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EDITORIAL

International Psychiatry – the way forward

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All psychiatrists would acknowledge that communication between individuals is fundamental to their speciality, but it is perhaps less obvious that the increasing ease and speed of communication worldwide are also having a profound effect on psychiatric practice. With this improved communication comes an awareness of the commonality of many mental health issues and recognition that there is much to learn from others working in very diverse environments. It is also true that many mental health problems have an international dimension, particularly when large numbers of people are displaced by war or other disasters. Increasingly we need to have a better understanding of other cultures and the relationship between culture, mental health and psychiatric disorder.

Simultaneously there have been dramatic advances in many areas of psychiatry, including basic biomedical research, as well as behavioural and clinical research. There have been new discoveries in related fields, such as genetics, immunology and cellular function, that are already affecting psychiatric practice, and new techniques for investigating clinical processes are continually being devised. Health systems and health services are also the subject of research, into issues such as health needs, coverage of populations, utilisation, cost-effectiveness and the relationship with broader aspects of the health economy. In addition, there has been extensive reorganisation of health services, including mental health services, in many countries, and this has affected the training of health care professionals and changed the way in which health care is provided.

These changes and advances form the context for the launch of the Board of International Affairs (BIA) at the annual meeting of the Royal College in Cardiff in the summer of 2002. It was set up because of the growing recognition by the College that, in the 21st century, it needs to play a more prominent role on the international stage, by forming partnerships with similar bodies in other countries and by developing strong links with international organisations involved in mental health.

With members in many countries, the College has a firm base for this development, but it has acknowledged that it needs to improve its communication with members abroad and, more importantly, to develop a dialogue with them, and between them, to provide a forum for mutual learning with a genuinely international perspective. *International Psychiatry* is the bulletin of the BIA and its first issue signals this more open approach.

International Psychiatry provides an overview of current policy and practice in psychiatry in different countries and will help all mental health professionals to learn about and keep abreast of what is happening elsewhere. This is valuable because the complex relationship between cultural variables and mental health differs from one country to another and this in turn affects treatment and attitudes to treatment. Learning about others' practices can act as a powerful but healthy challenge to entrenched assumptions. The bulletin's special features therefore include country profiles on mental health and mental health policy, which describe the structures for education, training, research, policy and practices, so that those who are interested in collaborative work, elective placements and so on have ready access to fundamental information. In addition, particular themes are explored in each issue from the perspective of different countries and international organisations, with commissioned reviews from experts on selected topics. The editors will actively search for sound and reputable work to provide readers with good information and there will be an emphasis on the policy and practice implications of new research. There will also be a section on forthcoming major events, worldwide. Information about the activities and working structures of the Royal College will be included so that members abroad can more easily identify with their College and know what is going on. There will be a correspondence section which, it is hoped, will foster multidisciplinary discussion and dialogue.

We hope you enjoy the first issue and feel encouraged to contribute to the future development of *International Psychiatry*.

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Contributions for future issues are welcome – please contact Hamid Ghodse at the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, UK. Fax: +44 (0)207 235 7976; email hghodse@sghms.ac.uk

Themes in *International Psychiatry*

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In this, the inaugural issue of *International Psychiatry*, we are highlighting the first of many themes that are of interest and concern to psychiatrists around the globe. Terrorism is both directly and indirectly the predominant topic in our media at present. What impact does living with such a threat, an 'ever-present danger', have on our mental health? Even if we are not directly affected by terrorism, psychiatrists cannot ignore the effects such incidents have had on societies in both the developed and the developing world.

We have commissioned a series of articles which report how different aspects of the terrorist threat have influenced the lives of people around the world. Four articles appear in this issue and a further set will follow in the second issue of *International Psychiatry*.

Herman and Susser discuss the effects of the events of 11 September 2001 on people living in Manhattan and make recommendations about how psychiatric services should respond in such circumstances. They emphasise the need for advance planning.

Njenga and colleagues discuss the traumatic events in Nairobi, Kenya, in 1998, when a huge bomb destroyed the American embassy. Many Africans suffer severe trauma more frequently than citizens in the United States, but their psychiatric services are far less well equipped to deal with the sequelae of such events. It is arguably a responsibility of psychiatrists in the developed world to assist in mental health promotion within developing societies. We learn about the Mental Health Policy Support Project, which is co-sponsored by the WHO and the UK Department for International Development; the hope is that the Kenyan model will be replicated in other countries.

De Jong, Komproe and Van Ommeren challenge psychiatrists to consider what is an appropriate professional role in response to terrorist-inspired events. In a controversial article, they argue that it is the responsibility (and indeed the nature) of a culture to respond with a network of supportive structures and rituals. This is exactly what happened in Kenya – a recourse to prayer and support from the family. We need to consider, though, whether this is enough. Njenga and colleagues think not. On the other hand, are we, in the Western world, in danger of going too far in the direction of 'pathologising' experience, to the extent that professional support will be sought after exposure to traumas that are a lot less dramatic than 11 September? And if so, does it matter?

Finally, in a thought-provoking reflection on events in Northern Ireland, Lord Alderdice discusses the way in which a society that has lived with 'Troubles' for many years adjusted to chronic threat. Despite the persistent danger, there is no evidence that this translated into heightened vulnerability to mental ill-health.

Our readers will understand that the views of the authors expressed in these articles are not the views of the Royal College; nor are they necessarily the views of the editors of this novel bulletin. Enjoy and reflect. We hope you will appreciate them as much as we did.

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The World Trade Center attack: mental health needs and treatment implications

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On 11 September 2001, the United States suffered the worst terrorist attacks in its history. In New York City, approximately 3000 persons were killed at the World Trade Center, while many thousands fled for their lives. Millions of other city residents observed the burning towers and breathed the acrid smoke that blanketed the city. Compounding the massive physical destruction and loss of life, the psychological impact of these terrifying events on the populace was profound – there were significant increases in mental distress and symptoms of disorder.

Prevalence of disorder

In a rapid needs assessment commissioned by local government in the immediate aftermath of the attacks, we estimated a minimum of half a million cases of diagnosable mental disorder in the New York region consequent to 11 September (Herman *et al*, 2002; Susser *et al*, 2002). Subsequently published research confirmed the massive emotional impact. A telephone survey of 1008 adult residents covering much of Manhattan (the borough of New York City in which the World Trade Center was located) found that 7.5% had probable post-traumatic stress disorder (PTSD) related to the attacks roughly one to two months after 11 September (Galea *et al*, 2002*a*). A web-based national survey conducted at approximately the same time estimated similar rates of probable PTSD among New Yorkers (Schlenger *et al*, 2002), while a third survey, by Hoven *et al* (2002), of approximately 8000 New York City schoolchildren in grades 4–12, found that 10.5% had PTSD related to 11 September. The Hoven study, and those by Galea's team, also documented increases in other disorders, including depression and agoraphobia. Beyond the development of diagnosable mental disorders, there was also evidence of a dramatic increase in sub-threshold psychological distress in adults and children across the United States following the attacks (Schuster *et al*, 2001).

Risk factors

As seen in the research on the Oklahoma City bombing of April 1995 (North *et al*, 1999; Sprang, 1999), the risk of developing mental disorder following a terror attack appears to be associated with the degree of exposure to the event. For instance, rates of depression were higher among adults who reported that a friend or relative was killed or who had lost their job as a result of the attack on New York (Galea *et al*, 2002*a*). Although systematic data have yet to be reported on rates of PTSD among persons who survived the evacuation of the World Trade Center and the surrounding buildings, there is evidence that being in one of these buildings during the attacks was associated with the development of symptoms of PTSD (Schlenger *et al*, 2002). Since the attack received an unprecedented degree of exceptionally graphic media coverage, including live television broadcasts of the airplanes' impact, victims falling to their deaths and people fleeing for their lives, some have wondered whether indirect exposure may also have increased the risk of subsequent disorder among viewers. While the direction of causality remains unclear, there appears to be evidence of an association between frequent viewing of these images and symptoms of disorder (Schlenger *et al*, 2002).

A previous body of research has documented the role of a variety of non-exposure-related risk factors on the psychological sequelae of disaster. Risk factors for adverse outcomes include both individual attributes (e.g. female gender, pre-existing psychiatric symptoms, history of exposure to trauma) and social factors (e.g. low levels of social support) (Norris, 2001). In the data reported so far in the aftermath of the attacks of 11 September, such factors associated with the development of PTSD include job loss, female sex, low social support and more life stressors experienced in the preceding 12 months (Schlenger *et al*, 2002; Galea *et al*, 2002*b*).

