to only two examples.

First, a junior consultant from my department was accepted on the IFP only 20 months after gaining the FCPS (Fellowship of the College of Physicians and Surgeons, Pakistan). During those 20 months there was no formal higher psychiatric training. Compare this with a specialist registrar in the UK who has to undergo 3 years of training in an approved higher-training scheme for a Certificate of Completion of Specialist Training (CCST).

Second, a child psychiatrist of Pakistani origin, who trained in the USA but without board certification or any other postgraduate qualification, was also accepted on the IFP. This person was keen to know whether he could be considered for a faculty position

at my university as he 'would be granted Membership of the Royal College of Psychiatrists (MRCPsych) as part of the IFP'. (To be considered for a faculty position at Aga Khan University one must possess the MRCPsych or US board certification or the Pakistani FCPS. This candidate does not possess any of these.)

Clearly, some of the 'stringent' procedures are not being followed.

The duplicity of the NHS

The NHS's duplicity is apparent in a number of ways. It denies recruiting in Pakistan, yet set up a recruitment stall at the World Psychiatric Association regional meeting in Lahore in September 2004, attended by many senior members of the College, including the President and the Dean. National Health Service (NHS) consultants have been holding regular recruitment meetings in five-star hotels in major cities of Pakistan. The NHS claims the IFP is for 2 years only, yet a consultant from my department recruited on the programme received a 5-year multiple-entry visa from the Home Office. There is no obligation to return home at the end of the 2-year period. With entry set at the consultant level, it is unlikely many will return.

Critical mass

In Pakistan, the IFP is increasingly viewed as yet another aspect of Western dominance. With little or no understanding of how precarious things are in mental health in Pakistan, the programme's supporters appear to have no qualms about draining the country's small pool of psychiatrists. In particular, they fail to understand that a developing country can afford to lose only some of its trained professionals once a critical mass of such people is reached. Sadly, with service provision at one psychiatrist per million population, Pakistan is far from achieving this.

How can the problem be addressed?

Britain and the NHS need to take note of the problems they have created. In particular, they need to reflect on their oft-stated rhetoric, reinforced by Goldberg (2003), of their intentions to improve mental health in countries like Pakistan. They should seriously consider the following.

Local solutions for local problems

Many of us in Pakistan who have worked in the NHS are baffled as to why many of the excellent staff-grade doctors are not being considered instead of the International Fellows. Many staff-grade doctors have excellent training behind them as well as Membership of the College and are far more competent than many International Fellows. Neither Goldberg (2003) nor Holsgrove (2005) has found it important enough to comment on this.

Funding to help psychiatrists return to Pakistan

Such a fund should be accessible to Pakistani psychiatrists not only from the UK but also the USA, Australia and other Western countries. The fund could pay for the airfare of doctors and their families, as well as supplementing the psychiatrists' salaries, which are a fraction of what consultants earn in the West.

A contribution to training

For every psychiatrist recruited from Pakistan, the NHS should contribute to the training of at least 10 other psychiatrists. Ways in which this could be achieved include: funding more training posts in the country, upgrading some of the training posts, support for the establishment of sub-specialty units, and the funding of research training of local psychiatrists, with a stipend payable to the trainees.

Beyond numbers

Holsgrove's (2005) statement that 'in the past few years very considerable progress has been made both by the College of Physicians and Surgeons Pakistan and … the Aga Khan University in improving medical education and examination' in Pakistan is patronising. If this improvement merely means more qualified psychiatrists will be lost to the NHS, then it will have been in vain. The statement clearly reflects the lack of understanding of the complexities that exist in the precarious healthcare systems of developing countries like Pakistan.

Above all, decision makers in the NHS and the Royal Colleges should get first-hand experience of what it is like to be poor and ill in Pakistan. Far removed from the reality of the situation in a poorly resourced, underdeveloped country, policy makers often become so short-sighted they have difficulty in looking beyond their figures. Increasing the numbers of consultant psychiatrists to make up the shortfall in the NHS by any means – even if this involves depriving other health services of this vital resource – is all that matters to them.

This is immoral, unethical, short-sighted and devoid of any rationality.

In Pakistan, the IFP is increasingly viewed as yet another aspect of Western dominance. With little or no understanding of how precarious things are in mental health in Pakistan, the programme's supporters appear to have no qualms about draining the country's small pool of psychiatrists.

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International recruitment: individual choice or ethical dilemma?

