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# Health inequalities

Hamid Ghodse

Director, Board of International Affairs, and Editor, *International Psychiatry*

**The association between mental illness and poor physical health has been known for decades (Philips, 1934). This is not a trivial relationship between mental ill health and minor physical problems but an association with such poor physical health that it results in premature death. For example, a study in the USA showed that the life expectancy of those with schizophrenia or other serious mental illness was 9 years shorter than for the general population (Dembling et al, 1999). Similarly, those with learning disabilities have an increased risk of early death, and this increase is greater in those with severe disability.**

A number of factors may account for a higher than average mortality rate among people who are mentally ill. For example, the nature of their mental illness and their lifestyle may increase the risk of suicide and accidental death. Psychotropic drugs used in the treatment of major illnesses can have serious physical side-effects; for instance, atypical antipsychotic drugs may cause or exacerbate diabetes, some psychotropic drugs are cardiotoxic and lithium can cause renal impairment. Furthermore, mental illness and psychological stress may affect behaviour in a way that adversely affects physical health. In particular, people with a mental illness may not take much care with their diet, and may drink and smoke excessively and take little exercise (Brown et al, 2000); also, they may fail to take essential prescribed medication for pre-existing physical illness.

Superimposed on all this are the consequences of the stigma and social isolation that are still associated with mental illness and that all too often lead to unemployment, poverty and poor housing – all of which are known to be associated with poorer physical health. Those with learning disabilities may suffer in similar ways and old age presents additional risk factors if declining physical health is combined with depression, anxiety or dementia.

Although the reasons for a high incidence of physical illness in people with a mental illness are predictable and well understood, physical illness often goes undetected. In part this is because the patients themselves may not bother to seek help for their symptoms. Indeed, they may not be registered with a general practitioner at all. If they do seek help, their underlying mental illness may make it hard for them to explain what is wrong.

This makes it all the more important that the health-care professionals with whom they come into contact take a holistic approach to their care and actively

seek to compensate for the problems outlined above, whenever they can. They should always take account of the physical health needs of their patients as well as their mental health problems. Sadly, there is evidence that this is not the case and that those with a mental illness or a learning disability, in addition to the physical problems inextricably linked to their mental state, also suffer significant inequalities in terms of their access to high-quality healthcare. For example, the proportion of women with a learning disability who receive cervical and breast screening is lower than in the general population (Stein & Allan, 1999; Davies & Duff, 2001) and levels of immunisation are also lower (NHS Health Scotland, 2004). Similarly, although people with a mental illness consult doctors more frequently than do the general population, they are less likely to be offered health promotion services (Cohen & Hove, 2001). All this adds up to serious health inequalities for some of the most vulnerable people in our society.

It is important to understand why this is happening and there are probably multiple, interlinking contributory factors. For example, in the UK, as in many other countries, there has been a move away from the institutional care of individuals with mental illness and learning disability in favour of treatment in the community, with outreach by specialist community mental health teams (CMHTs). It would be facile to pretend that long-term inmates of large hospitals used to receive high-quality care for physical ill health, but it is also important to acknowledge that it is difficult for the CMHTs, even in a well organised healthcare system, to provide such care in the community.

The treatment of multiple pathology of any kind is always more difficult than the treatment of a single, discrete condition, and requires particularly knowledgeable and experienced physicians. The management of multiple pathologies seems to have become even more difficult in recent years owing to increasing specialisation and sub-specialisation, which lead to a greater reluctance on the part of professionals to venture outside their own area of (often narrow) expertise. Many mental health doctors are now unwilling to carry out anything more than a basic physical examination, and tend to refer patients to another specialist for what used to be considered routine investigations such as electrocardiography.

In this context, the role of the general practitioner and the primary care team in the holistic care of those with a mental illness or learning disability is of prime importance for the increasing number of patients now being cared for in a community setting. However, their

Superimposed on all this are the consequences of the stigma and social isolation that are still associated with mental illness and that all too often lead to unemployment, poverty and poor housing – all of which are known to be associated with poorer physical health.

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The emerging solutions include training for a number of different groups, such as general practitioners, practice nurses and receptionists, to promote positive attitudes towards these patients and to improve their knowledge of medical and social issues linked to mental ill health and disability.

responses may be hampered by negative attitudes and stereotyping and by unacknowledged prejudices. They may make unarticulated assumptions about the value of interventions for these groups of patients, so that they are less often referred for specialist advice. Such feelings may be reinforced by the fact that, because of difficulties in communication, it may take much longer than usual (and longer than scheduled appointment times) to deal with these patients – and this may be problematic in a busy general practice. Finally, even the best primary care physician, when faced with a patient with known mental health problems or learning disability, may assume that new symptoms and signs of physical disease are attributable to the underlying condition and fail to carry out investigations that would be routine for other patients.

The major role of the primary care team in relation to the physical health of patients with mental illness has been acknowledged in some countries. However, much more is needed globally to make the provision of health services sensitive to the needs of these patients. Specifically, more attention must be paid to methods of communication with such patients so that, like the rest of the population, they are better informed and better able to participate in the healthcare decisions that affect them. Special approaches will need to be developed, in both primary and secondary care, to tailor preventive medicine programmes to meet the particular needs of patients with mental illness and learning disability.

In a few countries, concern about the health inequalities experienced by people with mental illness and learning disability has produced a response. In the UK, for example, the Disability Rights Commission has set up a formal investigation into these issues. Its aim is to 'shine a light on both health inequalities and potential solutions', and its focus is on practical approaches to reducing inequality within primary care. The emerging solutions include training for a number of different groups, such as general practitioners, practice nurses and receptionists, to promote positive attitudes towards these patients and to improve their knowledge of medical and social issues linked to mental ill health and disability (Disability Rights Commission, 2005). It also suggests that practitioners

should be trained by people with such disabilities and that disability issues should be integrated within the medical undergraduate curriculum.

Although the Disability Rights Commission's investigation focuses on primary care, there is much that is relevant to secondary care too, and this enquiry should act as a prompt to all who are involved in the care of patients with a mental illness or learning disability to reconsider the standard of care that they provide. The World Health Organization (2005) estimates that, worldwide, there are more than 450 million people with mental, neurological or behavioural problems. Psychiatrists in all countries – indeed, all mental health workers and their professional associations – have a responsibility to make sure that the physical needs of their patients are not only recognised but also responded to within their health service. Wherever and whenever psychiatrists are involved, they should be vigilant to ensure that these patients, who are often among the most vulnerable and the least legally protected, are not further disadvantaged by having their physical health needs overlooked or ignored.

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### THEMATIC PAPERS – INTRODUCTION

## Alcohol misuse among young people

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Recently, the UK government expressed concern about the rising tide of antisocial behaviour among young people who, in certain areas of the country, were habitually engaging in acts of minor delinquency – often fuelled by drink. On the other

hand, legislation was introduced to make it legal for premises that sell alcohol to remain open longer, up to 24 hours a day. This latter arrangement has courted considerable controversy. For example, the British Medical Association commented that any

**extension to licensing hours requires a programme of research, after its introduction, to look at its health consequences – both acute and chronic.**

It is indisputable that alcohol misuse among young people is more of a problem today than it was a decade ago, not only in the UK but also elsewhere in the world where alcohol is freely available. The key issues are reviewed in the paper by Sue Bailey and Richard Williams. Two alarming trends are highlighted by them. First, the use of alcohol in excess by children under the age of 18 years is rising substantially – as is their consumption of illicit drugs (the subject of a future issue). In the 10- to 14-year age-group there has been a doubling of alcohol consumption in the past decade, and one in three children report having been drunk at least once by the time they reached 13 years. Second, the misuse of alcohol by young women is rapidly approaching the same prevalence as we observe among young males. This trend can be seen clearly over the past 10 years and raises questions about what changes in societal structure could be fuelling their behaviour.

A different perspective on alcohol misuse among young people is portrayed by Mei-Yu Yeh and her colleagues, who review the attitudes to excessive drinking among two cultures in Taiwan. For the ethnic indigenous population, who are in the minority, alcohol is an important part of their culture. Among

the Han (immigrant Chinese) people this is less the case, and they also have a high prevalence of aldehyde dehydrogenase deficiency, so are less able to metabolise it. Alcohol misuse among young indigenous Taiwanese men is becoming an issue of social concern.

A potentially important but underestimated influence on young people's attitudes to drink is the role played by the media, especially television and the movies. Nowadays, we are far less likely to see romantic leads blowing smoke into one another's faces than was the case 50 years ago (witness *Casablanca*, a classic example of a movie in which such behaviour is commonplace). In contrast, alcohol consumption is not only socially acceptable but also virtually ubiquitous in mainstream American movies. Susannah Stern writes about the potential influence movies have in shaping attitudes among young people to the effects of alcohol excess. Audiences for the movies are getting younger all the time. She points out that little attention has been paid to the way in which indulgence in alcohol by movie characters can have negative effects upon young viewers in shaping their attitudes to such behaviour. Her work deserves to be better known. It is hard to enjoy a cult movie such as *Animal House* knowing that the lead character, John Belushi, died of the very excesses he portrayed in the film. Young children need to be educated that substance misuse is not really very funny, for anybody.

Nowadays, we are far less likely to see romantic leads blowing smoke into one another's faces than was the case 50 years ago (witness *Casablanca...*). In contrast, alcohol consumption is not only socially acceptable but also virtually ubiquitous in mainstream American movies.

#### THEMATIC PAPER – ALCOHOL MISUSE AMONG YOUNG PEOPLE

## Alcohol: younger people's favourite substance

Sue Bailey<sup>1</sup> and Richard Williams<sup>2</sup>

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**O**n 10 January 2006, ITV2, a UK television channel, ran a 90-minute programme called *Britain's Youngest Boozers*. It claimed that one in three younger people are binge drinkers and that one in six is dependent on alcohol. The comments in interviews with adolescents and families were stark and worrying. Although the age parameters were not clear at the start of the programme, it focused on those aged up to 25 years and presented enormously serious concerns about the changed patterns of drinking among Britain's younger people.

In the UK there are 3.9 million people aged 10–14 years and 3.8 million aged 15–19 years (Coleman & Schofield, 2005). There is evidence that the mental and physical health of these 7.7 million young people

is strongly affected by the degree to which they engage in risky activities (Viner & Macfarlane, 2005).

### Prevalence of the problem

One fact is plain: alcohol continues to be the most prevalent substance used and misused by people who are less than 18 years old (Harrington, 2000). We are aware of estimates that 3.4 million of the UK's 16- to 24-year-olds drink more than twice the recommended limit for alcohol (and those recommendations were developed for an adult population). In the past 7 years there has been a 15% rise in the number of young people taken to hospital for drink-related problems (4173 in 1997; 4809 in 2004–05). Thirteen children are admitted

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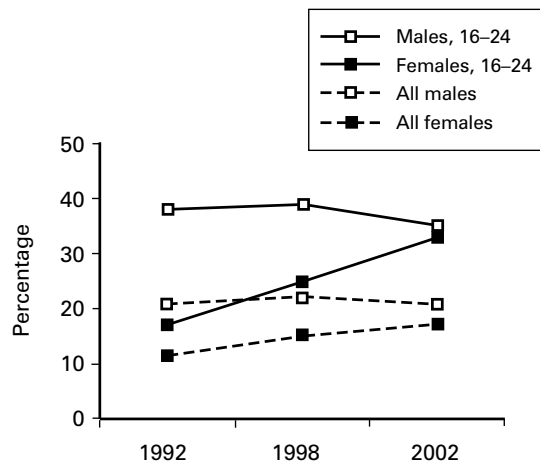


Fig. 1 Proportion of people consuming alcohol above the weekly benchmark for safe drinking. Data from General Household Survey.



Fig. 2 Mean weekly consumption of alcohol. Data from General Household Survey.