Time course

The ultimate course of these disorders remains to be seen. Regarding PTSD per se, short-term follow-up data suggest that the majority of cases may have resolved fairly rapidly; the reported rate of current PTSD related to 11 September in Manhattan had declined to 1.7% by January 2002, and rates of depression had also decreased significantly (Galea *et al*, 2002*c*). These declining rates are consistent with some but not all previous studies of PTSD (Kessler *et al*, 1995; North *et al*, 1999). None the less, the absolute number of persons experiencing ongoing PTSD resulting from the attacks several months afterwards still exceeded 100 000, while there may still be delayed-onset cases that have yet to manifest.

Service provision

Thus, the attacks of 11 September had a profound effect on the mental health of New Yorkers. What are the implications of these findings for psychiatrists and other mental health providers who may be called upon to respond to community needs following a major terror attack? In the aftermath of such an event, the requisite mental health service response can be expected to unfold in acute and post-acute phases. The duration of these phases is dictated by the intensity of the disaster, the degree of ongoing threat and the response of the community.

Acute phase

Services needed during the acute phase include crisis intervention, psycho-education, and social support to help people cope with psychological distress caused by exposure to the disaster. Much of this work is delivered '*in vivo*' – in schools, places of worship, and other emergency recovery settings, rather than formal mental health settings. In general, communities (including New York) have been inadequately prepared to mobilise resources in the immediate wake of mass disaster, and this has greatly limited their capacity to deliver interventions effectively. Although it is hoped that these early intervention efforts, in addition to their immediate palliative effects, will also confer ongoing benefits, there is scant empirical evidence of their long-term impact (National Institute of Mental Health, 2002). In particular, a recent review of studies of psychological 'debriefing' (the most commonly studied model) concluded that it is ineffective in reducing the risk of subsequent PTSD and other disorders (Suzanna *et al*, 2001).

Post-acute phase

After the acute phase, the focus largely shifts to the treatment of diagnosable mental disorders, to persons whose symptoms have not resolved and to those who have

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experienced delayed onset of such disorders. Fortunately, there is a somewhat more well established research literature regarding effective treatments for mental disorders most likely to result from exposure to mass violence and severe trauma (National Institute of Mental Health, 2002). A number of studies support the efficacy of cognitive–behavioural psychotherapeutic interventions for PTSD, while there is also some empirical support for group and individual psychodynamic therapy. Pharmacotherapy may also provide benefit for people experiencing PTSD, as dysregulation of numerous psychobiological systems is often associated with it. In addition, the high frequency of co-occurring psychiatric disorders among people with PTSD underscores the importance of considering pharmacotherapy in the treatment of PTSD (Foa & International Society for Traumatic Stress Studies, 2000).

Activities that focus on bringing together members of the community to provide social and emotional support for persons who have suffered significant losses enhance social cohesion and mutual support, which, in turn, have important health and mental health benefits.

Community response

Although the treatments described above are focused on individuals, families and small groups, the need to target interventions at the broader community level should not be overlooked. Activities that focus on bringing together members of the community to provide social and emotional support for persons who have suffered significant losses enhance social cohesion and mutual support, which, in turn, have important health and mental health benefits. As exemplified by New York Mayor Rudolph Giuliani's leadership in the days following 11 September, community resilience is also greatly enhanced by government leaders who can effectively promote a sense of common purpose and optimism even in the face of enormous tragedy.

Finally, it is essential to have an infrastructure in place beforehand if effective mental health interventions are to be delivered following large-scale terrorist events. This includes comprehensive planning for a coordinated response, a well-trained workforce, and greater recognition on the part of government authorities that attending to mental health concerns is a crucial component of public health preparedness in a time of terror.

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THEMATIC PAPER – TERRORISM

Africa: the traumatised continent, a continent with hope

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Many African countries gained political independence in the 1960s and 1970s and went through difficult times in economic, political and security terms in the 1980s and early 1990s. Mental health services and research were not spared and stagnated or deteriorated during this period. The effects of poor governance, inequitable distribution of resources and environmental degradation conspired with natural and man-made disasters (wars in particular) to drive Africa into an abyss of despair.

In East, West, Central and Southern Africa, there is presently fighting over issues that seem unclear even to the combatants. Conflicts, including wars and civil strife,

result in an increase in mental health problems. They place a heavy toll on the already overstretched health and other social services of the region. According to the 2001 *World Health Report* (WHO, 2001), between a third and a half of those affected by conflict suffer mental distress, including post-traumatic stress disorder (PTSD) and depressive and anxiety disorders.

Africa is home to large populations of refugees (approximately 1.5 million) (United Nations High Commissioner for Refugees, 2002) and of survivors of a myriad natural and man-made disasters. Somalia, Ethiopia, Sudan, Rwanda and Congo are examples of countries currently in armed conflict; they provide the region with a large concentration of refugees and internally displaced persons. Psychiatrists in the course of their work come closer to human suffering than workers in many other branches of medicine. For this reason they ought to be more aware of the fact that poverty, and political, social and economic inequalities between groups predispose to conflict (Stewart, 2001).

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The embassy bombing

The events of 11 September 2001 have underscored the fragile nature of peace as well as the global interdependence of nations. When hijacked planes crashed into the World Trade Center in New York, the theatre of action for terrorism had changed for good. Like many before them, Americans felt the deep sense of loss and violation of the most sacrosanct of their institutions. Important questions were soon to be raised with regard to events in Africa three years earlier.

On 12 August 1998, a fax was received at the Royal College of Psychiatrists from Dr F. G. Njenga, Chairman of the Social Responsibility Committee, Kenya Medical Association, after the bombing of the American embassy in Nairobi. It read:

> You will have heard of the disaster that struck our country in the hands of terrorists. We are about to start the recovery process but we are angry, confused and in some instances drowned by feelings of hopelessness…. The Kenya Medical Association (KMA) is now making this appeal to you personally and to your Organisation for any help and/or assistance that you may have either on account of having dealt with disasters of this nature or simply from your experiences. Kindly let us have your views and comments on our appeal at this, our greatest hour of need. (See Alexander, 2001)

Professor David Alexander was sent by the College to Nairobi to respond to the request on its behalf. He later wrote:

> several hours after I had arrived, my hosts took me to the bombsight. Despite my best efforts, nothing I had read nor the photographs I had viewed really prepared me for this sight. In particular, it was hard for me to imagine that the extended pile of rubble was once Ufundi House. Also, the scarred twin 21-storey towers of the Cooperative Bank had not a window left intact. On that morning, a one-ton terrorist bomb had exploded during the mid-morning rush hour and killed 253 and injured 5000 people. The destruction to property around the epicentre of the blast was extensive with a number of buildings including the American Embassy completely destroyed. (Alexander, 2001)

To some, Africa was in 1998 a dress rehearsal for New York on 11 September. What lessons did the world learn from the 'Dark Continent'? Did the world take stock of the failures and successes of the Africans? Some think not.

Operation Recovery was a home-grown project that responded to the immediate mental health needs of the Kenyan community. In the six months after the disaster, many questions were asked by Kenyans and remained unanswered. Perhaps more attention to the events of August 1998 could have given clues to the events of 11 September 2001. Why, for example, did the terrorists choose East Africa? What is the relationship between security lapses in 1998 and those of 11 September 2001? At a different level, what were the immediate and long-term mental health needs of those affected? How did Africans respond and what did Americans learn?

A study that followed the bombing in Nairobi involved 2800 subjects; it showed that the bomb injured a young (working) population (mean age 33.8 years), who were mostly married (64%); there were more men involved (54%) than women. Seventy-eight per cent had children and other dependants, and as a group they were the most highly educated Kenyans (76% had had university or secondary school education). Kenyans generally, it turned out, were a highly traumatised group even before the bomb. Of 290 respondents in one study, 98% had suffered one of a number of specified traumatic events, including hospitalisation/surgery, rape, mugging, robbery, loss of a loved one (child or parent), car-jack, internal displacement, harassment by a public authority, or road accident (Kenya Medical Association, 2000). They responded to the bombing of the embassy with marked symptoms of acute stress disorder (86%), as well as obstetric complications (62 of the 67 pregnant women interviewed reported complications). Typical Kenyan methods of coping included prayer and support from the family.

Kenyans generally, it turned out, were a highly traumatised group even before the bomb. Of 290 respondents in one study, 98% had suffered one of a number of specified traumatic events.

Lessons from Africa

Of all the lessons learnt from Kenya, how many were available to the Americans on 11 September?