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I am grateful to International Fellows, WHO officials and members of the Royal College of Psychiatrists for expressing their views at the debate, some of which have been included in this article.

The debate on international recruitment gained significant momentum after the International Fellowship Programme (IFP) was set up by the Department of Health. This article summarises some of the issues regarding the policy of the National Health Service (NHS) on the international recruitment of psychiatrists that were raised at the Royal College of Psychiatrists' annual general meeting last summer.

On the one hand, globalisation, world markets in human capital, freedom of movement and individual choice favour international recruitment on a large scale, while on the other hand there are ethical issues concerning the recipient country's responsibility not to damage the healthcare of the donor countries. From the perspective of international recruits, at both trainee and senior levels, the argument for individual choice (in favour of globalisation) is made.

Trainees who come to the UK are often driven out by lack of opportunities in their home countries and simultaneously drawn by the promise of good work experience in the UK. Most countries in the developing world produce more doctors than they can provide postgraduate training for. Access to these postgraduate positions and career progression in general are both poorly defined and often influenced by nepotism. Working conditions and salaries are generally of a comparatively low standard. In contrast, the UK system provides more opportunities, is more merit-based and provides better pastoral care to trainees. Moreover, the UK system pays trainees a living wage.

As far as individual development is concerned, the IFP has helped many professionals deal with job stagnation and stress, as it has made them realise both their professional and their monetary worth.

On the International Fellow level, international recruitment can be mutually beneficial to both the UK system and the donor country. In the donor country, the demand for psychiatrists overseas has made psychiatry a popular specialty and has raised its profile significantly. It has provided professionals with a wider range of clinical experience, especially in areas such as risk assessment and incident reporting. It has also broadened their own experience as trainers through both an experiential process and workshops on training and teaching methods. The diverse nature of services in the UK has provided a template for service development in the donor countries. In addition, these opportunities have led to the development of professional networks, which in turn have been useful in the development of both training and research links between countries. As far as individual development is concerned, the IFP has helped many professionals deal with job stagnation and stress, as it has made them realise both their professional and their monetary worth.

The other major argument in favour of ethical recruitment is globalisation. As travel and communication networks develop, the world is shrinking and people now make choices and decisions about their training and work based on quality and availability rather than simply geographical location. At this stage in the history of medicine, when we expect nothing but the highest professional standards from our doctors, would it be reasonable to expect them not to behave as career-minded professionals and seek the best career opportunities, just as other professionals do? Healthcare professionals are a mobile international workforce and, given the irresistible force of globalisation, it would appear unfair to deny a small group of professionals opportunities for career development based on political boundaries. The world can now be described as a global health community, with international patients travelling all over the world to gain the best balance of quality and cost. Keeping that in mind, it is important to maintain a free flow of healthcare professionals so that there is a better understanding of both cultural nuances and healthcare systems throughout the world.

Countering the above arguments are those opposed to recruitment in the UK of doctors from the developing world. In contrast to the one psychiatrist for every 15 000 population in the UK, there is only one psychiatrist for every 250 000 population in India or 1 000 000 population in sub-Saharan Africa. The major note of dissent has been against the active recruitment of well established consultants in low- and middle-income countries. These individuals are clearly highly driven and motivated professionals. This is exemplified by their willingness to move country mid-stage in their careers, which represents an even bigger loss to the donor country. These countries are thereby deprived of doctors in their prime, who have held senior positions and been responsible for teaching, clinical work and policy advice. The loss is, thus, not only restricted to healthcare delivery but extends to the profession as a whole.

This naturally raises major issues with regard to the four ethical cornerstones of the medical profession, namely: autonomy (here, individual versus

societal autonomy); justice (for all); beneficence; and non-malfeasance. The above arguments in favour of international recruitment produce an inherent conflict between the autonomy of professionals and wider society, towards which they have some responsibility. They also pose pertinent questions about justice for all, especially in the most deprived countries. The principles of beneficence and non-malfeasance, when extended to a societal perspective, also suggest a strong case for providing benefit to and not causing harm to communities as a whole. Some points of view would suggest that this is what occurs when healthcare professionals migrate for their individual benefit.

The criticism is mainly systemic and seems to be directed largely towards the Department of Health, but also, to a certain degree, towards the Royal Colleges and the governments of the donor countries for their complicity in the systemic asset stripping of these already deprived societies. Professional migration is not a new phenomenon but it has increased massively in recent years in response to policy development in recipient countries, and donor countries have consequently seen an exodus of the middle generations of professionals.