There is now relatively little difference between boys and girls in the prevalence of their use of alcohol. This is a change; previously, more boys than girls were drinking in this younger age range.

Consumption of alcohol tends to be concentrated on a small number of days in the week: younger people are more likely to drink in binges.

to UK hospitals every day suffering from the ill effects of binge drinking. Information from Wales shows that the main substance being used at the time of referral of younger people to services for those who misuse substances is alcohol (53% of referrals; more than twice the rate for heroin).

On 4 January 2006, the UK national press carried an article stating that:

'Hundreds of teenagers across Derbyshire and Staffordshire were admitted to hospital with alcohol related illnesses in the past year, Government figures have revealed. The Public Health Minister revealed that 170 people under 18 in one rural area of England were admitted to hospital for illnesses linked to alcohol abuse – admissions for mental behaviour disorders and the toxic effects of teenagers drinking too much.'

The General Household Survey of 2002, *Living in Britain* (reported by Coleman & Schofield, 2005), revealed, as expected, that adolescents' use of alcohol increases substantially with age (Fuller, 2005). A third of 15-year-olds report having been drunk at age 13 or earlier. Younger teenagers of both genders have doubled their consumption of alcohol in only a 10-year period. The latest in a series of school-based surveys (of 9715 pupils aged 11–15 years in 2004) showed that 23% had drunk in the last week and 'For the first time boys and girls were equally likely to have drunk alcohol in the past week' (Fuller, 2005). There is now relatively little difference between boys and girls in the prevalence of their use of alcohol. This is a change; previously, more boys than girls were drinking in this younger age range. Turning to an older age-group, 16- to 24-year-olds, consumption of alcohol by men has changed relatively little and, since 1992, may have decreased slightly. By contrast, alcohol consumption by women in late adolescence and early adulthood has more than doubled in the same period (see Figs 1 and 2).

## Patterns of drinking

The highest levels of consumption are in the 16- to 24-year-old age-group. None the less, only a tiny minority of men or women of this age report that they drink on each day of the week. It therefore appears that their consumption of alcohol tends to be concentrated on a small number of days in the week: younger people are more likely to drink in binges. This has been graphically illustrated by a succession of television documentaries on the habits of young women who drink at weekends.

These findings appear to us to say something extremely important about changes in the social behaviour, leisure activities and attitudes of young women in Britain. This is especially relevant at a time when the UK government has just allowed extended licensed opening of public houses, clubs and other places where alcoholic drinks are sold.

A cross-European comparison of alcohol-related problem behaviour (Currie *et al*, 2004) underlines just how worrying are the trends in Britain. England, Scotland and Wales now have some of the highest levels of alcohol use by young people in the European Union. They are more likely to get drunk and to report problems associated with drinking than their counterparts in other European countries. These findings illustrate major concerns for parents and carers, health educators and policy-makers.

Furthermore, these trends in alcohol use and misuse are occurring when, for the first time in England and Wales, the health of children and young people has started to receive the attention it deserves. There is now a joint focus on younger people's health needs that crosses several medical Royal Colleges and involves the specialties of psychiatry, paediatrics and primary care. A growing number of publications and policies substantiate this 'heightened equality of concern' (Warner & Furnish, 2002) for the health of our children and young people. They include: *Bridging the*

Gap, a review of adolescent health; the white paper *Choosing Health*; two National Service Frameworks, one for children and young people and the other on maternity services; and the government strategy paper *Alcohol Harm Reduction* (harm reduction refers to policies and practices that aim to assist people to move from harmful to less harmful patterns of substance use rather than solely focusing on abstinence as the goal of intervention).

A review of ethnic and gender differences in adolescents' patterns of drinking, smoking and drug taking reported on an anonymous self-report school-based survey of 15- and 16-year-olds from three counties in middle England (Rodham *et al.*, 2005). It showed that 'There are clear gender and ethnic differences in self-reported substance use'. More young men than young women reported drinking and the men were the heavier drinkers. Trend analysis revealed a significant difference with respect to drunkenness, with young men being more likely to be drunk more times in the previous year than young women. If these findings appear to contrast with the trends we have summarised earlier, review of Figs 1 and 2 shows that the levels of drinking in males in the UK were higher, but the trend is to the gap between the consumption by men and women closing. There are likely to be age-related and regional but also ethnic variations in patterns of drinking. Rodham *et al.* (2005) say:

'Asian, Black and Other boys and Black and Asian girls were less likely to report drinking during a typical week compared to White participants.... [But] at the more extreme end of the options (more than 11 drinks in a typical week), the drinking behaviour of Black and Other ethnic groups of both genders was similar to that of their White counterparts, while Asians of both genders remained less likely to drink than White respondents.'

In addition, it should be remembered that school-based research is at risk of biasing surveys towards lower reporting of substance misuse than is the case for the whole population of young people. This is because truants and young people who have been excluded from school will have been missed by school surveys.

## Policy considerations

On 3 January 2006, the *Daily Mail*, a national newspaper in the UK, reported a study in the USA of a random sample of 4000 18- to 26-year-olds which found that younger people who reported that they had seen more drinking advertisements also consumed more alcohol. The *Daily Mail* reported that Alcohol Concern, a voluntary organisation in the UK, had urged the alcohol industry not to advertise on television before 9p.m. (known in the UK as the 'watershed' time) because of young people's claimed susceptibility to alcohol marketing. A speaker

for Alcohol Concern was reported as complaining about the UK government not investing sufficiently in educating young people about the dangers of drinking. Greene *et al.* (2000) note that in the USA 'Tremendous resources are spent each year developing programmes and messages targeting adolescent risk behaviour', but, despite reasonable education about methods for reducing the risks they run, 'they fail to act accordingly'. Greene *et al.* explored adolescents' exaggerated sense of invulnerability. Their study indicated that risk-seeking and delinquent behaviours may be other latent factors. Perhaps these matters explain the findings of Babor *et al.* (2003), who highlight the poor track record of school-based education and health promotion programmes.

We conclude that young people should be provided with ready access to accurate, high-quality information by their families, by their schools and by other community services. Recent research in Wales shows that this and, highly importantly, opportunities for open discussion are what young people want (Williams *et al.*, 2005).

We think that the effectiveness of media-based education and prevention campaigns would be enhanced by ensuring that differences in drinking patterns and risk that are associated with gender, ethnicity and area of residence are recognised. This, tempered by awareness of theories about why adolescents' knowledge of risk may not be accompanied by actions to avoid harm, should influence how education and prevention programmes are designed and how services that deliver universal education, targeted prevention and intervention programmes are commissioned and delivered. The intention must be that these services reach the more vulnerable groups. The approaches taken should provide education about ordinary behaviour and address adolescents' tendencies to overestimate the number of their peers who engage in substance misuse. They are more likely to have an impact if they supplement the more traditional approaches to providing information and skill-enhancement training (Hansen, 1992).

Families, clinicians and policy-makers face a major challenge to help young people to understand and avoid the harm that can, all too easily, be associated with alcohol use and misuse. Hopefully, this important aspect of public health can be addressed through all health initiatives. We are keen to see substance misuse raised as a key topic in responses to the consultation on the European Union's contemporary paper on mental health policy. The aim should be to emphasise the importance of integrated and networked responses to improving adolescents' mental and physical health and to providing effective education and prevention programmes, as well as evidence-informed responses to younger people's misuse of substances that are sensitive to the circumstances of each young person. Above all, we must all be aware that, in the UK, alcohol is, increasingly, adolescents' favourite substance.

The approaches taken should provide education about ordinary behaviour and address adolescents' tendencies to overestimate the number of their peers who engage in substance misuse.

We are keen to see substance misuse raised as a key topic in responses to the consultation on the European Union's contemporary paper on mental health policy.

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## THEMATIC PAPER – ALCOHOL MISUSE AMONG YOUNG PEOPLE

## Alcohol use and problem drinking in Taiwanese adolescents: comparison of the Han and indigenous populations

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In the 1960s drinking was largely an act of harvest celebration but nowadays it is a problematic behaviour.

Although the selling of liquor to those under 18 years of age is prohibited in Taiwan, the prevalence rates of alcohol use for adolescents aged 12 and 17 years were found to be 11.3% and 31.4% respectively.

The population of Taiwan is 98% Han and 2% indigenous. Taiwanese Hans are, ethnically, an immigrant Chinese population. Traditionally, indigenous families make wine and, just like tea to the Hans or coffee in Western social settings, wine is served to entertain the guests in the indigenous culture. Alcohol drinking is a way of delivering a message of their conviviality. It also has a central role in traditional harvest festivals, ancestor worship and wedding ceremonies (Historical Research Commission of Taiwan Province, 1996).

Studies have ascertained, however, that alcohol drinking in indigenous society has changed over the past few decades (Chen, 1999). For example, in the 1960s drinking was largely an act of harvest celebration but nowadays it is a problematic behaviour. An epidemiological study found that the prevalence of alcohol misuse and alcohol dependence according to ICD-10 and DSM-III-R criteria was between 42.2% and 54.7% in the Taiwanese indigenous population, which is much higher than has been reported for the Taiwanese general population or for the United States. About 40% of alcoholics had become addicted to alcohol in their adolescence (Cheng & Chen, 1995).

Liou & Chou (2001) conducted an epidemiological study in Taiwan from 1991 to 1996; the results

suggested that the prevalence rate of alcohol use among adolescents was substantially greater than that of smoking. The prevalence rate of alcohol use for Taiwanese adolescents (drinking at least once a month) was 16.7%. In an examination of the different ethnic groups, Taiwanese indigenous adolescents showed a higher prevalence rate of alcohol use than Han adolescents (30.2% v. 16.7%). Although the selling of liquor to those under 18 years of age is prohibited in Taiwan, the prevalence rates of alcohol use for adolescents aged 12 and 17 years were found to be 11.3% and 31.4% respectively. The trends in adolescent use of alcohol in Taiwan, the United States and European countries, also from 1991 to 1996, were similar. Therefore, the study concluded that Taiwanese adolescents are at as great a risk of developing alcohol-related problems (Chou et al, 1999).

### A study of adolescent alcohol use in Taiwan

In a study by Yeh (2006), alcohol use was defined as drinking once a month. The results indicated that there were significant gender differences in alcohol use among Taiwanese adolescents – alcohol use by

males was about twice that by females – but the differences between ethnic groups (the indigenous group and the Hans) were not significant. Because male adolescents may be influenced by the values of Taiwanese mainstream behaviours, they may identify alcohol use as a ‘manly behaviour’ and treat it as a key component of social interaction between peers. On the other hand, females may be concerned about personal safety issues when they consume alcohol, so they may exercise more caution in doing so (Chiang *et al*, 2002).

Close examination of the contributory factors related to alcohol use in the indigenous and Han groups revealed between-group differences. The main factors for the Han group were: father drinking, mother drinking, family relationships, single parent, peer relationships and peer drinking (Yeh & Chiang, 2005). These findings were congruent with the findings of a study by Olds & Thombs (2001). In contrast, the main factors affecting the indigenous group were only father drinking and peer drinking. These findings suggested that factors affecting Han alcohol use were similar to those in Western cultures (Yeh & Chiang, 2005).

#### Problem drinking

In Yeh’s study, the incidence of problem drinking (drunkenness at least once a month) among adolescents differed significantly between the ethnic groups: the indigenous adolescents were 2.98 times as likely to get drunk as the Han adolescents (Yeh, 2006).

#### Aldehyde dehydrogenase

Chen *et al* (1989) found that 51% of Hans lack aldehyde dehydrogenase (ALDH). Alcohol is metabolised to aldehyde and in people who have no ALDH this is stored in the blood after drinking and causes flushing. Because the indigenous people are of Malayo-Polynesian stock, among whom the rate of ALDH deficiency may be up to 6.4%, their physiological reactions to alcohol are significantly different from those of the Hans.