Smith *et al* (1990) studied the prevalence of psychiatric disorder following an airplane crash into a hotel and found that more than half the subjects met criteria for a psychiatric disorder after the disaster. Following a similar crash involving flight number KQ103 in Abidjan (Ivory Coast) in 2001, no studies were set up (which underscores the lack of research in developing countries). How, one might ask, could the world benefit from studies in Africa? Shariat *et al* (1999), in a prospective study of the long-term health outcomes among survivors of the Oklahoma City bombing, concluded that a large proportion of survivors of a

terrorist bombing, especially those seriously injured, will experience long-term physical and emotional effects, and have a need for the treatment of bomb-related medical conditions. Four years after the African bombing of the American embassy, no prospective studies are in place – much trauma, no research.

Wider problems

In March 2000, Mozambique suffered the most severe flooding in recorded history. For many hours after the onset of the disaster, the Mozambican Government as well as its neighbours watched helplessly as human lives and property were destroyed. Also in March 2000, the largest mass suicide occurred in Uganda, when nearly 1000 people died. The horror attendant on these tragedies is matched by the absence of a mental health response to attend to the community, the survivors, relatives and rescue workers. The effects of the genocide in Rwanda in 1994 are yet to be studied and understood in full. The long-term psychological effects are unknown.

Most of sub-Saharan Africa is listed by the 2002 *World Development Report* (World Bank, 2002) as existing below the poverty line, while the 2001 *World Health Report* (WHO, 2001) points to the relationship between poverty and mental disorder. Stewart (2001), in an article on the root causes of conflict in developing countries, concludes:

> The sharp economic and social difficulties between western societies and the Muslim world are a clear example of international horizontal inequalities that predispose to conflict.

Other seemingly peripheral issues to be addressed by Africans include poor governance, political instability and high social morbidity due to natural and man-made calamities (including wars).... All these factors conspire to give Africans some of the highest levels of independent risk factors for mental disorder of any continent.

Other seemingly peripheral issues to be addressed by Africans include poor governance, political instability and high social morbidity due to natural and man-made calamities (including wars). In consequence, Africa has some of the largest numbers of refugees per population in the world. All these factors conspire to give Africans some of the highest levels of independent risk factors for mental disorder of any continent. The story of trauma in Africa makes very depressing reading. Is there reason for hope?

The next part of this paper demonstrates that, hopeless as the picture painted above may seem, there is reason for hope. The project described below is an excellent example of collaboration between Africa and Europe, for the benefit of both.

Mental Health Policy Support Project

Mental health policy is a government's mission statement on mental health and mental health care. As such it represents the formal, written aspirations of the government, which will be implemented, to varying degrees, in the field. The inevitable disparity between policy and practice will vary between countries and between different areas of the same country, depending on the timetable for implementation, on the resources and will for implementation, and on the opportunities and obstacles. The WHO's collaborating centre at the Institute of Psychiatry, King's College, London, under the directorship of Professor Rachel Jenkins has developed a two-year project, funded by the Department for International Development (DFID) in the UK, to provide mental health policy support to the governments of Tanzania and Kenya.

The goal of the project is to reduce poverty through a reduction of the global burden of mental disorder. Mental health promotion is a multidimensional concept that implies the creation of individual, social and environmental conditions that enable optimal overall psychological development. The project is focused, among other concerns, on personal autonomy, adaptability, and ability to cope with stressors, self-confidence, social skills, social responsibility, and tolerance. Prevention of mental disorders could be one of its outcomes (Hosman & Jane-Liopis, 1999).

The Kenyan component is aimed at building upon the lessons learnt, and at identifying more common issues and lessons that will be used as building blocks for a model that can be replicated in other countries. The main thrust of the project is to evaluate the method of delivery of policy support as a model for DFID's future work in the region, and to make available the findings to the WHO's wider programme on mental health.

The project is implemented through a network of researchers and mental health workers and coordinated by a local project officer in Tanzania and in Kenya.

The main expected project outputs include:

- specific mental health support to Kenya and Tanzania
- the identification of issues unique to each country
- the support of primary care in tackling mental illness
- the establishment of continuing education programmes
- promotion of the use of guidelines
- evaluation of the results of policy support
- the development of a transferable model for policy support for other low-income countries.

The various components of the project are described below.

Country Profile

The Country Profile is an instrument developed by the International Consortium for Mental Health Policy and Services for its project on international mental health policy, programmes and services.

For policy decisions, information on current and future resources is required. Resources are those elements that are injected (input) into the total mental health system in terms of finance, personnel, equipment and buildings. These elements are important and closely related to the types of services provided (Jenkins, 1990; Tansella & Thornicroft, 1998).

The Country Profile gathers the information required to assess the overall mental health situation in a country that is relevant to policy development, in a standardised way, with due regard to sociocultural context. Its main objectives are:

- to provide a database of information about mental health policy, strategy and service
- to facilitate the use of this information to support evidence-based policy development

- to enable comparative analysis between countries, to help identify areas where urgent action is needed and to point to potential solutions
- to provide a common format for the assessment of mental health policy and programmes
- to provide a reference source for United Nations agencies, non-governmental organisations, intergovernmental agencies and for professionals working in the field.

The main work in the development of the Country Profile has now been completed. Kenya has completed the profile and the data are available to the Government and its various divisions to help plan services.

Epidemiological survey

As part of an assessment of the needs of the community, a baseline epidemiological survey using instruments drawn from the British National Mental Health Survey was performed in Maseno division, which has a population of 65 000, situated in Nyanza Province in Kenya. The instruments were translated into the local Dholuo language and primary health care workers administered them and collected the data. The preliminary analysis indicates a prevalence of mental disorder of approximately 11%. The survey is aimed at providing a basis for planning of services at the national level.

Another survey, covering the city of Kisumu, is planned for later in 2003. This will provide information on the urban population. These findings will be compared with those of the British National Mental Health Survey.

Depression attitudes survey

A depression attitudes questionnaire originally used on primary care physicians in the UK was adapted. So far, four surveys to assess attitudes to depression have been conducted. These have been among community health workers, also referred to as village health workers, health workers at a primary care centre (Chulaimbo Health Centre), traditional health practitioners and traditional birth attendants. This will be followed by training sessions based on the responses. A post-training evaluation will be done with a view to making recommendations for wider usage in the rest of the country. Results of the surveys will form the basis for some of the training materials being developed for the second phase of the project. No difficulties were encountered in the translation or administration of the questionnaires to the various groups.

General Health Questionnaire

The 12-item General Health Questionnaire (GHQ) has been administered to patients at a primary care health centre, as they exit after being seen. An analysis of diagnoses and GHQ scores is then done. A training package is planned on that basis for post-training evaluation and eventual recommendation.

Adaptation of WHO primary care guidelines for mental health for Kenya, Tanzania, Zanzibar and Zambia

Through a series of meetings and consultations, various mental health experts drawn from the above countries have reviewed and adapted the guidelines for the specific local conditions and a draft has been produced for distribution to key players in mental health at various levels of care, as per the primary care model.

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Conclusion

The joint project is our evidence of hope. The fact that the WHO centre in London, DFID, the Kenyan government, the Kenya Psychiatric Association and the University of Nairobi have come together to run a joint project is reason to hope.

We expect that the Royal College will, through the Board of International Affairs, encourage and facilitate projects of this nature in Africa and other parts of the world.

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Terrorism, human-made and natural disasters as a professional and ethical challenge to psychiatry

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The consequences of terrorism, wars and natural disasters are a challenge to the psychiatric profession. The large numbers of people estimated to have mental health problems surpass the capacities of existing mental health services, whether modern or traditional. The bulk of the 35 million refugees and internally displaced people worldwide reside in countries that, on average, have less than one psychiatrist or psychologist per 100 000 people (WHO, 2001). Even the 500 000 people estimated to need some form of psychological support after the attack in New York on 11 September 2001 exceeded the service capacity, despite the fact that New York has the highest density of mental health professionals in the world (Herman & Susser, this issue, pp. 2–4). Elsewhere, many survivors of various types of disaster reside in peripheral areas of countries and are not covered by modern mental health services.

Research in post-conflict situations has gravitated towards the epidemiology and treatment of post-traumatic stress disorder (PTSD). Yet the study of this Western diagnostic category in non-Western contexts may lead to its reification without evidence that this category is the most relevant of possible descriptions of local survivors' mental health problems.

Services for survivors

Survivors often belong to a different ethnic or socioeconomic group from those who seek to offer help. They express their plight in a specific discourse and use a variety of explanatory models. Modern mental health services, even if they are community oriented, tend to exclude specific groups. There are several reasons for this:

- many mental health professionals are not adequately trained to deal with certain types of people
- many survivors are stigmatised (especially rape survivors)
- many survivors are too poor to pay for services or too afraid to travel to access services
- many survivors do not trust or understand the rationale of modern psychosocial or mental health support.