Various measures have been proposed and implemented by donor and host countries to mitigate the effects of this exodus. Some countries train their doctors in the local language, which also helps to retain them. This may not be the most progressive solution to the problem, but more realistic solutions have also been proposed. These include financial reparation to the donor country, an obligation on doctors to spend a certain amount of time in the public health service in the donor country, and improvement in training and employment conditions in both developing and developed countries. There has also been pressure on developed countries to restrict immigration from certain deprived countries. The Department of Health has made a start in this direction by having a code of ethics to guide its international recruitment, but its critics suggest that success has been merely symbolic, owing to the complicity of governments of developing nations like India. A process of reciprocal recognition of qualification may help redress the longer-term imbalance, as a significant number of doctors would like to go back to work in their own countries but find it difficult to do so, because of the lack of parallel recognition of qualifications obtained in a different training system.

The issue needs to be debated in international forums such as the World Health Organization and the United Nations. It is not in the interests of either the professionals who have migrated or the host country to keep the debate going. The governments in the donor countries have not been particularly proactive in addressing the conflict. In these circumstances the onus to keep the debate alive is on professional organisations like the Royal Colleges and the General Medical Council.

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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

International Associates

The introduction of membership of the College's International Divisions via the title of 'International Associates' has attracted considerable interest. Since January 2005, 11 psychiatrists have been accepted in this role, which allows them to be active in their respective International Divisions and receive all the publications of the College that members receive. More details can be found on the College website at http://www.rcpsych.ac.uk/members/membership/about.htm

Volunteer schemes for senior psychiatrists and specialist registrars

Our database is now up and running, and there are a good number of experienced colleagues willing to offer their expertise. We hope that the database will now become known throughout the International Divisions and will be of considerable assistance to services lacking specific types of experience and knowledge. Full details of both schemes are available on the College website at http://www.rcpsych.ac.uk/college/spcomm/bia/senior.htm

International Divisions at the College annual meeting in Glasgow, 10–13 July 2006

For the first time, all six International Divisions of the College will have their own sessions at the College meeting in 2006 and there will be a joint session of the College and the World Psychiatric Association (WPA) involving the Presidents of the two organisations.

On the volunteer schemes, see the report by Andrew Sims and Ruth Sims on page 18 of this issue

Human rights abuses

The College has agreed to set up a new committee to concern itself with human rights issues. Its terms of reference and relationship to WPA responsibilities are to be clarified and agreed in the coming months.

College links with Sociedad Española de Psiquiatría (SEP)

The Presidents of the College and the Sociedad Española de Psiquiatría (SEP) have drafted an agreement on a general framework for potential collaboration between the organisations in a wide range of activities over the next 4 years, including working within the framework of the European International Division of the College.

World Congress of Psychiatry, Cairo, September 2005

The WPA held its 13th World Congress in Cairo last September. It was the first to be held on the continent of Africa and was attended by more than 5000 psychiatrists, of whom around 500 were from the UK.

The College and its Board of International Affairs were prominent in many aspects of the Congress. The College exhibition stand with its publications was popular, as were applications to become an International Associate of the College.

The College and its Middle Eastern Division hosted a reception attended by many leaders of psychiatric organisations around the world. The hospitality of Dr Nasser Loza, chair of the Middle Eastern Division, was much appreciated.

College links with the Ministry of Health and Population, Egypt

During the course of the Cairo conference in September, the Minister of Health, His Excellency Professor Awad Tag-El-Din, invited the College President, Professor Sheila Hollins, and other senior officers to meet with him. Discussions led to a memorandum of understanding to collaborate in a number of areas, including examinations, exchange schemes, public education, research, continuing professional development and carers' rights. The Middle Eastern Division of the College will be actively involved in any collaboration.

BIA session at Cairo

The College's Board of International Affairs organised a session with representation from all six of its International Divisions at the WPA conference in Cairo. The session was chaired by Professor Hamid Ghodse and Dr Afzal Javed. It was attended by a number of College members, including the President, Professor Sheila Hollins, and immediate past President, Dr Mike Shooter. Representatives of five of the Divisions presented papers. The speakers included Professor George Christodoulou and Dr Athanassios Douzenis (European Division), Professor Nalaka Mendis (South Asian Division), Professor M. P. Deva (Western Pacific Division), Dr Nasar Loza (Middle Eastern Division) and Dr Frank Njenga (African Division). It was a very lively session: speakers described in detail the various potential roles of their Divisions in contributing to the further development of mental health services, as well as teaching and training in their respective regions and how interactions with the College could facilitate this.