#### Results from focus groups

The results of focus groups held with indigenous adolescents indicated that alcohol use allowed them to demonstrate their adulthood and identification of male roles. They also believed that drinking relieved them from anxiety, emotional stress and the burden of social expectations. According to traditional custom among the indigenous population, drinking with others shows respect, just as the general population drinks tea with guests. In addition, the indigenous adolescents may drink to show their happiness, especially at festivals, rituals and weddings (Yeh, 2003).

Another finding was that social assimilation and territorial attitude had a negative effect upon indigenous adolescent drinking. More obvious problem drinking behaviours were found among indigenous adolescents who had negative attitudes towards the Han people (i.e. believed that Han people were taking advantage of them, did not believe that Han people could live peacefully with indigenous people, or preferred that Han people did not enter indigenous society at all) (Yeh, 2004). The study also found that the determinants of drinking behaviours included not only acculturative factors but also genetic factors, expectation for drinking and social norms.

## Conclusion

Based on the results of our studies, alcohol use among Taiwanese adolescents was initially more likely to be affected by social and cultural factors, and the behaviour of parents and peers, but less by genetic factors. However, as they started to misuse alcohol, genetic factors played a major role in influencing the frequency and amount of drinking.

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The results of focus groups held with indigenous adolescents indicated that alcohol use allowed them to demonstrate their adulthood and identification of male roles. They also believed that drinking relieved them from anxiety, emotional stress and the burden of social expectations.

#### Agenda items for the Chairs of International Divisions

The Chairs of the International Divisions will hold a business meeting with College officers on 11 July at 5–6 p.m. Members of International Divisions should contact their respective chairs to discuss possible items for the agenda.

# The role movies play in alcohol consumption by youths

Susannah R. Stern

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A small number of scholars have systematically evaluated the imagery surrounding alcohol use in movies to see what messages young people may encounter. Their research indicates that images of drinking in movies are extremely common.

Drinkers in films are depicted as being of higher socio-economic status and as being more attractive, romantic, sexual and aggressive than other characters.

**A**lcohol use and misuse among young people continue to be a major public health concern, despite decades of initiatives aimed at educating young people about the hazards of alcohol. Yet where do young people learn about alcohol use? How do they form attitudes about the effects and risks of drinking? Increasing evidence suggests that young people learn not only from real people (e.g. peers and parents) in their everyday lives but also from characters whose lives they witness through the media. In fact, the mass media have been recognised as significant sources of information about substance use that can influence young people's beliefs and expectations (Bahk, 2001; Sargent *et al*, 2002).

Movies, in particular, deserve attention because of their broad youth appeal. Attending the movies remains one of the most popular pastimes for teenagers. For example, although 12- to 17-year-olds comprise only 11% of the US population, they accounted for 19% of total cinema admissions in 2004, according to the Motion Picture Association of America (2004). On average, the majority of teenagers watch films in cinemas at least monthly and on video weekly (Roberts *et al*, 1999). DVDs, the internet, pay per view, movie networks and television broadcasts further heighten their access to movies, and make it easier to view a film now than ever before. Accordingly, it comes as little surprise that about two-thirds of young people (those aged 9–17) say that it is 'important' to see the latest movies (cited by Roberts *et al*, 1999). What do they learn about alcohol consumption from these popular storytellers?

## The imagery

A small number of scholars have systematically evaluated the imagery surrounding alcohol use in movies to see what messages young people may encounter. Their research indicates that images of drinking in movies are extremely common. For example, Everett *et al* (1998) documented that four out of five films among the top money-makers from 1985–95 showed at least one major character drinking alcohol. However, adults are not the only characters in films to drink alcohol. Indeed, in their analysis of the most popular movie rentals from 1996 to 1997, Roberts *et al* (1999) found that 22% of characters who appeared to be under the age of 18 were shown drinking alcohol. More recently, Stern (2005) found that

two-fifths of the teenage characters in the most successful teen-centred films from 1999–2001 were shown drinking. Moreover, of all characters shown drinking alcohol, more than half were depicted as drunk, and almost a tenth were shown driving while drunk.

## Behaviour modelling

Such depictions of teenagers, in particular, may play a role in real teenagers' actual alcohol usage and attitudes, by shaping shared understandings of common or appropriate teenage behaviours. Moreover, real teenagers may view teenage characters in the media as appealing models and consequently adopt similar behaviours and attitudes in their own lives.

One framework for understanding this process of media effects is social cognitive theory (Bandura, 1986). This proposes that people learn by observing others either directly in real life or vicariously, such as through watching television or a movie. The media can thus affect viewers' beliefs, attitudes and behaviours by providing models from whom viewers can learn. Viewers are most likely to pay attention to those media models they see as similar to themselves. Consequently, a media model who is the same age as a teenage viewer is particularly likely to be influential (Hoffner & Cantor, 1991).

Models whom viewers consider to be attractive or desirable, such as those who are good-looking, financially well-off and powerful, are also more likely to be influential. This phenomenon is particularly troubling in the light of evidence that drinkers in films are depicted as being of higher socio-economic status and as being more attractive, romantic, sexual and aggressive than other characters (Everett *et al*, 1998; McIntosh *et al*, 1999). Stern (2005) did not find distinctions between drinking and non-drinking teenage characters in her study; however, since nearly all the main characters in the teenage films examined rated above average in terms of their physical appearance and virtuosity, drinking characters would be just as likely to draw the attention of teenage viewers as non-drinking characters, according to social cognitive theory.

By watching what happens when similar and attractive media models perform activities on screen, young viewers can develop expectations about the consequences that certain behaviours and attitudes – such as those relating to alcohol consumption – will have for themselves. Incentives and disincentives teach

viewers about social norms and values by indicating what rewards (e.g. happiness, love, acceptance) and punishments (e.g. health problems, loss of control, social isolation) one can expect when one acts in accordance with media models. Viewers need not actually engage in any action to acquire knowledge about normative values and rules of conduct (Bandura, 1986). For example, research has shown that young people have well developed beliefs and expectations about alcohol use well before they ever experiment with it (Goldman *et al.*, 1987).

Unfortunately, the negative consequences of alcohol consumption are rarely portrayed in films. Indeed, only one-tenth of the films analysed by Roberts *et al.* (1999) contained an anti-alcohol message. Stern (2005) investigated both short-term and long-term consequences of drinking behaviours by teenage characters in teenage films. Only one-third of the characters in the study were shown to suffer any negative short-term consequences (e.g. getting sick) and only one-quarter endured negative consequences in the long term (e.g. failing academically). Showing characters who openly regret their substance use is another way in which films can demonstrate negative consequences, but only a tenth of all characters shown drinking in the films Stern analysed exhibited any regret about their alcohol consumption. Moreover, although showing a teenage character declining an invitation to drink can go a long way to suggest to teenage viewers that an offer is not an obligation, in Stern's study only one character in the entire sample of films refused an offer of a drink.

The idea that media depictions of alcohol consumption affect young viewers is not simply theoretical. In fact, Bahk (2001) showed that the greater the role attractiveness and perceived realism of drinking characters in films, the more favourable were viewers' attitudes towards drinking and the more disposed they were to drink alcohol. Similarly, Rychtarik *et al.* (1983) found that viewing drinking scenes in television programmes increased the likelihood that youths would select an alcoholic beverage as more appropriate than water for serving to adults. Kotch *et al.* (1986) found that viewing depictions of negative consequences in television programmes decreased young people's expectations that alcohol had good effects.

More research is clearly warranted, given the findings of these studies, as well as the mounting evidence

that depictions of other types of substance use, particularly smoking, affect viewers' beliefs and behaviours.

## Conclusion

Altogether, research indicates that movies commonly provide images of alcohol use by both adults and teenagers. Such imagery is of concern, especially given the dearth of depictions demonstrating the negative consequences that often follow alcohol consumption. Equally notable is the apparent message in many films, especially those targeting young people, that drinking is normal, appropriate and fun. Such patterns may help explain why many teenagers view drinking as an acceptable youth behaviour. This possibility, as well as the growing amount of research demonstrating media effects, signals that we should concern ourselves with movie messages about drinking as one important part of our effort to reduce unsafe drinking practices among young people.

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Unfortunately, the negative consequences of alcohol consumption are rarely portrayed in films.

Moreover, although showing a teenage character declining an invitation to drink can go a long way to suggest to teenage viewers that an offer is not an obligation, in Stern's study only one character in the entire sample of films refused an offer of a drink.

### International Divisions in Glasgow

All six International Divisions of the College will be holding academic sessions at the College annual meeting in Glasgow:

African Division: The interface of traditional healers and psychiatry in Africa, 11 July, 9.00–10.15 a.m.

European Division: Psychiatric education in Europe, 10 July, 9.00–10.15 a.m.

Middle East Division: The role of the family in management of psychiatric disorders in the Middle East, 12 July, 2.00–3.30 p.m.

Pan-American Division: Complementary and alternative medicine in the Americas: good, bad or indifferent, 11 July, 10.45–12.00 a.m.

South Asian Division: The mental health component of primary care, 12 July, 4.00–5.30 p.m.

West Pacific Division: Improving the capacity of primary care health workers to identify mental health problems, 12 July, 10.45–12.00 a.m.

# Psychiatry in Afghanistan

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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](mailto:saxenas@who.int)).

Decades of war and violence are reflected in Afghanistan's health statistics, which are among the poorest in the world.

**A**fghanistan's historic strategic position between the great civilisations of India, Persia and Central Asia has made it from the very beginning both a crossroads for trade and cultural exchange and an almost continuous battlefield. In the years since the Soviet invasion in 1979 the country has become the stage of an ongoing complex humanitarian emergency. The period of Soviet occupation was characterised by massive human rights violations. The Soviet army and its allies were involved in indiscriminate bombardments and targeted executions, while the *mujahedeen* were involved in guerrilla warfare. The USSR was forced to withdraw in 1989 and the remnants of Afghanistan's communist regime were defeated in 1992.

Rivalry among the *mujahedeen* groups in the early 1990s led to the destruction of large parts of the capital, Kabul, and divided the country into different regions belonging to different ethnic groups.

The rise of the fundamentalist Islamic Taliban movement was accompanied by a period of harsh rule, in which individual freedom was curtailed and the rights of women were severely restricted. In November 2001 the Taliban were ousted from power by the former *mujahedeen*, supported by a US-led multinational coalition. The situation has stabilised since, but violence is not over yet, with continued insurgent activities targeting government officials, schools for girls, non-governmental organisations and United Nations agencies.

## Effects on health

The effects of 25 years of violence in Afghanistan on the physical and human infrastructure have been enormous. The war caused an estimated 1 million deaths (Human Rights Watch, 2003). At the height of the crisis, the total number of Afghan refugees in Iran and Pakistan reached 3.7 million, amounting to 15% of the total population of Afghanistan, which is estimated at between 21 and 28 million. Afghanistan is one of the countries most severely affected by mines and other types of unexploded ordnance (International Campaign to Ban Landmines, 2001).

Decades of war and violence are reflected in Afghanistan's health statistics, which are among the

poorest in the world. Life expectancy at birth is 43 years (World Bank, 2004), the mortality rate for children under 5 years of age is 257/1000 (fourth highest in the world) and the maternal mortality rate is 1900/100 000 (second highest in the world) (UNICEF, 2005).

## Mental health status

The few publications from the pre-war period about mental health and mental healthcare in Afghanistan give the impression that Afghanistan was not very different from any other developing country in the region (Waziri, 1973).

Little is known about the effects of the war on the mental health status of the Afghans during the Russian occupation and the armed resistance of the *mujahedeen*. In the refugee camps in Pakistan, clinicians reported that they saw many patients with anxiety and depressive symptoms (Dadfar, 1994).

The Taliban policy of extreme gender segregation and the denial of basic human rights to women led to increased rates of depression and anxiety. A study conducted in 2000 by the organisation Physicians for Human Rights compared the mental health of women living in a Taliban-controlled area with that of women living in a non-Taliban-controlled area, and found that major depression was far more prevalent among the women exposed to Taliban policies (Amowitz *et al*, 2003).