Traditional services offer support to survivors but do not always break through social stigmas, can be expensive and are of varying effectiveness. Collaboration between allopathic and traditional services is often advocated but is also a challenge (Hiegel, 1996; de Jong, 2001).

A further challenge to psychiatry is that most conflicts are the result of political, economic and sociocultural processes, and the sequelae of such conflicts can likely be resolved only by multilevel, multisectoral public health approaches informed by social sciences (especially medical anthropology), behavioural sciences and epidemiology.

Most protracted conflicts are related to competition for power and resources, and result in predatory social formations; they affect large, displaced and mostly poor populations and they are often accompanied by cycles of violence (Hamburg *et al*, 1999). Conflicts that are protracted require flexible but sustainable solutions, both functionally and geographically, and may require that paraprofessionals from among the survivors move to other areas together with the displaced persons when the armed conflict dictates a continuation of their journey. Public mental health activities in such regions must thus accomplish more than the training of helpers.

Frameworks are necessary for setting up mental health systems in diverse circumstances. An example of such a framework is the organisation of mental health care within primary care (de Jong, 1996; WHO, 2001). Survivors of extreme stressors such as war, genocide, persecution, political repression, torture, ethnic cleansing or terrorism in developing countries are prone to a range of additional vulnerability factors, such as increased economic hardship, lack of skills fitting the new environment, marginalisation, discrimination, acculturation, poor physical conditions and a collapse of social networks (de Jong, 2002). Most mental health problems of survivors in these contexts are not likely to have been solely determined by traumatic events but also by changes in the social context. As a result, both psychological and social interventions have a role.

The overextension of Western categories

Mental health professionals are increasingly trained to orient their interventions and service delivery models towards evidence-based practice. Research in post-conflict situations has gravitated towards the epidemiology and treatment of post-traumatic stress disorder (PTSD). Yet the study of this Western diagnostic category in non-Western contexts may lead to its reification without evidence that this category is the most relevant of possible descriptions of local survivors' mental health problems (Marsella *et al*, 1996; Shrestha *et al*, 1998). This is resulting in selective attention to PTSD in many intervention programmes at the expense of other types of mental health problems. For example, we studied psychopathology in post-conflict Algeria, Cambodia, Ethiopia and Gaza. As expected, we found a 3- to 10-fold increase in

PTSD among those who had been exposed to violence. However, we also found a 1.2- to 6-fold increase in mood disorder and non-PTSD anxiety disorder (de Jong *et al*, 2003). Moreover, we found that disability was more associated with mood disorder and anxiety disorder than with PTSD. This calls for a paradigm shift among professionals who focus more or less solely on PTSD within trauma rehabilitation programmes.

Another challenge is the sole use of prevalence rates to estimate need for treatment. A recent study showed that US prevalence figures for psychiatric disorders decreased by 17–32% after adjustments were made for help-seeking, life interference and use of medication (Narrow *et al*, 2002).

With respect to psychotherapeutic research, we suffer from a 'redundancy fallacy': research funds tend to gravitate to prove what is proven. The consequence of this is that, in the West, most funds are spent on research into cognitive–behavioural approaches. We doubt, however, whether it is appropriate to use this approach with survivors worldwide. Even if the evidence on cognitive therapies can be generalised, such therapies are not easily learned. Given the absence of mental health professionals outside the West (WHO, 2001), it is unlikely that cognitive therapies can be made widely available in the foreseeable future. Approaches that may be implemented by para-professionals appear more feasible, such as problem-solving approaches (Gath & Mynors-Wallis, 1997) or group, family or individual psychosocial counselling.

A preferred direction

Within the public mental health field, criteria other than prevalence should be used to select priorities (de Jong, 2002; de Jong & Komproe, 2002). Examples of such criteria are:

- level of functioning
- perceived needs of the population
- motivations for help-seeking
- problems that may be treated with limited resources
- cost-effectiveness.

The main question is how to reformulate mental health care policy to strengthen a process of natural healing, especially after emergencies. To enable this process, a modest attitude towards the role of psychiatry is desirable: psychiatry does not have a monopoly on the healing of extreme stress. The field of community psychology, for example, has a lot of experience in strengthening coping, social support and empowerment within communities (Dalton *et al*, 2000).

Although experience in the management of the consequences of conflict is mostly from the West, the concepts of coping and social support without doubt also play a central role in non-Western contexts (Emmelkamp *et al*, 2002). Cultures develop resiliency and coping strategies in the form of mourning, healing, purification, reconciliation and commemoration rituals (de Jong, 2002). The local community may be reinvigorated by people taking up the daily routine of work or caring for children, or through income-generating activities, rural development and micro-credit schemes. Collaboration with community development workers will advance the field. The overall approach has to fit within the public health structure. It is therefore necessary to adopt a systemic approach, to link individuals, families, communities and the society at large. The sequelae of traumatic events need to be conceptualised as consequences that manifest themselves on different levels, not merely within the individual.

Elsewhere, we have described a wide variety of preventive and curative interventions (de Jong, 2002). To find out which interventions are effective demands a large amount of creativity and courage from our profession with respect to intervention programmes, funding and research.

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Mental health, illness and communal violence in Northern Ireland

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Many psychologically informed books and papers have been published during the past 30 years that have explored different elements of the Northern Ireland problem. These have ranged from Padraig O'Malley's (1990) fascinating examination of the world of the hunger strikers and their families, to a recent socio-psychological study of sectarianism in young children, which was sponsored by the Community Relations Council (Connolly *et al*, 2002). The latter careful piece of work demonstrated that while children of three years of age are beginning to identify different cultural symbols, there is not much evidence of sectarian attitudes until about five or six years of age. By this time they have not only begun to recognise and identify with partisan symbols, but also to express deeply antagonistic sectarian attitudes. These are not wholly unexpected findings, but the purpose of good research is to enquire whether things are in fact the way one might expect them to be. When it comes to research on clinical psychiatry there is less material but the most interesting and unexpected finding that emerges from the published work of psychiatrists in Northern Ireland is the limited evidence of any increased violence-related psychiatric illness in the population as a whole.

It seems that a population may experience serious prolonged violence but not necessarily exhibit a significant increase in the rate of psychiatric disorders.

The pattern of politically motivated violence in Northern Ireland has not been entirely consistent since 1968, when the 'Troubles' began. During the first couple of years there was extensive civil disturbance, with serious street rioting in urban areas. While these areas remained a major focus throughout subsequent years, the transition to a terrorist campaign, with the bombing of military and economic targets as a central component, extended the geographical spread to affected border populations and the commercial centres of provincial towns. Later still assassinations became a major feature, which changed the communal experience of the violence significantly.

In the early 1970s the descent into chaotic lawlessness was dramatic. As Cairns (1994) pointed out, in the 1960s the number of murders in the Greater Belfast area did not reach double figures. (In the period 1960–64 only one murder was reported in the city.) In 1972, however, at the height of the civil disturbances, 467 people died in violent circumstances. Despite this, Alec Lyons (1971), a senior consultant psychiatrist in Belfast, noted no increase in the number of psychiatric hospital admissions and no increase (indeed, a small decrease) in attendances at general practice surgeries at this time. While other work by Lyons tended to suggest an inverse relationship between suicide rates and violent deaths in the community, further enquiry has left this uncertain.

Lyons' interest was followed throughout the 1980s and 1990s by another consultant psychiatrist, Peter Curran, who, with a team of colleagues based in North Belfast, one of the areas of most intense violence, did significant work using the construct of post-traumatic stress disorder (PTSD) to measure the psychological consequences of terrorist violence on individuals (Loughrey *et al*, 1988; Curran *et al*, 1990). In two valuable review articles in 1988 and 2001, Curran noted the methodological difficulties in assessing the psychological impact of civil disorder and terrorism (Curran, 1988; Curran & Miller, 2001). He reviewed various research material that used community surveys, hospital admissions and referral data, psychotropic drug usage, suicide and attempted suicide rates, and data from assessment of the actual victims of violence. He came to the conclusion that while, clearly, many individuals in Northern Ireland have been seriously damaged physically and psychologically it is not easy to know why some have survived their experience better than others, nor why the impact on psychiatric services as a whole has been limited. He showed that, in a number of studies, less than 10% of referrals and admissions had as their precipitants any violence-related issues. It seems that a population may experience serious prolonged violence but not necessarily exhibit a significant increase in the rate of psychiatric disorders.