Business meeting of the Middle Eastern Division

A business meeting of the Middle Eastern Division was held during the Cairo congress, which was attended by Members and Fellows from the region. Discussions took place regarding developing communications, developing representation by country within the Division and future regional meetings of the College. Dr Fuad Antun from the Lebanon proposed hosting a meeting in Beirut during 2006.

Recruitment of psychiatrists

During the General Assembly, the College raised concerns about shortages of psychiatrists and active recruitment from countries with less developed services by those with more developed services. The WPA Assembly agreed to establish a task force to consider this important issue and some specific proposals of the College.

WPA elections

Members of the College were elected to the executive of the WPA. These included Professor Mario Maj (as President Elect) and Professor Alan Tasman (Secretary for Education), adding to the existing College members on the executive (Professor John Cox and Professor Sam Tyano).

The new executive of the WPA began office during the congress. Its members are:

- Professor Juan Mezzich – President
- Professor Mario Maj – President Elect
- Professor John Cox – Secretary-General
- Professor Sam Tyano – Secretary for Finances
- Professor Alan Tasman – Secretary for Education
- Professor Helen Herrman – Secretary for Publications
- Professor Pedro Ruiz – Secretary for Meetings
- Professor Miguel Jorge – Secretary for Scientific Sections

In other elections, Dr Michel Botbol from France was elected as the representative for the Western European Zone – the Zone of which the College is a member. He takes over at the end of the 6-year term of Dr Brian Martindale from the College.

Medical students' attitudes to psychiatry

Sir: I am writing in response to the article on medical students' attitudes to psychiatry by Pailhez *et al* (2005). Having experienced psychiatric practices in different cultures myself, I felt that a periodical like *International Psychiatry* was long needed to address such issues. (I have been a keen reader for some time now and congratulate the Royal College of Psychiatrists and all the editorial board for their untiring efforts to make it appealing and interesting to a range of readers.)

Traditionally, psychiatry has been treated as a specialty of 'least preference' by most medical graduates (although not all), especially in developing countries, for a number of reasons. Perhaps the most important reasons have been:

- a misconception on the part of medical students regarding the nature of mental health problems and available treatments (mainly electroconvulsive therapy, which has been misrepresented in the media and sometimes depicted as a way of assaulting and punishing patients for being mentally ill)
- the poor representation of psychiatry in undergraduate academic curricula
- the lack of active persuasion and measures on the part of professionals already in the field to change this outlook and attract students to this ever-evolving science.

The situation is particularly difficult in developing countries, where the resources to provide healthcare are already strained. The lack of a standardised structure of training and of legislation to safeguard the interests of patients, the use of illegitimate practices and a gross mismatch between the number of graduates and existing training opportunities are some of the other factors further affecting the situation.

The attitudes of medical graduates are largely determined by the social and cultural views of society. Despite the fact that the model of care is gradually shifting away from paternalism, in some parts of the world psychiatry is still practised by those who enjoy the social prestige and sense of supremacy it can bring. In this scenario, psychiatrists are inherently going to fall behind their medical colleagues, who are treated differently because of their ability to deal with 'life and death' situations. Students who enter medical schools with a notion that they can do their job best only by making such differences to patients' lives run a risk of being disillusioned if faced with a career in psychiatry.

Furthermore, the recent trend towards recruiting qualified professionals from underdeveloped countries has created a bottleneck for medical graduates, thereby potentially frustrating their aspirations and diverting them into subjects they are less interested in. As pointed out by Pailhez *et al*, the process that finally leads to recruitment is not as simple as it sounds and is qualitatively different to that in other specialties.

On the positive side, it is also true that, despite all these difficulties, psychiatry has managed to change over the past couple of decades and will undoubtedly continue to do so. It has certainly received much wider recognition than ever before.

The responsibility to expand psychiatry on a global platform rests with organisations like the Royal College of Psychiatrists. The College has responded promptly to this challenge by making appropriate changes to its policies and thereby stepping onto the global stage. However, it will surely face a huge challenge in breaking the barriers at various levels to bring uniformity in the application of psychiatric knowledge worldwide.