The fall of the Taliban regime has not resulted in dramatic improvements in the mental health status of the population. A nationwide survey (Lopes Cardozo *et al*, 2004) and an in-depth survey in Nangarhar province (Scholte *et al*, 2004) both found persistently high prevalence rates of depression and anxiety, in particular among women, with elevated scores on depression questionnaires in around two-thirds of all women (58.4% and 73.4% in the two studies respectively) and anxiety symptoms in four-fifths of all women (78.2% and 83.5%). The studies found a clear relationship between the number of traumatic events and the likelihood of developing psychopathology. The prevalence figures mentioned here must be interpreted with caution, since there are several possible sources for bias from the use of self-report questionnaires (Bolton & Betancourt, 2004).

## Use of opiates and other drugs

Afghanistan is the largest producer of opiates in the world. Despite efforts to control poppy cultivation, in 2004 the country produced 87% of the world's opium (Todd *et al*, 2005). No reliable epidemiological data about the prevalence of opiate misuse among the Afghan population are available. The use of all intoxicants (*nasha-i-mawad*) in Islam is forbidden (*haram*), and in Afghanistan the Taliban have left a legacy of severe punitive measures for drug users (UNODC, 2003). None the less, it is estimated that Kabul alone has at least several tens of thousands of opiate users. Injection drug use appears to be a relatively new phenomenon and is thought to be on the increase, in particular among former refugees from neighbouring countries. Afghanistan has a Ministry of Counter Narcotics, which has drafted a national strategy for narcotics (2003, revised in 2005), a demand reduction policy (2003) and a harm reduction policy (2005). At present, harm reduction and drug treatment programmes are available only on a small scale. In Kabul the psychiatric hospital has a maximum of 20 beds for patients with substance misuse. Some Afghan non-governmental organisations (NGOs) have limited treatment facilities (10–20 beds) for heroin users in Kabul and provinces such as Kandahar and Paktya.

The prevalence of cannabis use is significant, especially in rural areas of the country, where it is not considered harmful. No data are available on the use of alcohol.

## Mental healthcare facilities

In the 1980s the Department for Mental Healthcare in the Ministry of Public Health attempted to decentralise mental healthcare and develop community mental health services. This resulted in four community mental health centres being established in Kabul, but the process was halted in other parts of the country by the rising civil war. Much of the qualified workforce and technical expertise have left the country. Currently, a mental healthcare system hardly exists outside Kabul. The mental health hospital in Kabul was so severely damaged in the course of fighting in the capital that the building was eventually demolished. A newly built psychiatric hospital in Kabul with a total of 60 beds opened in 2004. Small in-patient facilities for psychiatric patients exist in Jalalabad and Mazar i Sharif. A few provincial capitals have asylums (*marastoon*), whose main function is to provide shelter and food for homeless people, drug addicts and psychiatric patients with severe behavioural disturbances who have no family support.

Many people with mental disorders medicate themselves with psychopharmacological drugs or seek refuge in traditional religious shrines (van de Put, 2002).

## Mental health in primary care

The new health authorities have declared mental health a priority (Fatimi, 2004). In 2005 a department

for mental healthcare within the Ministry of Public Health started to function again, and a beginning was made to integrate mental health into general health policies. The government, backed by major international donors, has decided to contract NGOs for health service delivery in the most underserved parts of the country.

The Ministry of Public Health has developed a 'Basic Package of Health Services' (BPHS) that defines the medical interventions to be made available in all districts of the country (Government of Afghanistan, 2003). The BPHS drafts the necessary interventions in seven priority areas: maternal and newborn health, child health and immunisation, public nutrition, communicable diseases, disability, essential drugs, and mental health. It is a novelty for a low-income country to give mental health such a high priority. The Afghan government justifies this by pointing at the clearly felt need for mental healthcare by its population after decades of war and internal conflict. Besides, this mirrors developments in international health policy.

The creation of available, accessible, affordable and acceptable mental health facilities in Afghanistan can be accomplished only through a major policy shift away from hospital-based psychiatry and towards integration of mental health into primary care services (Ventevogel *et al*, 2002). In the past few years the government, with the assistance of NGOs, the World Health Organization (WHO) and donors, has started to integrate mental health into primary care (Ventevogel & Kortmann, 2004).

## Psychosocial assistance

The need for psychosocial programmes is obvious (Baingana *et al*, 2005; Bolton & Betancourt, 2004). Several NGOs have developed focused psychosocial programmes for children (De Berry, 2004) and for women who have been subjected to violence. Others offer psychological assistance through counselling centres in different parts of Kabul or through community-based psychosocial services linked to the primary care system.

## Specialist education

Recent data collected by the WHO and Ministry of Public Health for the Assessment Instrument for Mental Health Systems (AIMS) demonstrated once more the paucity of human resources. The country has only two trained psychiatrists, one working in the WHO and the other in private practice. About 60 doctors work in mental healthcare but their training varies from almost nothing to some in-service training or short courses in institutes abroad. In 1999 a 3-month diploma course was held in northern Afghanistan to train 20 doctors in psychiatry (Mohit *et al*, 1999). Because of ongoing violence this initiative could not be followed up.

Afghanistan is the largest producer of opiates in the world. Despite efforts to control poppy cultivation, in 2004 the country produced 87% of the world's opium.

The prevalence of cannabis use is significant, in particular in rural areas of the country, where it is not considered harmful. No data are available on the use of alcohol.

The unmet mental health needs of the Afghan people are enormous. The challenge to increase the capacity of the mental health sector will remain huge over the coming years.

There is no postgraduate training in psychiatry and mental health is hardly represented in the undergraduate curricula for medical doctors, nurses or midwives. Psychologists at Kabul University are trained but there are no training institutes for clinical psychology, psychiatric nursing or social work.

## Conclusion

The unmet mental health needs of the Afghan people are enormous. The challenge to increase the capacity of the mental health sector will remain huge over the coming years. Sustained efforts of government, NGOs, institutional donors and United Nations bodies are needed to expand the coverage of basic mental healthcare and psychosocial services to the whole population of Afghanistan.

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## COUNTRY PROFILE

# Psychiatry in Ukraine

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**Ukraine, at 603 700 km<sup>2</sup>, has the second largest landmass in Europe. It has a population of about 47.4 million. Ukraine is a lower-middle-income country with a gross national income per capita of US\$1 260 (World Bank, 2002).**

## Healthcare

The health and well-being of the Ukrainian population, as in other former Soviet countries, are generally very poor. Life expectancy at birth is 69.7 years (64.4 years for men and 75.3 years for women). Overwhelmingly the most important reason for this is the combination of poverty, poor diet and living conditions, and lifestyle factors such as tobacco and alcohol use. Cardiovascular disease and trauma (accidents and poisonings) are the two most common causes of death, followed by cancer (UNDP & UNICEF, 2002).

Healthcare expenditure amounts to 3.5% of gross domestic product. In-patient care accounts for two-thirds of total healthcare expenditure. The number of physicians per 100 000 is 229; hospital bed provision is 903.2 per 100 000 (1998 figure), much in line with the average of 812.0 per 100 000 across Europe.

During the past 10–15 years government programmes have sought to strengthen primary health-care on the basis of family medical practice, to develop a system of health insurance, and to create the conditions for private medical practice. A key feature of the current situation in Ukraine is the low level of remuneration for doctors and other healthcare staff (International Labour Office, 2001).

## Mental health services

In-patient psychiatric care is delivered in 89 psychiatric hospitals. Of a total of 44 812 psychiatric beds, only

In-patient psychiatric care is delivered in 89 psychiatric hospitals. Of a total of 44 812 psychiatric beds, only 1468 are in general hospitals.

1468 are in general hospitals. There are also 6535 beds in 40 in-patient drug misuse facilities. The main features of the network of mental health services are their centralised structure, their focus on patients with a psychosis and their relative separation from other medical services.

## Mental health legislation

The Law on Mental Healthcare was adopted by the Ukrainian Parliament in February 2000. It defines the legal and organisational principles for the provision of psychiatric care to citizens. The Law also defines forms of mental healthcare and the legal basis for psychiatric assessment, as well as for out-patient and in-patient treatment. For the first time, the Law set up a system for the provision of involuntary psychiatric care. Also, the responsibilities of state authorities with respect to the protection of the rights and legitimate interests of persons with mental disorders are defined in the Law. Further, it sets out the rights and obligations of the persons responsible for the provision of psychiatric care.

## Training

The graduate 6-year study programme in a medical university includes an obligatory 54 hours of training in medical psychology and 108 hours of training in psychiatry. Internship to become a specialist in psychiatry lasts 2 years. The programme includes some training in child psychiatry, the treatment of substance misuse, psychotherapy and neurology, but most of the training is in adult psychiatry.

After 3 years of work as a physician after graduation from medical university it is possible to receive training in the following specialties: psychiatry, child psychiatry, the treatment of substance misuse (in Ukraine and other post-Soviet countries this is a separate specialty named narcology), psychotherapy and sexology. This training takes 4–5 months.

Every psychiatrist should receive at least 1 month of professional training once every 5 years.

## Resources

The state network of mental health services employs 3477 psychiatrists (7.33 per 100 000 population); of this total, 1783 work in out-patient facilities, 238 are psychotherapists, 94 are forensic psychiatrists and 1317 are narcologists (2.78 per 100 000). Other mental health professionals, such as nurses, psychologists, occupational specialists and social workers, are not included in the official statistics. Also, there are private mental health and substance misuse services, primarily in large cities, but again statistics are unavailable.

## Research

There are wide networks of scientific institutions and departments of psychiatry at medical universities.

However, few papers reporting Ukrainian research in the field of mental health appear in the world literature.

In 2002 the Ukrainian Psychiatric Association, in collaboration with Division of Epidemiology of the Department of Psychiatry at the State University of New York at Stony Brook and Kiev's International Institute of Sociology, conducted the first epidemiological survey of mental health and substance use disorders. This found that close to one-third of the population experienced at least one psychiatric illness in their lifetime, 17.6% had experienced an episode in the past year and 10.6% had a current disorder. There was no gender difference in the overall prevalence rates. In men, the most common diagnoses were alcohol disorders (26.5% lifetime) and mood disorders (9.7% lifetime); in women, they were mood disorders (20.8% lifetime) and anxiety disorders (7.9% lifetime). The rates of treatment seeking were very low. The person to whom respondents talked most often about their symptoms was their general medical provider. For lifetime mood disorders, 16.6% talked to a professional; for anxiety disorders, the figure was 21.1%. The rates were higher in those with more severe forms of these disorders. Thus, for the subgroup of respondents with mood disorder who acknowledged suicidal thoughts, the percentage who talked to a professional was 25.1%.

## The Ukrainian Psychiatric Association

The Ukrainian Psychiatric Association (UPA) is a non-governmental, non-profit organisation working in the field of psychiatry and professional training. It was founded in 1990. The UPA has become a leader among the similar organisations in Eastern Europe and Central Asia. It is an information centre for psychiatrists, psychiatric nurses, psychologists, lawyers and politicians working in the field of mental health and health system reform.

Since its inception, the UPA has considerably widened its network: there are now 31 UPA branches and more than 800 members. A priority for the UPA is to diminish the 'information isolation' of Ukrainian medical specialists.

In 1990 the UPA founded its special Experts' Commission for rendering social and legal assistance to mental health service users and their relatives. It provides assistance on a daily basis to all those who appeal to it. People appeal to the Commission with requests to protect their rights. The experts working on it represent the interests of people with psychiatric illnesses in the courts and provide juridical and social assistance to them. Their activities are wide in scope: specialist consulting; legal assistance (including representation in court); the assistance of forensic psychiatrists (including support in courts); the provision of consultations by forensic psychologists; psychological help; and the attendance of a social worker. The

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The UPA publishes two periodicals, in Ukrainian, the *Review of Contemporary Psychiatry* and the *UPA Bulletin*. These are distributed not only to psychiatrists in Ukraine and other ex-Soviet countries, but also to psychiatric patients and their relatives.