Cairns & Wilson (1984) took a different approach. Instead of using official health statistics or clinical studies, they conducted community surveys using the General Health Questionnaire and came to the conclusion that while there was evidence of increased stress on the population in a violent area, it accounted for only a minor component of the variability. Cairns (1994) speculated that 'denial' might be an important element in the coping mechanisms of the population, and in his later work reported some evidence that distancing, denial and religious interest and involvement may help to account for how the people of Northern Ireland have adapted to living long-term with the threat of violence. Certainly it has often been remarked with some puzzlement by psychotherapists in Northern Ireland how infrequently the Troubles are a focus in their work with patients, except for those who present with direct traumatic experience.

Prior (1993) not only reviewed the clinical and community survey evidence but also addressed the impact of the Troubles on mental health services and found that,

despite the obvious pressures, the integration of hospital and community work and of health and social services, and a significant per capita increase in public spending on health care, led during this period to worthwhile improvements in mental health services. These are things that may or may not have happened had peace prevailed.

That services have improved and the population as a whole has coped remarkably well does not mean, of course, that those individuals who are seriously affected do not require appropriate help and treatment. Daly (1999) examined the treatment needs of the community generally as well as specific victim groups such as the security forces, children, the bereaved and prisoners. This raises a further but as yet still anecdotal observation. After the much publicised cease-fires there was a substantial, albeit ragged, reduction in terrorist activity; however, many health care professionals would corroborate the remark by Curran & Miller (2001) that with this reduction in violence there has been some increase in the presentation of victims of the Troubles. One implication may be that once the curiously 'holding environment' of the Troubles is lifted we may observe a negative as well as a positive 'peace dividend'. Who knows if it may yet be too early to be fully clear about the impact of the past 30 years on the psychological welfare of the people of Northern Ireland?

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COUNTRY PROFILE

Development of mental health services in Pakistan

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Background

Pakistan is a country comprising four provinces: Punjab, Sind, Northwest Frontier Province and Baluchistan, in addition to the federally administered tribal areas and the federal capital territory of Islamabad. It is bordered by China, Afghanistan, Iran and India. It has a population of 152 million (excluding an estimated 3–4 million Afghan and Bangladeshi immigrants) and an area of 796 095 km^2.

The per capita gross national product (GNP) is $483 and the budget of the Ministry of Health is 5% of the national budget, or 0.7% of the GNP (1997 figures). The annual per capita expenditure on health by the Ministry of Health is $3.5, compared with the national expenditure of $31. The ratios of beds, doctors, dentists and nurses to 10 000 population work out at 6.9, 6.0, 0.25 and 4.1, respectively. The mental health budget is 0.4% of the overall health budget.

From a modest beginning in 1947, when there were only three mental hospitals, at Lahore, Hyderabad and Peshawar, and a psychiatric unit at the Military Hospital in Rawalpindi, psychiatric units were gradually established in all the medical colleges of the country, especially during the 1970s.

Training

At the undergraduate level, behavioural sciences have been incorporated in the curricula of all the medical schools in Pakistan. An indigenous behavioural sciences teaching module has been developed for medical students and a demonstration project of community-oriented medical education with an emphasis on behavioural sciences was established in 1998 in four of the public sector medical colleges in all the provinces of the country.

At the postgraduate level, fellowship (FCSP), MD and diploma courses are available. The College of Physicians and Surgeons Pakistan (CPSP) is the main certifying body for postgraduate training in psychiatry; a four-year training programme leads to a fellowship in psychiatry. This training is carried out at specified institutions under the supervision of certified trainers. The training involves exposure to adult, forensic, child and adolescent, geriatric and liaison psychiatry patients in a graded manner that is monitored by the CPSP through regular reports from the supervisors, trainees and its own inspectors. The trainee has to complete a research project and submit a dissertation during this training period, besides attending workshops (organised by

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the CPSP) on research methods, biostatistics and communication skills. The primary FCPSP examination focuses on basic sciences relevant to psychiatry, while part II forms the summative evaluation at the end of training.

In addition, universities also offer MD and diploma training courses of shorter duration. There are 320 psychiatrists based in major urban centres; of these, 70 are fellows of the CPSP, 50 are members or fellows of the Royal College, and the rest have qualifications from the American Board, European institutions or local universities.

There are two centres at Lahore and Karachi for the training of clinical psychologists; together they train about 30 every year. Currently about 200 clinical psychologists work in the country.

Psychiatric nursing is being offered as a separate subject at all the nursing institutions in the country and a curriculum for psychiatric nursing has been developed. A two-year postgraduate diploma for psychiatric nursing has been initiated in nurse training colleges in the country and so far 52 psychiatric nurses have qualified.

There is no provision for the training of psychiatric social workers at the university departments.

Junior psychiatrists have been trained in community mental health to act as resource persons in the development of community mental health programmes in their areas, and to provide the training, referral and evaluation support to facilitate the integration of mental health within primary care.

Epidemiology

Epidemiological studies carried out in Pakistan have shown that 10–66% of the general population suffers from mild to moderate psychiatric illnesses, in addition to the 0.1% suffering from severe mental illnesses (Mumford *et al*, 1996, 1997, 2000; Husain *et al*, 2000).

The prevalence of severe learning disability in children aged three to nine years has been estimated at 16–22/1000 and according to recent (2000) estimates 4 million people misuse substances in Pakistan. The most common substance of misuse is heroin (49.7%) and 71.5% of the abusers are below 35 years of age. There are about 232 facilities for drug detoxification in the country (Subcommittee on Mental Health and Substance Abuse, 2003).

Development of mental health services

The national programme of mental health was the first such programme to be developed, in 1986, at a multidisciplinary workshop; it was incorporated in the 7th–9th five-year national development plan. In the light of the above, it is evident that it will not be possible in the foreseeable future to realise the objective of the programme if reliance is placed exclusively on specialised workers. Instead, the aim is to incorporate mental health services within primary health care. This has been initiated in five districts of the country (each of the four provinces, plus Azad Kashmir). The government of Pakistan has now allocated a separate budget of more than Rs22 million for this purpose. This model was initially developed in two sub-districts of Rawalpindi, and is presently being replicated.

The majority of the policy and field-level administrators have been provided, including some from the armed forces. Mental heath training programmes, as part of the ongoing in-service training programmes of the district health development centres, are being initiated in the five target districts. These centres have been set up to build the capacity of primary care personnel to handle common health problems, by organising on-the-job training for them. More than 2000 primary care practitioners have so far been trained in mental health. Similarly, more than 40 000 lady health visitors (LHV), multipurpose health workers (MPHW) and lady health workers (LHW) have received training all over the country, in a decentralised manner, within the district health development centres, using indigenously developed training manuals.

In addition, so far more than 78 junior psychiatrists have been trained in community mental health to act as resource persons in the development of community mental health programmes in their areas, and to provide the training, referral and evaluation support to facilitate the integration of mental health within primary care. As well as psychiatrists from Pakistan, mental health professionals from Iran, Egypt, Tunisia, Afghanistan, Morocco, Yemen, Sudan, Palestine and Nepal (Mohit *et al*, 1999) have been trained in community mental health, to act as resource persons in their respective countries.

Another major development has been the incorporation of indicators for mental illnesses as part of the national health management information system.

Development of a school mental health programme

The school mental health programme works through a series of four phases: familiarisation, training, reinforcement and evaluation (Mubbashar, 1989; Rahman *et al*, 1998; Saeed *et al*, 1999).

During the year 2000, a mental health component was included in the teacher training programmes at national level. So far more than 150 education administrators from all provinces have been given orientation training.

Training of master trainers from all provinces (batches of 40 for four months each) started in January 2001. Textbook boards of all provinces are being approached for inclusion of mental health issues in the school curricula being prepared by them.

Activities with faith healers

Faith healers and religious leaders are the first port of call for the majority of people with a mental illness. One research project has shown that about 16% of the patients presenting to faith healers in a subdistrict of 0.5 million were given 'medical diagnoses' and referred to the nearest health facility. This marks a significant departure from past practices (Saeed *et al*, 2000).

Activities with non-governmental organisations

Non-governmental organisations (NGOs) are taking on an increasingly important role in developmental activities. The National Rural Support Programme (NRSP) is an organisation active in the fields of income generation, education, agriculture, forestry, tourism and health; it has direct access

to about 20 000 village-level organisations. The NRSP and its sister organisations have agreed to include mental health among all their activities and about 20 000 community activists will be trained each year through this initiative; this highlights the role of mental health in national development activities.

Research and publications

Lack of indigenous research has been a major hindrance to the rational planning and allocation of resources; however, over the past few years a number of research papers have been published. Major areas of research activity include: mental health policy research, epidemiology (Minhas *et al*, 2001), health systems, economic evaluation of models of mental health care delivery (Chisholm *et al*, 2000), the development and validation of research instruments (Saeed *et al*, 2001), the evaluation of intersectoral linkages (Mubbashar *et al*, 2001) and clinical research.