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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@sgul.ac.uk

Forthcoming international events

3–6 March 2006
Affective Disorders: Integrated Approaches Across the Lifespan
International Society for Affective Disorders, WPA co-sponsored conference
Lisbon, Portugal.
Email: Carolina.holebrook@iop.kcl.ac.uk
Website: http://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: http://www.aep.lu or http://www.kenes.com/aep2006

23–25 March 2006
Working Together Towards a Consensus on Mental Health
APAL regional meeting and WPA zonal meeting
Email: secretariat@cantv.net or wpazone4@cantv.net

29–31 March 2006
WPA regional meeting and Second Congreso PanAmericano de Salud Mental
Havana, Cuba
Email: crisma@infomed.sld.cu

30 March–1 April 2006
Perspectives on Crime and Punishment
15th annual meeting of the International Association for Forensic Psychotherapy
St Catherine's College, Oxford, UK
Email: 2006reg@forensicpsychotherapy.com

30 March–2 April 2006
Self-Harm and Suicide: Psychoanalytic Perspectives on Theory, Practice and Prevention
Website: http://www.tavi-port.org (select conferences)

19–22 April 2006
Juan J Lopez Ibor Centennial Congress
Madrid, Spain
Email: centenariolopezibor@tilesa.es
Website: http://www.tilesa.es/cententariolopezibor

3–5 May 2006
Evidence Based Psychiatry
2nd International Conference on Psychiatry
In connection with the Ministry of Health
Jeddah, Saudi Arabia

4–8 May 2006
19th Panhellenic Congress of Psychiatry
Hilton Hotel, Athens, Greece
Contact: Prof. George Christodoulou
Email: gchristodoulou@ath.forthnet.gr
Organising secretariat: ERA Ltd info@era.gr

16–20 May 2006
2nd Kyoto Conference: The Interfaces Between Psychology, Psychotherapy, Analysis and Buddhism
Email: dalemathers@yahoo.co.uk or 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: http://www.aep-epidemiology2006.fr

10–13 July 2006
Royal College of Psychiatrists' annual meeting
Glasgow, UK
Email: conference@rcpsych.ac.uk
Website: http://www.rcpsych.ac.uk/2006

12–16 July 2006
Psychiatry: Uniqueness and Universality
WPA International Congress in collaboration with the Psychiatric Association of Turkey and the Turkish Neuropsychiatric Society
Istanbul, Turkey
Email: kuey1@superonline.com
Website: http://www.wpa2006istanbul.org

16–19 August 2006
28th Nordic Congress of Psychiatry: New Tools for Clinical Practice
Tampere, Finland
Website: http://www.psy.fi/ncp2006

22–26 August 2006
19th World Congress of Psychotherapy in conjunction with the 12th Malaysian Conference on Psychological Medicine
Kuala Lumpur, Malaysia
Contact: Sheryn Leong
Email: sheryn@icem.com.my
Website: http://www.2006wcp-mcpm.com

13–16 September 2006
VI World Congress of Depressive Disorders and International Symposium on Addictive Disorders.
WPA co-sponsored conference
Mendoza, Argentina
Contact: Dr Jorge Nazar
Email: jorge_nazar@hotmail.com
Website: http://www.mendoza2006.org

25–28 September 2006
XIX World Congress of the International Federation for Psychotherapy
Tokyo, Japan
Contact: Dr Tsutomu Sakuta
Email: Sakuta-nakayama@cb.wakwak.com

4–6 October 2006
5th International Conference on Early Psychosis
Birmingham, UK
Email: E.event@happenings.com.au or secretariat@iepa.org.au
Website: http://www.iepa.org.au

1–4 November 2006
XXIV APAL Congress, Latin American Psychiatric Association
Santo Domingo, Dominican Republic
Email: cesarm2@verizon.net.do

9–12 November 2006
56th Annual Meeting of the Canadian Psychiatric Association
WPA co-sponsored conference
Toronto, Ontario, Canada
Contact: Alex Saunders
Email: asaunders@cpa-apc.org
Website: http://www.cpa-apc.org

30 November–3 December 2006
WPA regional meeting with the Peruvian Psychiatric Association
Lima, Peru
Email: app@amauta.rcp.net.pe

22–25 April 2007
Third International Congress on Hormones, Brain and Neuro-psychopharmacology
WPA Section on Interdisciplinary Collaboration
Marakkosh, Morocco
Contact: Dr Uriel M. Halbreich
Email: urielh@acsu.buffalo.edu

16–19 May 2007
New Treatment Methods in Psychiatry in a Challenging World
15th World Congress for Dynamic Psychiatry
St Petersburg, Russia
Email: congress2007@dynpsych.de