For the first time in this country a competent and determined person has been appointed to the post of the Chief Psychiatrist.

Commission has registered an increase in the number of cases pertaining to human rights and psychiatry abuses. This serves to confirm, unfortunately, the inadequacy of government assistance. The UPA's Expert Commission regularly informs the mass media, legal and law-enforcement authorities in relation to the human rights of people with a mental illness in Ukraine. The UPA more generally fulfils an important societal service, through its independent expert groups, in carrying out regular monitoring of human rights abuses in the field of psychiatry. The UPA provides assistance and consultations without charge. Since its establishment in 1990, the UPA has been actively engaged in overcoming the stigmatisation of psychiatric patients in Ukraine.

The UPA publishes two periodicals, in Ukrainian, the *Review of Contemporary Psychiatry* and the *UPA Bulletin*. These are distributed not only to psychiatrists in Ukraine and other ex-Soviet countries but also to psychiatric patients and their relatives. Moreover, the UPA has assisted in starting other journals, such as *Social, Psychological and Medical Aspects of Cruelty* and *Social Policy and Social Work*.

The research activities of the UPA have included the implementation of programmes in the following fields:

- sociological – 'monitoring of human rights observance', 'public opinion on mental health and psychiatric illness'
- economic – 'provision of a basic economic rationale of psychiatric system reorganisation'
- epidemiological – 'mental health of children', 'Chernobyl disaster victims', 'alcoholism and mental disorders in Ukraine'
- historical – 'history of psychiatry in pre-revolutionary and Soviet periods'.

In addition, a special project has been launched on the adaptation of ICD-10 in Ukraine, in cooperation with American psychiatrists.

## Conclusion

The outline above reflects only one aspect of the situation, the formal one, as described by many international experts from the World Bank and other agencies.

The situation has another side, however, and it is a sad one. As in all post-Communist states, our psychiatric service is archaic (it does not correspond to the political, legal and economic realities of the country), ineffective and costly. The principles of evidence-based medicine are ignored within the

system of psychiatric services. The collection of medical statistics, for example, is archaic and not of the best quality. Epidemiological studies (in the Western sense of the term) have not been carried out in this country. Financial institutions have never sought to examine the cost-effectiveness of the existing mental health system, responsibility for which is dispersed across at least seven government ministries and departments.

The Ministry of Healthcare of Ukraine formally admits the use of out-of-date, exotic and harmful methods of treatment (ranging from the well known sulfazine of Soviet punitive psychiatry to unmotivated psychosurgical intervention and inadequate application of electroconvulsive therapy).

Only recently has there emerged some hope that the system will be improved. For the first time in this country a competent and determined person has been appointed to the post of the Chief Psychiatrist. Hope is also inspired by the establishment of a national service users' association, the activism of the officers of the Department of Mental Health and Substance Dependence, and the World Health Organization's collaboration with various partners in this country.

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### Board of International Affairs at the conference of the American Psychiatric Association

The Pan-American Division of the College has organised the symposium on 'Migration and Mental Illness Around the World'; College members and fellows from seven countries will be speaking. It forms part of the conference academic programme and will be held on 22 May at 2–5 p.m., at the Toronto Convention Center, North Level 100, room 104C.

All College members attending the annual meeting of the American Psychiatric Association in Toronto are welcome to attend the reception organised by the Pan-American Division, which will be held on Monday, 22 May at 6.30–8.30 p.m., at the Sutton Place Hotel, at Wellesley and Bay Streets, in the Royal Sutton room A on the lobby level.

# Psychiatry in the Czech Republic

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The profound political, social and economic changes that occurred after the end of communist rule in Central Europe in 1989 had a profound influence on Czech psychiatry. In the socialist Czechoslovakia the healthcare system was fully owned, financed and organised by the state, in so-called regional institutes of healthcare. These had obligatory catchment areas of about 100 000 inhabitants and comprised in-patient as well as out-patient care facilities, including psychiatry. The main trends after 1989 were decentralisation of the healthcare system, rapid privatisation, especially of out-patient services, and financing through the newly established health insurance corporations.

## Medical education

In the Czech Republic the system of education is similar to systems in other European states: there are 9 years of primary and 3 years of secondary education; doctors do 6 years of study in medical school. Psychiatry is usually taught during the 4th, 5th or 6th year, mainly in a 3- to 4-week course, totalling about 60–100 hours. Classes typically have about 10 students. There are also obligatory courses in medical psychology and ethics and electives in psychotherapy and in communication skills.

Postgraduate training of physicians was until recently centralised and organised by the Institute of Postgraduate Studies of Physicians, an organ of the Ministry of Health. A law regulating the postgraduate training of healthcare workers, passed by the Czech Parliament at the beginning of 2004, has substantially changed these procedures. Medical schools as well as other accredited institutions are allowed to participate in postgraduate training. Training in psychotherapy became a common part of physicians' education.

Specialisation in general adult psychiatry includes 5.5 years of practising psychiatry at accredited departments, with rotation in various types of ward and out-patient facilities. Internships in internal medicine and neurology lasting 3 months each are obligatory. There are also special separate courses and specialisations in child psychiatry, old age psychiatry, drug addiction and sexology.

## Service provision

We estimate that less than 3.9% of the healthcare budget has been allocated to mental healthcare,

which is one of the lowest rates in the European Economic Area (Commission of the European Communities, 2005). In recent years the number of physicians working in psychiatry (Health Statistics, 2004) has been increasing and in the year 2002 there were 1210 (11.8/10000 population), most (49.8%) working in out-patient clinics. Since 1995 about 80% of psychiatric ambulatory clinics have been in private hands. There is free access to these specialists, who have no catchment areas.

There was no period of rapid deinstitutionalisation in the Czech Republic but the number of psychiatric beds was substantially reduced in the 1990s (from 14/100 000 in 1990 to 11.1/100 000 in 2002). However, in recent years this trend has stopped. In the year 2002 there were 21 psychiatric hospitals with a total of 10 045 beds (four of those hospitals specialise in child psychiatry and have a total of 368 beds) and 33 psychiatric units in general hospitals, with 1546 beds (Health Statistics, 2004).

Every psychiatric hospital has a catchment area of about 1 million inhabitants. The distance from a patient's home is sometimes up to 200 km. Officially, only chronic patients should be hospitalised in these facilities. However, owing to the lack of acute beds in general hospitals about a third of their capacity is occupied by acute admissions. The average length of hospital stay, despite its decline in the last decade, remains high, at 80 days in psychiatric hospitals and 22.5 days in general hospitals. Almost all psychiatric beds (99%) are state owned.

The relatively high number of beds in the Czech Republic can be explained both by the tradition of in-patient care in central Europe and by the fact that psychiatry is substituting for a lack of social care and community services. It is estimated that up to about one-third of the patients are hospitalised for social reasons; these include patients with a learning disability, some with chronic schizophrenia, as well as elderly patients who have no accommodation, relatives or other social support (Raboch, 2003).

There are no official statistics regarding community psychiatry but from the European research project EDEN (European Day Hospital Evaluation) we know more about the functioning of day care centres in the Czech Republic (Kallert *et al*, 2002). There are 35 members of the association of day care and crisis intervention centres. They are located mainly in larger cities; for example, the capital, Prague, has eight. They concentrate on psychotherapy for patients with various

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For details of the EDEN research project see <http://www.edenstudy.com>

types of neurotic disorder and on the rehabilitation of patients with chronic psychiatric illnesses, such as schizophrenia or alcohol and drug dependencies. Programmes for older adults with dementias are still lacking. In the treatment of acute psychiatric disorders, day care centres are not very frequently employed as an alternative to hospitalisation.

### Legislation and patients' rights

Under Czech law there is neither a specific act on mental health nor a comprehensive act regulating involuntary admission, involuntary treatment or use of coercive measures concerning persons with a mental illness. As a principle, diagnostic and therapeutic measures may be carried out only with the consent of the person concerned or if the consent can be anticipated. According to the Healthcare Act, diagnostic and urgent measures without the patient's consent may be carried out or a patient may be admitted to a medical establishment if, besides other conditions, a person with signs of a mental disorder or intoxication threatens him- or herself or others.

The Czech Republic has recently been criticised by various European bodies and authorities (e.g. the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment of the Council of Europe) for using cage and net beds. Cage beds are not used any more in Czech healthcare facilities. Net beds, of which there are about 100–200 in the whole country, are still used (and not only in psychiatric facilities), especially in the treatment of emergency states in patients with a learning disability or psychosis and as a safety measure for patients with dementia with night-time confusion. In recent years their number has decreased rapidly.

Every psychiatric institution has transparent and strict rules on how to use restrictive measures, in what situations they should be used, how to document their use and how to supervise these. However, the number of auxiliary nurses and other healthcare personnel is very low in Czech psychiatric facilities (on average 0.36 per bed) and frequently no other technical support, such as modern seclusion rooms, is available (Commission for the Realisation of Reform of Psychiatric Care, 2004).

In order to stress the international and European involvement of Czech psychiatry in this very sensitive part of mental healthcare, we should mention that two Prague psychiatric facilities are participating in the EUNOMIA project (European Evaluation of Coercion in Psychiatry and Harmonisation of Best Clinical Practice) (Kallert *et al.*, 2005). This was set up under the 5th Framework Programme of the European Commission. In the 3-year study period the use of coercive treatment measures in psychiatry in 11 member states of the European Union and in Israel will be mapped on the basis of data collected on two groups of psychiatric patients: those involuntarily admitted and those voluntarily admitted but who feel coerced.

### Professional associations and collaboration

The Czech Psychiatric Association is one of the oldest Czech medical societies. It was founded in 1919, after the formation of the independent Czechoslovakia (Czech Medical Society, 2000). More than 1000 of the 1200 physicians working in psychiatry are members. It has 16 sections, the most active of which are biological psychiatry, psychopharmacology, forensic psychiatry, child and adolescent psychiatry, social psychiatry, psychosomatics, eating disorders and hospital psychiatry. The Association has monthly meetings and regular working days at the Psychiatric Department of Charles University in Prague.

A taskforce of the Association has prepared a report on the reform of psychiatric care, which has been approved by the Ministry of Health. This pointed to the need to strengthen the continuity of care for patients with severe mental disorders, to widen the system of community care and acute hospital care, and to find adequate and functional boundaries between chronic psychiatric and social care (Commission for the Realisation of Reform of Psychiatric Care, 2004). A special advisory commission to the Minister of Health was recently established for the realisation of the reform and will push for the advice of the January 2005 meeting of European Ministers for Mental Health in Helsinki to be put into practice.

Czech psychiatrists are also very active internationally, especially in hosting various major international congresses. Prague hosted the regional meeting of the World Psychiatric Association (WPA) in 1993, the conference of the Association of European Psychiatrists (AEP) in 2000, the European Congress on Cognitive Behavioural Therapy in 2003, and a meeting of the European College of Neuropsychopharmacology in 2003. A regional meeting of the Collegium Internationale Neuropsychopharmacologicum (CINP) in 2004 was held in Brno. The World Conference for Social Psychiatry in 2007 and World Congress of Psychiatry in 2008 will take place in Prague.

### Conclusion

After 1989, psychiatric care provided in the Czech Republic started to change. New social phenomena appeared that required action (more stressful life, an increasing number of people seeking psychiatric care, drug issues, homelessness, unemployment, etc.) but positive modern trends also emerged, as well as new ways of problem-solving and new programmes. The prevailing institutional psychiatric care is already being complemented by community services and by user and family member programmes. At present, we are looking for political and financial support to be able to realise our very concrete plans.