Legislation

The government of Pakistan has repealed the Mental Health Act of 1912–26. The new mental health law, promulgated on 20 February 2001, embodies the modern concepts of mental illnesses, treatment, rehabilitation, and respect for civil and human rights. The first meeting of the Federal Mental Health Authority to develop an implementation mechanism for mental health ordinance 2001 was held on 29 December 2001. The ordinance provides for the prevention of mental illnesses, and the promotion of mental health through mental health literacy, the establishment of mental health services with stress on community-based services and integration with primary health care, the protection of the human rights of people with mental illnesses, and the reduction of stigma and discrimination.

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Lack of indigenous research has been a major hindrance to the rational planning and allocation of resources

COUNTRY PROFILE

Psychiatric country profile: Chile

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Chile has approximately 600 psychiatrists for its 15 million people. Although in the capital city, Santiago, the provision (per capita) is twice as high as in the rest of the territory, it is possible to see over the past decade a progressive increase in the number of these specialists in the other main cities. There are no more than 50 child psychiatrists and several cities have no local resource in this sub-speciality.

Training

Ten schools of medicine offer medical undergraduate education. The seven-year curriculum includes courses on medical psychology, psychopathology and general psychiatry.

Physicians may become specialists in psychiatry through a three-year postgraduate programme of studies, provided by seven universities. All these residence programmes

have similar coverage of neurology, in-patient wards and out-patient facilities and community mental health, as well as some adult and child psychiatry, the amount of which depends on the final speciality. Examinations vary across the residence programme: sometimes there are full examinations but, more frequently, there is formal approval after each one of the 6- or 12-month rotations.

Another way to obtain a speciality certificate is by undertaking formal clinical work, in a psychiatric clinical facility, that lasts at least five years; accreditation requires attendance at postgraduate courses and passing a formal examination, one week long, in a university centre.

Finally, a national independent organisation, CONACEM, is the authority for specialist certification of physicians; the certificate is necessary for professional work and insurance purposes.

Websites

Ministry of Health
www.minsal.cl

Sociedad Chilena De Neurología, Psiquiatría y Neurocirugía
www.sonepsyn.cl

Sociedad Chilena de Salud Mental
www.schilesaludmental.cl

Corporacion Nacional Autonoma de Certificación de Especialidades Médicas
www.conacem.cl

Fondo Nacional de Desarrollo Científico y Tecnológico
www.fondecyt.cl

Professional bodies and research

Three main societies provide for scientific exchange among Chilean psychiatrists:

- The Society of Neurology, Psychiatry and Neurosurgery of Chile, founded in 1932, has a membership of 200 psychiatrists, in eight thematic working groups. It holds regular seminars, courses and a congress, and publishes two periodicals, the quarterly *Revista Chilena de Neuropsiquiatría*, and *Folia Psiquiátrica*, which appears three times a year
- The Chilean Society of Mental Health, founded in 1983, is a multiprofessional body; it has almost 300 members, more than 100 of whom are psychiatrists. Besides regular congresses and courses, it publishes one periodical, *Revista Psiquiatría y Salud Mental*.
- The Chilean Society of Psychiatry and Neurology of Childhood and Adolescence, which was founded in 1970.

Research by psychiatrists is largely into the epidemiology of mental disorders, quality of life associated with mental disorders and handicaps, evaluation of programmes and facilities, and, in the clinical arena, depression, suicide, personality disorders, post-traumatic stress disorder, drug and alcohol problems and adolescent mental health problems.

Mental health services

The public health sector, which provides medical services to 70% of the population, employed 168 general psychiatrists and 39 child psychiatrists in 2001. The numbers have been steadily increasing over the past 12 years.

The 28 territory general health services comprise a widely distributed primary health care network. This includes dispensaries and small, undifferentiated general hospitals, second-level speciality out-patient care, and large general hospitals with medical speciality wards, including psychiatry, in the main cities.

A new National Mental Health Plan issued in 2000 resumed developments made in the previous 10 years, and marked the beginning of a new period which will see a transition from the traditional model of centralised care meeting the spontaneous demand of the population, to a network of facilities and programmes in which multiprofessional teams develop appropriate responses to mental health problems and preventive practice.

Some examples are given below:

- A national programme for the treatment of depression through primary health care, with the necessary second-level support, met the goal of treating 18 000 women in 2001 and 24 000 in 2002. For 2003, the goal is to offer protocol-guided treatment to 66 000 women and men all over the country. One public health aim for 2010 is to reduce the prevalence of depression by 10% from the 7.5% rate measured in the 1990s.
- A national case register of patients with schizophrenia is supporting the prescription of clozapine and risperidone (in addition to the usual neuroleptics), through protocol-based distribution, to more than 3000 affected persons (83% of the estimated number of patients being treated within the public sector).
- Thirty-one day hospitals were opened in the year 2001, all over the country. This is a new type of psychiatric facility in Chile. Its goals are to diminish in-patient bed needs and the duration of hospitalisation; they provide more cost-effective care, nearer to patients' families. After a few months of operation, early evaluation has been promising.
- A growing number of treatment centres for drug and alcohol problems have been established since 2001. There are six treatment protocols in place: detoxification, dual pathology, ambulatory (first response, basic and intensive) and residential.
- A special form of consultation–liaison psychiatry service has been developed, called mental health consultation. Teams comprising at least one psychiatrist and one psychologist visit a particular primary care facility, once or twice a month, for a technical and planning meeting with the local team. The review of clinical problems of patients in the charge of both primary- and secondary-level teams is at the core of the visit.
- Some major changes are also occurring within the in-patient wards, such as the differentiation of short- and medium-term hospitalisation, with a maximum of 60 and 189 days respectively. This has introduced a new dynamism in in-patient care.
- Finally, a gradual reduction in hospitalisation for chronic patients, together with the development of supervised community residence facilities, is in progress. Initial results have been good. Half-way and more permanent homes for chronic patients, many of whom drop out of care from the existing four psychiatric hospitals, now have 700 residential places.

Conclusion

Chilean psychiatrists are coping with changes in the mental health care model. The process of reform in the health sector represents an opportunity and new challenges.

Brazilian public mental health policy: education and research

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Brazil is a country with 170 000 000 inhabitants (census for the year 2000), of whom 138 000 000 live in urban areas. The illiteracy rate, that is, people over 15 years of age who cannot write or read even a simple message, is 13.4%. About 25.6% of the population live on a family income less than half the minimum wage (1999 figures). Brazil's gross internal revenue is R$564 800 per capita (1998 figures, about US$1680 today).

The Brazilian population experiences the diseases typically found in underdeveloped countries as well as the pathologies of developed countries. With the exception of obstetrics, most of the morbidities found in hospitals are diseases of the respiratory tract (16.2%) and those of the circulatory system (9.5%), followed by infectious and parasitical diseases (7.4%). Mental and behavioural disorders account for 3.5% of hospital cases (see Table 1).

Table 1. Proportion of hospital admissions by speciality, 2000

Speciality	Proportion of hospital admissions
General practice	34.3%
Surgery	23.0%
Obstetrics	24.1%
Paediatrics	3.3%
Psychiatry	3.3%
Psychiatry (day hospital)	0.2%

Source: Ministry of Health – System of Information on Hospitals of the SUS (SIH-SUS).

Table 2. Costs of treatment for mental and behavioural disorders in 2001

Diagnosis	ICD–10 code	$R
Dementia	F00–F03	16,879,254
Mental and behavioural disorders due to the use of alcohol	F10	60,145,522
Mental and behavioural disorders due to the use of psychoactive substances	F11–F19	9,061,261
Schizophrenia, delirious and schizotypal disorders	F20–F29	264,195,266
Mood (affective) disorders	F30–F39	31,783,555
Neurotic and somatoform stress-related disorders	F40–F48	1,878,384
Mental retardation	F70–F79	47,668,801
Other mental disorders		56,932,658
Total		*488,544,702*

Source: Ministry of Health – System of Information on Hospitals of the SUS (SIH-SUS).

Psychiatric services and reform

Even though the proportion of psychiatric admissions to hospitals is 3.3% (Table 1), when we analyse the average expenditure on hospital admissions by the Unified Health System (SUS) by speciality, that is, the amount of expenditure divided by the total number of admissions, the amount spent on psychiatry is about four times higher than that on general practice, and twice as high as that on surgery. The costs of treatment for mental and behavioural disorders, such as schizophrenia, delirious and schizotypal disorders, are far higher than the costs for other disorders (Table 2).