Czech Psychiatric Association:  
<http://www.ceskapsychiatrie.cz>

For the EUNOMIA project see <http://www.eunomia-study.net>

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### SPECIAL PAPER

## Teaching psychiatry in Ethiopia

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**T**here is a pressing need to train psychiatrists in low- and middle-income countries. Psychiatrists from high-income countries have an opportunity to share expertise in teaching and assessing trainees, while learning much in the process. Three trainees from a London psychiatric hospital were invited to help organise a revision course for the Department of Psychiatry, Addis Ababa University, and this paper reports their experiences.

### Background

Ethiopia, with a population of nearly 70 million (Central Statistical Authority, 2000), has less than one psychiatrist per 6 million people (Alem, 2004). The vast majority of people with a mental illness have no access to psychiatric treatments and instead rely on traditional methods (Alem, 2000). A major stumbling block to an increase in the numbers of psychiatrists in Ethiopia has been the need for doctors to obtain specialist psychiatric training abroad. This has inevitably led to a draining of psychiatrists away from Ethiopia to countries with greater rewards and career prospects. In addition, psychiatric training in high-income countries may not be wholly relevant to the Ethiopian setting.

In January 2003, the Department of Psychiatry at Addis Ababa University began postgraduate psychiatric training. The objective is to provide 'highly qualified clinical psychiatrists who would also teach other health professionals and conduct basic research in mental health in the country'. Since then, 23 trainees have received two half days of teaching

per week and clinical supervision provided by psychiatrists from Amanuel Hospital and Addis Ababa University, together with intensive periods of teaching from visiting psychiatrists. Ultimately the teaching programme will be self-sufficient.

Through existing links between the Institute of Psychiatry, London, and the Department of Psychiatry, Addis Ababa University, psychiatrists from the Institute of Psychiatry were invited to assist with training Ethiopian psychiatrists. The teaching objectives were:

- to provide Ethiopian psychiatry trainees with experience of teaching and assessment methods commonly used in high-income countries
- to teach general examination skills relevant to the forthcoming end-of-year examination
- to introduce skills essential for continuing professional development.

### Methods

#### The teachers

The visiting teachers, C.H., D.F. and D.S., were trained at a London psychiatric hospital and have extensive experience of teaching. The local teachers are Drs Abdulreshid Abdullahi (Associate Professor), Mesfin Araya (Assistant Professor and Head of Department) and Atalay Alem (Associate Professor). All are consultant psychiatrists who were trained overseas.

#### The teaching programme

This was developed in conjunction with the Department of Psychiatry, Addis Ababa University. Specific

A major stumbling block to an increase in the numbers of psychiatrists in Ethiopia has been the need for doctors to obtain specialist psychiatric training abroad. This has inevitably led to a draining of psychiatrists away from Ethiopia to countries with greater rewards and career prospects.

Methods for teaching and assessment now commonly used in high-income countries and increasingly favoured for formal trainee assessment seemed to be well received by Ethiopian psychiatry trainees.

The OSCEs were not used as a means of formal assessment but generated most reactions from the trainees.... 'It is a new and very difficult experience'.

areas of focus were needs led, as indicated by the Ethiopian trainers, and included: multiple-choice questions (MCQs), essays, critical appraisal (in the form of a journal club), objective structured clinical examinations (OSCEs) and case presentations. We also asked the trainees to prepare a clinical presentation as a group in the form of a grand round. An important component was a mock examination that tested both written and clinical skills. Further details of the teaching programme are available from the authors.

#### Feedback

Trainees were asked to complete feedback forms at the end of each day. These were reviewed daily by the visiting trainers to allow modification of the revision course as it proceeded. For analysis, numerical codes were given to the categories as follows: excellent = 3, good = 2, fair = 1, poor = 0.

### Outcomes

The trainees' feedback is summarised in Table 1.

#### Formal assessment

The majority of trainees found the MCQ examination the most difficult and performed least well in this part of the assessment, owing to difficulty interpreting the language of MCQs and unfamiliar topics. Performance in the essay examination was better, although the format was still unfamiliar to some. Essays were of good quality, with thoughtful, well constructed answers. Candidates seemed most comfortable in the clinical examination and rated this teaching module highly.

#### Non-assessed modules

The OSCEs were not used as a means of formal assessment but generated most reactions from the trainees. Initially this session was approached with some trepidation: 'It is a new and very difficult experience'. Later in the week trainees reported that this new mode of learning was beneficial: 'I was afraid ... to participate in role-playing but later on I found it [a] very good approach for me to [acquire] good skill'. Interestingly, the trainees gave the most positive feedback to the sessions in which they had had the greatest involvement: the grand round, journal club and OSCEs. They reported that critical appraisal skills

were daunting to acquire and that some of the papers critiqued in the journal club appeared less relevant to local needs.

## Discussion

#### Which training methods?

Methods for teaching and assessment now commonly used in high-income countries and increasingly favoured for formal trainee assessment seemed to be well received by Ethiopian psychiatry trainees. Our teaching programme emphasised non-directive learning, in the form of OSCEs, a grand round and critical appraisal. These teaching modules scored most highly in the trainee feedback. The skills required for critical appraisal may seem technical, difficult to acquire without easy access to scientific journals and of a lower priority for hard-pressed clinicians; however, the benefits are likely to become increasingly apparent as access to free electronic journals becomes a reality.

#### How to assess?

The Ethiopian trainees performed well across assessments but struggled with the MCQs. In the UK, entrants to the psychiatry membership examination who had trained in a non-UK medical school were less likely to pass (Tyrer *et al*, 2002). The effect was, however, more marked with the clinical examination. The UK Royal College of Psychiatrists has expressed the hope that the introduction of OSCEs, with their more standardised assessment, will overcome the so-called 'linguistic bias' experienced by overseas students (Tyrer *et al*, 2002). By conducting our clinical assessment with local clinicians, any bias may have been circumvented.

#### What to teach, and to whom

Teaching priorities for Ethiopian psychiatrists will naturally differ from those of UK trainees, for example because of a different frequency of particular conditions, their presentation and the resources available for management. Different emphases within the curriculum are required to ensure Ethiopian trainees become psychiatrists well prepared for the challenges they will face in their own country.

A more contentious issue is whether valuable curriculum time should be spent learning about conditions, investigative techniques and therapies

Table 1 Trainees' feedback<sup>1</sup>

	MCQ pre-test	MCQs	OSCEs	Journal club	Essay skills	Case presentations	Grand round	Teaching objectives met
Monday	16/21	17/21	19/21	18/21		16/18		17/18
Tuesday		16/21	18/21	19/21	18/21	18/21		16/21
Wednesday		19/21	21/21	21/21		20/21	20/21	20/21
Total (%)	16/21 (76%)	52/63 (83%)	58/63 (92%)	58/63 (92%)	18/21 (86%)	54/60 (90%)	20/21 (95%)	53/60 (88%)

1. Grading of the components of the course by all trainees. Excellent = 3, good = 2, fair = 1, poor = 0.

which have little immediate relevance in the Ethiopian setting. We argued that this was likely to facilitate greater inclusion in the worldwide community of psychiatrists, in terms of training recognition as well as ability to participate in research. A disadvantage raised by Jablensky (1999) is that Western conceptualisations of psychiatric illness and treatment may come to dominate, precluding the emergence of alternative understandings of mental ill-health.

Jacob (2001) has discussed the problems inherent in transferring models of psychiatric care provision from high-income to low-income countries. He raised questions about the appropriateness of focusing on psychiatrists as the longer-term providers of services to people who are mentally ill, although he sees a role for them more immediately in the training of non-specialist primary care personnel. Mental health nurses have been trained in Ethiopia since 1987 and provide most mental healthcare outside the capital city, albeit with psychiatric supervision. Future teaching collaborations may usefully provide consultancy for nursing education, as well as expertise from clinical psychologists.

#### Where might training occur?

As the number of Ethiopian psychiatrists working in Ethiopia has increased, together with government support, it has become possible to train psychiatrists in Ethiopia. Not having to send doctors abroad for their training may help to decrease the loss of psychiatrists to high-income countries. High-income countries have been accused of exploiting low-income countries to solve their own shortages of psychiatrists (Patel, 2003; and as discussed in previous issues of *International Psychiatry*). Psychiatrists trained within low- and middle-income countries are, however, still likely to be subject to models of psychiatric service and biomedical paradigms inherited from high-income regions. There is also concern that curricula in low-income countries may be constrained to the acquisition of clinical skills, neglecting the role of the psychiatrist in research, service development and primary care (Farooq, 2001).

For psychiatrists from high-income countries, experience of different systems, priorities and understandings of mental illness may enrich development, and usefully inform evolving psychiatric practice in the home country. Psychiatry trainees from high-income countries can learn skills useful to psychiatric practice in multicultural societies (Subramaniam, 2002).

#### Developing a transferable collaborative teaching model

We believe that psychiatrists from high-income countries have a role to play in assisting the training of mental health personnel in low-income countries. What can be most usefully offered will depend on the priorities of the country and existing educational resources. Transferable skills such as educational methods, modes of assessment and even the provision

of well-worked curriculum materials could be areas where psychiatrists from the developed world can most usefully contribute. Where curricula are more established, expertise in psychiatric specialties may complement existing practice. Broadening the teachers and audience to include non-medical mental health workers recognises the crucial part they play in mental health provision.

We propose the following model for collaborative training:

- training goals developed in close liaison with the host institution, addressing its priorities and needs
- trainee feedback to allow the training programme to be modified and more appropriately tailored as teaching proceeds
- sharing expertise in sub-specialisms of psychiatry, particularly substance misuse, forensic psychiatry, liaison psychiatry and child psychiatry
- visiting trainers having the opportunity to be able to learn about local services, common clinical presentations and conditions of work where they are teaching
- a commitment to regular and sustained input from outside trainers to allow better planning and integration within the existing curriculum.

#### Structural support

The Royal College of Psychiatrists has been called upon to develop partnerships with low- and middle-income countries; this should involve directly providing training appropriate to the needs of those countries and in return benefiting from the cultural exchange. The responsibility is to 'actively advocate equality of mental health worldwide' (Ghodse, 2001). The recent College initiative to support voluntary service overseas for specialist registrars could assist the provision of teaching expertise over an extended period. However, the College could play a more active part in promoting training activities, in the following ways:

- allowing overseas centres to register their interest with the College, stating their training needs and priorities
- suggesting standard clauses to be inserted into UK clinical contracts that would encourage the granting of study leave for these purposes
- lobbying the Department of Health for financial support, allowing the government to demonstrate its commitment to mutual development in the face of the International Fellowship Scheme.

#### Conclusion

One response to the critical shortage of mental health workers in the developing world is for high-income countries to make a commitment to mental health training worldwide. Our experience of teaching trainee psychiatrists in Ethiopia is that this can be a highly enjoyable and mutually enlightening process.

Transferable skills such as educational methods, modes of assessment and even the provision of well-worked curriculum materials could be areas where psychiatrists from the developed world can most usefully contribute.

The Royal College of Psychiatrists has been called upon to develop partnerships with low- and middle-income countries; this should involve directly providing training appropriate to the needs of those countries and in return benefiting from the cultural exchange.

## Acknowledgements

Drs Mesfin Araya, Abdulreshid Abdullahi and Menilik Desta are thanked for their kind hospitality. The Manchester course organisers, Dr Nigel Blackwood and Dr Al Santhouse, and Identic Ltd are thanked for allowing the use of the MCQs, and Dr Michael Dilley for the use of the OSCEs. We also thank Professor Robin Murray and Associate Professor I. Harry Minas, Director of the Centre for International Mental Health in Melbourne, Australia, for their departments' financial support.

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### POINTS OF VIEW

# What is important for quality of life of psychiatrists?

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This paper was presented at the annual meeting of the Royal College of Psychiatrists, Edinburgh, 22 June 2005, at the session 'The recruitment and migration of psychiatrists from developing countries'.