The high costs of schizophrenia are well demonstrated by Leitão (2001), who, by studying patients with the illness in the state of São Paulo, showed that 2.3% permanently resided in hospital and 3.7% had been in hospital for less than one year.

The Conference for the Restructuring of Psychiatric Attention, held by the Pan-American Health Organization in November 1990, passed the Declaration of Caracas, which emphasised a policy of hospital bed reductions and highlighted the frequent violations of human rights that took place at psychiatric hospitals in Latin America. This position had already been adopted by the Brazilian Association of Psychiatry (see below).

There are some 10 000 psychiatrists working in Brazil. According to Zago *et al* (2001), the number of specialists is sufficient (5.75/100 000 inhabitants), but they are largely concentrated in the south and south-east of the country.

Until the mid-1980s, public mental health policies strongly favoured admissions to psychiatric hospitals. This approach has since begun to change, slowly but systematically. As a result, there has been a reduction in both the number of hospital beds in psychiatry and the number of admissions. There were 410 003 admissions to psychiatric hospitals in 1997. Data from the Ministry of Health show that this had decreased by 12.8% in 2001, in spite of the population growth during the same period. Admissions to day hospitals doubled, from 10 268 to 22 183.

In April 2001, the Brazilian President passed the Law of Psychiatric Reform after 11 years of discussions in the Congress and wider debates. Law No. 10.216 of 6 April 2001 is explicit with regard to the rights of people with mental disorders, in the area of both psychiatric admission and mental health community services. It clearly defines the issue of self-commitment, that is, admission with the consent of the user, as well as involuntary commitment, which takes place without consent. After extensive discussions, this law determined that the term 'user' should replace the term 'patient'. Involuntary psychiatric admission,

which must be reported to the Public Ministry by the direction of the hospital, was subject to much controversy but was eventually adopted.

Education in psychiatry

Brazil has at present 95 medical colleges from which about 9300 doctors graduate each year. According to Zago *et al* (2001), only 16 of them conduct scientific research.

Scientific research in Brazil began in a modern form after the creation of postgraduate education in 1969. In the area of mental health, there has been a very important increase in the number of indexed Brazilian journals since 1990, while the situation in other areas, such as haematology, rheumatology and oncology, has remained the same. Postgraduate programmes have undergone considerable improvement recently. Nowadays two centres, the University of São Paulo and the Federal University of São Paulo, gain the best ratings in the external evaluation carried out by the Ministry of Education. Other centres – such as the Federal University of Rio Grande do Sul, the Federal University of Rio de Janeiro and the Federal University of São Paulo (Ribeirão Preto campus) – also showed good results in this evaluation.

Residence in psychiatry

The National Council of Medical Residence (CNRM) was created in September 1977 by means of Decree 80.281. It defines medical residence as a modality of postgraduate education in the form of specialist courses characterised by in-service training aimed at doctors. The programmes comprise two years in psychiatry, with an optional third year. Presently there are 462 residence places in psychiatry in Brazil, most (43.7%) of them in the state of São Paulo.

Professional bodies

The Brazilian Association of Psychiatry (ABP), founded in 1966, has about 3000 associated psychiatrists. It holds congresses (originally biennial and now annual). The last, the XX Brazilian Congress, was attended by 3100 medical professionals, most of whom were psychiatrists.

In June 1993 the ABP was one of the organisers of the 9th World Congress of Psychiatry, held in Rio de Janeiro, which had approximately 7000 participants. The ABP has published the *Revista Brasileira de Psiquiatria* (Brazilian Psychiatry Journal) since 1979; at first it was called *Revista ABP–APAL*, when it was jointly produced by the ABP and the Latin-American Psychiatry Association (APAL). The ABP's newsletter, *Psiquiatria Hoje* (Psychiatry Today), was founded in 1976. Both the journal and the newsletter are distributed to all members.

The Association maintains ongoing educational programmes via the internet at www.pecabp.ecurso.com.br

The Institute of Psychiatry at the Federal University of Rio de Janeiro also publishes a journal of good scientific quality and national circulation, the *Jornal Brasileiro de Psiquiatria* (Brazilian Journal of Psychiatry).

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COUNTRY PROFILE

Psychiatry in India

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India is a low-income country that is characterised by huge diversity within and between its 35 states and union territories. For example, the infant mortality rate (per 1000 live births) ranges from a low of 16.3 in Kerala to a high of 86.7 in Uttar Pradesh, over a fivefold difference (International Institute for Population Sciences & ORC Macro, 2001). This considerable variation is evident in virtually every aspect of human development in India, and any summary figures are likely to be unrepresentative of most parts of the country. Within the scope of this short article, this important limitation of averages must be recognised at the outset.

The latest population figures for India show that the population has now crossed the 1 billion mark and is continuing to grow, although at a gradually slower pace than before. The substantial epidemiological evidence base in

relation to mental disorders shows that severe and common mental disorders are at least as common as in the developed world. The social and economic risk factors for mental disorders are on the rise in many parts of the country and there has been a reduction in the already pitiful level of spending by the Government on health and social welfare (5.2% of gross domestic product). There is evidence that a substantial proportion of health care in India is delivered in the private sector; some estimates put this at above 75% of all health consultations.

Mental health resources

There are an estimated 4000 psychiatrists in India, which represents a ratio of approximately one psychiatrist for 250 000 people (WHO, 2001). However, as mentioned earlier, this rate varies hugely between urban and rural areas, and between more developed and less developed states. Thus, in some states the ratio falls to one psychiatrist for more than one million people. The majority of psychiatrists work in urban areas, and in the private sector. The number of other mental health professionals, such as psychologists or psychiatric nurses, is even lower: there is one nurse for every 10 psychiatrists and one psychologist for every 20. There are an estimated 25 000 psychiatric beds in the country, or one bed for every 40 000 people. About 80% of these beds are situated in mental hospitals, where the quality of care has been found to violate even basic human rights (National Human Rights Commission, 1999).

If one considers that the estimated number of persons with schizophrenia alone is 10 million, it is obvious that the vast majority of persons with mental disorders will not have access to a mental health professional in India. The numbers of professionals in specialised areas of psychiatry, such as child, substance misuse or elderly mental health, cannot even be estimated because, barring in a few academic centres, these specialities do not exist (the provision is within general services). Thus, it may be fair to say that the primary provider of mental health care in India is the primary health sector, with its wide (though uneven) network of primary health centres and general hospitals, in both the private and public sectors.

The traditional and complementary medical sector is also a vibrant player in mental health care. This sector includes an array of religious, spiritual and alternative healing systems such as Ayurveda, faith-healing and *unani* medicine. Recently, there has been a renaissance of traditional systems of health promotion, such as yoga.

The non-governmental sector is also playing a key role in mental health care, in particular by filling in niche areas of need such as child mental health care, and by developing innovative community-based models of care (Patel & Thara, 2002).

A large, mostly indigenous, pharmaceutical industry ensures that most psychotropic drugs are available in India, often at a fraction of their cost in high-income countries; however, this low cost does not translate into consistent availability in Government-run primary and general health care settings.

Mental health education and qualifications in psychiatry

India has about 125 medical colleges, most of which have departments of psychiatry; about a quarter of these departments are recognised by the local universities for higher training in psychiatry. The most common qualifications are the MD (doctor in medicine), which is different from the MD in the USA (in that it is a specialist qualification) and that of the UK (in that a research dissertation is only one component; the other components include written and clinical examinations). The MD requires a residency of three years, followed by another three years of senior residency training to become a consultant.

Other qualifications include the Diploma in Psychological Medicine (DPM), which requires a two-year residency, and the Diplomate of the National Board, administered by the National Academy of Medical Sciences, which is an all-India examination styled along the lines of the Membership of the Royal College of Psychiatrists.

Government policies and programmes

Mental health has been receiving increasing attention in national health policy and programming; this is best illustrated by a specific mention of mental health as a priority area for the new National Health Plan drafted for the coming decade. The National Mental Health Programme was formulated in 1982 with the objective of ensuring the availability and accessibility of basic mental health care, particularly to the most vulnerable and under-privileged sections of the population. The programme, though visionary in its conceptualisation, made slow progress, mainly because of a lack of dedicated finances. It is implemented at present in 22 districts (out of 593) and will be extended to over 100 districts in the next few years. The key approaches used are the training of primary health care personnel, the provision of neuropsychiatric drugs in peripheral institutions, the establishment of psychiatric units at the district level, with streamlined referrals, and the encouragement of community participation. However, it is worth noting that, despite this programme, less than 1% of the total health budget is devoted to mental health.