**T**he concern for the mental health of people living in low-resource and industrially developing countries has been blown out of proportion. Economic well-being, as a psychological factor, has a complex association with mental health and may prove to be good or bad for it; after all, mental health in low- and middle-income countries (even with few psychiatrists!) is generally better than it is in high-income countries. Government funding may be low but there are innumerable socio-cultural resources, many more than in most high-income countries. The number of psychiatrists per population may be low but numerous (informal and alternative) mental health services exist, many more popular and even more effective than psychiatry. The healthcare systems are so different that, whereas the average waiting period for a psychiatric patient in the UK may be about 90 days, it is about 90 minutes in India (and all patients are seen the same day). In fact, less than 10% of mental health problems are seen by psychiatrists!

It is sad to see that there is a publication bias, as only reports questioning the migration of health professionals are being published. The current tirade against migration smacks of prejudice against new National Health Service (NHS) fellows. Should psychiatrists from poor nations serve only patients in their home nation? Should they not venture (or earn) elsewhere, even if they are jobless and struggling in

their own country? Is it right to leave high-income countries to their own mercy, even if they are short of staff? Is it ethical to let the jobless remain jobless, to let poor doctors remain poor, to destroy a professional's dreams and aspirations, to infringe on an individual's rights and freedom of choice, and to insist that a doctor born in a poor country remains there?

## The drift hypothesis

The factors that persuade clinicians to emigrate are poor remuneration, bad working conditions, academic politics, job insecurity and the threat of violence, low standards of living, a wish to provide a good education for their children, and discrimination. Factors that force medical researchers to emigrate are lack of funding, poor facilities, limited career structures, poor intellectual stimulation and dissatisfaction. Health professionals are driven away from their home nations by lack of jobs (for example in India there are 250 training posts in psychiatry every year for less than 10 jobs), low wages, bureaucratic frustrations, indignity and stagnation. The saving grace has been provided by well paid jobs in the UK NHS and multiple opportunities offered by other high-income countries.

The NHS International Fellowship Programme has provided an avenue for those in permanent jobs to take a much-needed break from their routine, and thereby acts to postpone (or even prevent) eventual burnout. Consultant psychiatrists in India have no

options – no changes are allowed, there is no locum system, no job hopping, no movement to better opportunities – they are stuck until they retire or resign. There are no fellowships for senior psychiatrists.

There is also a gradual reverse drift, with people who migrated in the 1980s returning to India, for family or socio-cultural reasons (or even because of the English weather!). More than 10% of fellows have returned prematurely. Quite a few consultants have returned to their countries of origin, and this refutes the claims of critics that most professionals will stay in the UK.

## Social impact on the host country

There are speculations and unfounded fears about the adverse social impact of migration. There is no evidence of a worsening of mental health conditions or situations, or of people going without care, or of any appreciable effect on national training and policies. On the contrary, there are many advantages, like making way for younger professionals to advance, learning a different system of practice, fighting job stress and burnout, and realising one's own worth.

The Fellowship gave me multiple opportunities to broaden my knowledge and experience the practice of psychiatry in a different setting. In return, it was common to share my own experiences from home with colleagues in the UK. Other contributions from professionals who have left their home countries are financial, academic, clinical, research, social and developmental.

## Who lures health professionals?

A large number of specialists who emigrate from low- and middle-income countries are attracted by international organisations. The World Health Organization (WHO) attracts the best health specialists to fulfil its mandate from 191 countries, many of which are poor countries.

The WHO recruitment process is by nomination, unlike the NHS fellowships, for which there is global advertisement. In NHS recruitment, equal opportunities are ensured and the process is transparent; there is also adequate time for induction and so on. Sadly, in India posts are advertised but not filled, selection procedures are opaque and there is *ad hoc* cancellation of selections.

## Stopping recruitment

If recruitment is stopped from those countries that have jobless doctors, will it help? No amount of coercion and regulation will prevent people from seeking a livelihood. Such coercion would be considered dictatorial, immoral and unethical. The idea of compensating home nations is baseless and lacks logic. Would reimbursing the cost of training improve health? What would such reimbursement cover – medical training, further education, schooling, childhood, antenatal care? There is no evidence in any case that reimbursement would be a solution. Those who choose to migrate will have been tax payers and have invariably repaid their 'dues'. Coercion is harassment, abuse and bullying. The services of harassed, abused, frustrated health professionals, provided against their will, are no good for anyone. In contrast, fellowships lead to professional growth.

If we stop migration, the countries seeking doctors will have longer waiting lists and a poorer state of health for their populace. The countries sending doctors will have more unemployed, frustrated, poor doctors, and a similarly poorer state of health for their populace. It would be bad for the medical profession and it would persuade some to change profession.

The situation in rich countries will only get worse. The more you have the more you need, it is said; the less you have, the less you learn to live with. Rich countries need to look at ways to improve their healthcare systems. They should examine the strengths of healthcare delivery in low- and middle-income nations, and adopt or adapt some ideas.

We need better evidence on the extent of the problem of professional migration, its effect on both countries, and the effectiveness of measures to deal with it. The future of sensible migration lies in conducting campus interviews and selection. Health trusts in the UK could liaise or collaborate with centres in low- and middle-income nations. Such exchange of professionals could strengthen health systems mutually and globally.

My own fellowship experience was a pleasant break from routine, with learning opportunities. The most memorable moments were the farewell meetings with the carers group, the trainees, and a farewell from my patients. My British patients said they were sad that I was leaving them, but that I was not leaving psychiatry and that I would still make differences in the lives of people in a different part of the world. How I wish the critics of the Fellowship Programme would heed these comments.

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*International Psychiatry* is now available by subscription to mental health institutions, libraries and postgraduate centres throughout the world. Please recommend this journal to your local institution: it is entitled to a free sample issue. Alternatively, readers can contact Clair Grant-Salmon (email [cgrant-salmon@rcpsych.ac.uk](mailto:cgrant-salmon@rcpsych.ac.uk)) with the email and postal details of their institution.

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, UK, email [Brian.Martindale@stw.nhs.uk](mailto:Brian.Martindale@stw.nhs.uk)

WHO atlas interactive website: [http://www.who.int/mental\\_health/evidence/atlas/](http://www.who.int/mental_health/evidence/atlas/). Hard copy can be ordered from the WHO (email [bookorders@who.int](mailto:bookorders@who.int)) quoting reference number 11500632

Council of Europe draft resolution available at <http://assembly.coe.int/Mainf.asp?link=/Documents/AdoptedText/ta05/ERES1460.htm>

## The WHO mental health atlas, 2005

The World Health Organization (WHO) has updated its mental health atlas, which contains important information for mental health planning around the world, especially for low- and middle-income countries. It contains a global overview as well as country-by-country surveys, covering 16 themes such as: the state of mental health policy, legislation and financing, mental health facilities, numbers of psychiatric beds and professionals, programmes for special populations, and the availability of therapeutic drugs and other treatment modalities. It also has vital information on the epidemiology of mental disorders for all low- and middle-income countries.

## The European Commission

The European Commission is becoming increasingly active in the mental health field. For example, it has agreed to co-finance a trans-national exchange project, led by Mental Health Europe, with the aim of demonstrating the link between mental health problems and social exclusion. The project will focus in particular on existing best practices that can contribute to tackling the inequalities that people with mental health problems encounter in access to health, employment and education and training services, as well in the protection of their civil and human rights. Through trans-national exchange and comparison of effective practices, policy proposals to achieve social inclusion will be prepared.

The Council of Europe has produced Draft Resolution 1460 (2005), 'Improving the response to mental health needs in Europe', and is hoping national governments will bring into practice the items pointed out under article 16.

## The College response to the earthquake in Pakistan

Immediately after the earthquake disaster in South Asia, Professor Sheila Hollins (College President) and Professor Hamid Ghodse (Chair of the Board of International Affairs) set up a task force to streamline support for colleagues affected by the disaster and wrote to the chair of the South Asian Division and the Pakistan Federal Health Minister offering assistance for trauma-related services. The College has also invited the British Pakistani Psychiatrists Association and the British Indian Psychiatric Association to inform their members of the College's Volunteer Programme so

that we have information about those experts willing to offer assistance with mental health relief efforts. All interested persons are requested to send their details to the College (c/o Joanna Carroll). The College has also initiated training events for professionals going to earthquake areas and these workshops are planned for the spring.

The Board of International Affairs will be represented by Dr Afzal Javed at the national workshop on disaster management in Lahore. This meeting will address future psychosocial rehabilitation plans for the survivors.

## Psychiatry, Iraq and the College

The Iraqi Sub-Committee (ISC) of the Board of International Affairs (BIA), chaired by Dr Majid Al-Yassiri, held its inaugural meeting on 21 November 2005. The ISC will inform and advise the BIA on matters related to mental health services in Iraq that the College will be able to support. The draft terms of reference and action plan were subsequently agreed by the BIA. The ISC will:

- support (as part of the College Volunteer Programme) psychiatrists wishing to have sabbatical leave from their mental health trusts to volunteer their expertise to develop mental health in Iraq
- facilitate training in the UK for Iraqi trainees through the College's Consultant Assisted Sponsorship Scheme
- fund (jointly with other organisations) the development of a multidisciplinary teaching tool kit
- make College journals available online, free of charge, to psychiatrists practising in Iraq
- support five Iraqi researchers to present posters at the 2006 College annual meeting
- support the Iraqi Psychiatric Association to develop as a democratic and representative professional organisation.

The College Council noted that this could be a model for similar area-focused committees. For details on the ISC and how you can help please email [Majid.Al-Yassiri@swlstg-tr.nhs.uk](mailto:Majid.Al-Yassiri@swlstg-tr.nhs.uk).

## Africa Mental Health Foundation

The Africa Mental Health Foundation was recently founded. It is dedicated to research, evidence-based policy and practice, and the promotion of mental and neurological health and healthy behaviour. It welcomes collaborative research partnerships. Its website is <http://mentalhealthafrica.com>

## The Jean Delay Prize

The Jean Delay Prize is the most prestigious award of the World Psychiatric Association (WPA) – indeed, it is regarded as the Nobel Prize in psychiatry. It is named after Jean Delay, who was the President of the first World Congress of Psychiatry (Paris, 1950) and the first President of the WPA. It is awarded to any individual who has made a major contribution to the biological, psychological or social aspects of our discipline, or who has built bridges between these domains. The prize consists of a diploma, a medal, and a donation of €40 000, and the recipient delivers a plenary lecture at the World Congress of Psychiatry.

Professor Steinfeldt-Foss of Norway is the third recipient of the prize. He was chosen by the jury as the candidate best representing the spirit of Professor Jean Delay, having dedicated his entire career to understanding and improving the dignity and human rights of patients with mental disorders. This information is taken from the WPA website (<http://www.wpanet.org>), from which the plenary lecture by Professor Steinfeldt-Foss, 'Patient and human rights in light of biopsychosocial developments in psychiatry', can be accessed.

## Specialist registrars can do placements abroad

Two excellent reports have recently been received – one by a specialist registrar (SpR) who was given 3 months' sabbatical to work in tsunami-affected areas and the other by a colleague working in Malawi. Both were supported by the College's Volunteer Programme. Both have provided vivid accounts of their experience (one is available online at <http://www.rcpsych.ac.uk/college/spcomm/Malawi.htm> and the other will be added soon).

The College supports trainees in 'out of programme' placements overseas. Specialist registrars (in year 2 or 3) are eligible for an overseas placement, for up to 1 year, approved by a relevant Specialist Advisory Committee (SAC). The placement should offer an affiliation or formal attachment to a university department, a hospital or the ministry of health. This is important if research or audit requires ethical or other approval, and will also ensure that relevant organisations know about the trainee's project so that it is organised to complement other national programmes.

All trainees will have an in-country mentor (usually a member or fellow of the College or an individually approved senior psychiatrist). Where possible, the College will place a consultant volunteer with the trainee in the same area, providing opportunities for mutual support, supervision and mentoring for the trainee. There will also be a UK mentor with knowledge of the placement country (usually an approved UK trainer) and contact should be maintained and progress monitored. Trainees will be expected to

write a detailed report about an audit, research project or a clinical case study, with supervision from the UK mentor.

## News from the UEMS

The Section and Board of Psychiatry of the Union of European Medical Specialists (UEMS) met in Košice, Slovakia, in October 2005. Dr Anne Lindhardt from Denmark was succeeded as President of the Section by her fellow countryman Dr Torben Lindskov Hansen.

The Section has recently finalised a report outlining the competences and tasks of a contemporary European psychiatrist, aimed at other medical professionals, educators, politicians, decision-makers and the general public. Psychiatrists in Europe practise in varied settings and diverse communities. Exercising professional standards, making ethical judgements and being aware of the need for tolerance are all fundamental. Multilingual societies, immigration and the rapid cultural change that follows require psychiatrists to demonstrate an understanding of this cultural diversity and a commitment to personal equality. Sufficient skills and knowledge are required to work within diverse and complex structures as an administrator and as a leader. Psychiatrists have a duty to oppose abuse of psychiatry for the purpose of excessive social control or political repression. Out of the process of European harmonisation, a sense of common European professional identity is gradually emerging.

## World Psychiatric Association International Congress

It will be a great honour for the psychiatric community of Turkey to welcome psychiatrists and mental health workers to Istanbul for the WPA's International Congress on 12–16 July 2006. With its rich cultural heritage and bridging of continents and cultures, Istanbul is a perfect place for developing new collegial alliances and exploring new scientific possibilities in our field.

Harmonising the universal scientific knowledge and the uniqueness of care for every human being is a challenge for psychiatry, both in theory and in practice. Under the general theme 'Psychiatry: Uniqueness and Universality', this congress will cover scientific studies on every theoretical and practical aspect of psychiatry and mental health. Studies covering fields such as neurology, psychology, general medicine, sociology, philosophy and anthropology are also welcomed.

Along with a high-quality scientific content, the Bosphorus will also host a rich social and cultural programme.

Psychiatrists of the world are invited to meet where the continents meet.

*Levent Küey, Associate Professor of Psychiatry  
Chairperson, Organising Committee*

The full text of the UEMS report can be found at <http://www.uemspsihchiatry.org/section/reports/2005Oct-PsychiatristProfile.pdf>

Details of the trainee schemes can be found at <http://www.rcpsych.ac.uk/college/spcomm/bia/senior.htm>

### World Psychiatric Association and the Royal College of Psychiatrists: regional reflections

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](mailto:hghodse@sgul.ac.uk)

**Sir:** I have just completed a journey 'up the Nile'. This voyage began in Cairo, where I examined for the Arab Board, and ended at the source of the Nile in Uganda some days later. I was reminded of the life-giving energy of this great river and of the enriching vibrancy and humanity of its peoples, with their contrasting mental health services. Unfortunately, I could not on this occasion visit Sudan.

The journey to Uganda was primarily a private visit to spend Christmas and New Year in a country I first lived in over 30 years ago. The timing of the visit was fortuitous, coinciding with the annual conference in Kampala of the Psychiatric Clinical Officers, and a visit by my former Keele colleague, Jed Boardman.

Both the World Psychiatric Association (WPA) and our College (one of its larger and most established member societies) are developing increasingly conspicuous and mutually enhancing regional policies. The fledgling College Africa Division could, together with the African Association of Psychiatrists and Allied Professions, provide a renewed focus for a realistic sense of 'African psychiatry'. The first African postgraduate textbook published for some decades, *Essentials of Clinical Psychiatry for Sub-Saharan Africa* (edited by Frank Njenga, Wilson Acuda, Vikram Patel and Mario Maj and published by the WPA), is a most valuable statement of new developments in postgraduate training and research.

The WPA, through its 18-strong Board of Elected Zonal Representatives, is also establishing a more tangible regional structure. The Asian Federation of Psychiatric Associations, for example, has been established, led by a distinguished Fellow of the College (Professor Parameshvara Deva), and the WPA President (Juan Enrique Mezzich) is committed to enhancing the contribution of member societies from low- and middle-income countries – and so am I. The energy and commitment of the psychiatrists in Uganda were self-evident, and the developments in mental health services now include a credible regional and district strategy.

It is now much to be hoped that the global energy witnessed at the World Congress in Cairo September 2005 will, like a Scottish salmon, move upstream, so that mental health services in the culturally rich but economically poor sub-Saharan Africa will be sustained. Here lies a challenge for our College and for the WPA.

Debates about a 'brain drain' are indeed important but we must listen carefully to those at the sharp end

of personal decision-making and to colleagues living in countries where political instability is frequent. All strength to our College President, who has grasped this nettle and who articulated the issues succinctly at the WPA General Assembly. The increased institutional strength of the WPA and the evident will of the College to take seriously its international obligations are striking developments in our increasingly smaller world.

I plan to attend a regional meeting in Addis Ababa on 24–25 April 2006 and it is much to be hoped that the Board of International Affairs will also support the important WPA regional meeting planned for Nairobi in March 2007, to be hosted by the Kenyan Psychiatric Association with Frank Njenga and colleagues at the helm.

John Cox

Secretary General, World Psychiatric Association  
Past President, Royal College of Psychiatrists

### Psychiatry as a career: a trainee's perspective

**Sir:** The thematic papers section discussing recruitment into psychiatry in issue 10 of *International Psychiatry* (October 2005) provided thought-provoking reading. From its inception, psychiatry has struggled to convey its merits to medical graduates and consequently has suffered from low recruitment. I would like to report my experience of psychiatry as an undergraduate medical student in India and as a postgraduate trainee in the UK.

The first factor which influenced me as a graduate student was the stigma and prevalent negative attitude towards anything to do with mental illness. As pointed out by Bruce Tonge in that issue, one of the factors that deters graduates from making psychiatry a career choice is the fear of being held in low social regard by family and colleagues. The proportion of the health budget allocated to mental health was appallingly low in India, which hence affected the quality of care of patients, as well as undergraduate teaching. Access to journals was limited, and this prevented me from exploring the research base in psychiatry. However, when I undertook my clinical rotation in psychiatry I became deeply interested in the complex interactions of mental illness and the whole personality of the patient and the patient's surroundings. The interpersonal skills employed to communicate with patients were empathic and psychiatry seemed to have a more human touch than other specialties.

These experiences, though stimulating, were not strong enough for me immediately to embark on a career in psychiatry. After completion of my internship

## French psychiatry

**Sir:** I read the country profile on French psychiatry in the January 2006 issue with great interest as a graduate from France with post-graduate experience in a French private psychiatric clinic.

When I was an undergraduate student we had very little exposure to clinical psychiatry. It was not a compulsory posting and was never the first choice on students' 'clerkship list'. At specialisation level, most students go into psychiatry because their ranking does not allow them to opt for the more sought-after posts in medicine and surgery.

I did a 3-month posting as medical student in a large centralised psychiatric hospital. Similar hospitals in the UK have closed down since. My supervising consultant was a surgeon who had converted to psychiatry. I enjoyed her pragmatic approach.

However, I gleaned most of my experience working at postgraduate level in a private clinic. The approach was based on experience with a psychoanalytic flavour. Rarely was ICD-10 or DSM-IV quoted. This contrasts with the evidence-based British approach.

Most French psychiatrists work in private practice, and their voluntary patients are usually admitted to private clinics. The latter are in direct competition with the *hopitaux publics*, which have an in-patient population with more severe disorders.

The legacy of French psychiatry is undisputed. But with English being the language of the scientific community, the French are suffering from the paradox that the French language has narrowed the diffusion of current French psychiatry to a Francophone auditorium.

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## College International Divisions

The executive committees of the College International Divisions are now fully functional with all officers in post as follows:

International division	Chair	Secretary	Financial officer
African	Prof. Tuviah Zabow (South Africa) Elected 24 January 2005	Dr Olufemi B. Olugbile (Nigeria) Elected 24 January 2006	Dr Frank Njenga (Kenya) Elected 19 October 2005
European	Prof. George Christodoulou (Greece) Elected 24 January 2005	Prof. Manuel Gómez-Beneyto (Spain) Elected 19 October 2005	Dr Anne Lindhardt (Denmark) Elected 19 October 2005
Middle Eastern	Dr Nasser Loza (Egypt) Elected 24 January 2005	Dr Faud Antun (Lebanon) Elected 24 January 2005	Dr Walid Sarhan (Jordan) Elected 24 January 2005
Pan-American	Dr Nigel Bark (USA) Elected 24 January 2005	Dr Oscar Meehan (Argentina) Elected 19 October 2005	Dr Simon Brooks (Canada) Elected 19 October 2005
South Asian	Prof. S. Haroon-Ahmed (Pakistan) Elected 24 January 2005	Dr Nalaka Mendis (Sri Lanka) Elected 24 January 2005	Dr Mohammad Mullick (Bangladesh) Elected 24 January 2006
Western Pacific	Prof. Scott Henderson (Australia) Elected 24 January 2005	Prof. M. Parameshvara Deva (Malaysia) Elected 24 January 2005	Prof. Helen Fung Kum Chiu (Hong Kong) Elected 19 October 2005

# Forthcoming international events

2–5 May 2006

**Psychology and Communication, Friendship and Unity**  
Association of Psychology and Psychiatry for Adults and Children (APPAC)  
Athens, Greece  
Email: appachella@yahoo.gr  
Website: <http://www.epsep.org.gr>

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

8–10 May 2006

**8th World Congress on Innovations in Psychiatric Research**  
World Forum for Mental Health  
Oxford University, UK  
Email: worldforum@aol.com  
Website: <http://www.worldforum.co.uk>

16–20 May 2006

**2nd Kyoto Conference: The Interfaces Between Psychology, Psychotherapy, Analysis and Buddhism**  
Email: dalemathers@yahoo.co.uk or miller@norwich.edu

8–10 June 2006

**International Psychiatric Meeting 2006**  
WPA-sponsored regional meeting  
Midlands Psychiatric Research Group, Coventry, UK  
Email: afzal.javed@ntlworld.com

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>

17–22 July 2006

**International Congress of Group Psychotherapy. Groups: connecting individuals, communities and cultures**  
São Paulo, Brazil  
Email: iagp2006@eventus.com.br  
Website: <http://www.iagpcongress.org>

16–19 August 2006

**28th Nordic Congress of Psychiatry: New Tools for Clinical Practice**  
Tampere, Finland  
Website: <http://www.psy.fi/hcp2006>

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

26–30 September 2006

**A World of Drugs, a Universe of Treatments**  
International Society of Addiction Medicine (ISAM)  
Oporto, Portugal  
Contact: Dr Antonio Pacheco Palha  
Email: apalha@sapo.pt  
Website: <http://www.isamweb.org>

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>

5–8 October 2006

**Third International Conference 'Together Against Stigma'**  
Psychiatric Association of Turkey  
Istanbul, Turkey  
Contact: Aslihan Polat  
Email: stigma@stigmaistanbul.org  
Website: <http://www.stigmaistanbul.org>

6–8 October 2006

**Pacific Rim College of Psychiatrists Congress**  
Taipei, Taiwan  
Contact: Dr Allan Tasman  
Email: allan.tasman@louisville.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

6–8 June 2007

**Coercive Treatment in Psychiatry: A Comprehensive Review**  
WPA thematic conference  
Economia Study Group in collaboration with the Czech Psychiatric Society  
Dresden, Germany  
Email: cstolz@intercom-dresden.de  
Website: <http://www.wpa2007dresden.org>

19–22 June 2007

**Royal College of Psychiatrists annual meeting**  
Edinburgh, UK  
Email: conference@rcpsych.ac.uk  
Website: <http://www.rcpsych.ac.uk>

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