Psychiatric associations

The flagship psychiatric association is the Indian Psychiatric Society, established in 1947. The Society holds an annual conference and organises continuing medical education; it also publishes the *Indian Journal of Psychiatry*. The Society has five regional zones, which all hold annual conferences; some also publish their own journals.

There are several other associations in India, including the Indian Association for Child and Adolescent Mental Health, the Indian Association for Social Psychiatry, Indian chapters of world associations, such as the World Association for Psychosocial Rehabilitation, and, most recently, the Indian Association for Private Psychiatry.

The social and economic risk factors for mental disorders are on the rise in many parts of the country and there has been a reduction in the already pitiful level of spending by the Government on health and social welfare.

The traditional and complementary medical sector is also a vibrant player in mental health care. This sector includes an array of religious, spiritual and alternative healing systems such as Ayurveda, faith-healing and *unani* medicine.

Research and journals

India has a substantial research base in mental health. A recent review of the contribution of various non-Western countries to the international psychiatric literature found that 14% of the papers published over three years in six high-impact journals were from India, a figure second only to Japan (Patel & Sumathipala, 2001).

The requirement that every MD in psychiatry must complete a research dissertation means that about 100 research projects are completed each year; many, however, suffer from methodological problems as a result of inadequate supervision and research skills (Patel, 2001). Another problem is that the research often consists of drug trials funded by industry, with the primary purpose of meeting the national regulations for the introduction of new medicines. Health services and public health research is conspicuously missing.

The research infrastructure in India centres on medical school departments of psychiatry and national centres for higher research, such as:

- the National Institute for Mental Health and Neurosciences (NIMHANS) in Bangalore
- the All India Institute for Medical Sciences (AIIMS) in New Delhi
- the Post-graduate Institute for Medical Education and Research (PGIMER) in Chandigarh.

Research is also being conducted by non-governmental organisations; some of the best-known studies on schizophrenia in India, for example, have been the result of research by the Schizophrenia Research Foundation (SCARF) in Chennai (Thara & McCreadie, 1999).

There are more than 10 journals in psychiatry and allied specialities in India, the best-known being the *Indian Journal of Psychiatry* and the *NIMHANS Journal*. However, despite a continuous publication record of several decades, the *Indian Journal of Psychiatry* is still not indexed on major international citation databases, and this limits its impact on world psychiatry. Not surprisingly, some of the best scientific studies from India still go to international journals.

Mental health legislation

The Mental Health Act of 1987 replaced the Indian Lunacy Act of 1912. The Act has provided new definitions, simplified admission and discharge procedures, introduced licensing of psychiatric hospitals, set up central and state mental health authorities and promoted human rights for people with mental illnesses (WHO, 2001). However, the implementation of this law has been very uneven across the states. Courts in India have provided much support to the mental health field by repeatedly asking the Government to provide better care, within the framework of basic human rights. Another key piece of legislation has been the Persons with Disabilities Act, which includes mental disabilities, and which provides access to social welfare and employment schemes. The Narcotic Drugs and Psychotropic Substances Act (amended in 2001) deals with the prevention, treatment and rehabilitation of people with drug-dependence.

Role of Indian members of the Royal College of Psychiatrists

India has a considerable human resource base for mental health initiatives, but this base is very inadequate to meet the mental health needs of the population. The key to closing the treatment gap is to use the resources available (for example, including private psychiatrists and non-governmental organisations in mental health programmes), strengthening services in primary care, providing more effective referral systems and building the research evidence on cost-effective health service interventions. Members of the College can play a number of important roles by strengthening links with Indian associations and organisations. In our view, the key priorities for such collaborations are:

- to build research capacity through collaboration on specific research projects and strengthening research training opportunities
- to share models of training for primary and general health care practitioners in mental health interventions
- to share models for the development of community care, in particular for severe mental disorders, learning disabilities and mental disorders affecting children and the elderly
- to facilitate the training of general psychiatrists in specialist areas such as substance abuse, child psychiatry and forensic psychiatry
- to facilitate the process of reforming mental hospitals in India by enabling hospital staff to improve the physical, social and therapeutic environment of the hospital.

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World Psychiatric Association and the College

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I greatly welcome this opportunity to contribute to the first edition of *International Psychiatry* and to wish it well on its maiden voyage; the aim of this contribution is to outline those structures and objectives of the World Psychiatric Association (WPA) that are relevant to members of the Royal College of Psychiatrists.

The WPA is an organisation of psychiatric societies; its objective is to advance psychiatric and mental health care, education and public policy across the world. The Royal College of Psychiatrists is one of 122 member societies in 105 countries and has contributed actively since the first World Congress, held in Paris in 1950. Sir Martin Roth and Linford Rees, for example, were both influential at this Congress and Dennis Leigh was the widely respected second Secretary General – renowned for his enthusiastic commitment to links with member societies.

My election last year as Secretary General at the General Assembly in Japan catapulted me into the heart of WPA planning, with the expectation that British psychiatrists will continue to work within this value-laden global organisation. Several distinguished members and honorary fellows are making huge contributions to its work. Sir David Goldberg was awarded the Jean Delay Prize, Professor Eugene Paykel was the zonal representative for Western Europe (now succeeded by Brian Martindale) and several past Presidents of the WPA – Felice Lieh Mak, Norman Sartorius and Juan Lopez Ibor – are honorary fellows of the College in recognition, *inter alia*, of their services to world psychiatry.

At present, the renewed internationalism of the College and the establishment of the International Board led by Hamid Ghodse will ensure that the College continues to contribute actively to the WPA and to share its institutional strength with others. The WHO and WPA work closely together and represent the potential clout of governments and the collective wisdom of clinicians to improve the care of patients with mental disorder. Recently, new joint task forces on various mental disorders have been established and, for example, member societies are producing updated information for the next edition of the *World Atlas*, which so starkly illustrated the inequities in the provision of mental health services across the world.

The WPA has been likened to a family and certainly there is no shortage of squabbles; yet I have been impressed by the determination of its leaders and the evident commitment of its members, often isolated and lacking institutional strength, to realise the vision that the world's psychiatrists can and should speak out and help each other to advance the knowledge base of our subject.

WPA: purpose and structure

The purposes of the WPA include:

- advancing knowledge and skills in the treatment of mental disorder
- promoting mental health
- preserving the human rights of those with mental illness
- establishing the core roles and responsibilities of psychiatrists.

The General Assembly is the governing body and meets every three years. It is democratic in its structures, which are carefully described in the *Manual of Procedures*. Major decisions are taken by ballot and the voting system ensures that no single member society, however large, can dominate decision-making. A representative of each member society (usually its president) has to be present to vote. The Executive Committee (Table 1) has the responsibility of governing the WPA between assemblies. The term of office of Executive Committee members is six years (i.e. two World Congresses). Executive Committee members hold honorary appointments.

There are five regions and 18 zones, each with a zonal representative elected by the General Assembly for a three-year term, with an expected further term (Table 2). The College is in the Western Europe Zone.

The meeting in June with WHO, UEMS and AEP representatives in Vienna could further advance thinking about the responsibilities of psychiatrists and how European psychiatry can make a greater impact. The College as a member society through its enhanced international groups can assist to strengthen these WPA regional initiatives.

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WPA news also features in 'News and notes', this issue, pp. 21–23

Science

The scientific arm of the WPA is undoubtedly the 55 sections. Many College members working in the UK are active in this work as office bearers, including Chris Thompson, Cornelius Katona, Mohammed Abou-Saleh, David Nutt, Nick Bouras, Rachel Jenkins, Hugh Freeman,

Table 1. The WPA Executive Committee, 2003

Office	Current holder
President	Ahmed Okasha (Egypt)
President elect	Juan E. Mezzich (USA)
Secretary General	John Cox (UK)
Secretary for Finance	Sam Tyano (Israel)
Secretary for Meetings	Pedro Ruiz (USA)
Secretary for Education	Roger Montenegro (Argentina)
Secretary for Publications	Mario Maj (Italy)
Secretary for Sections	George Christodoulou (Greece)

Peter Tyrer and Linda Gask. Ian Brockington was the first chair of the Women's Mental Health Section.

Many sections, but not all, are active and all have the problem of matching aspiration with the minimal resources available. However, they *are* the backbone of the World Congresses and members of the College who wish to contribute to world psychiatry and to meet with colleagues from large and small societies will find these scientific meetings stimulating and leading to collaborative research, as well as new friends.

Table 2. The WPA's zones and representatives, 2003

Zone	Geographical region	Current representatives	Representative's country
1	Canada	Werner Pankratz	Canada
2	United States of America	Allan Tasman	United State of America
3	Mexico, Central America and the Caribbean	Enrique Camarena	Mexico
4	Northern South America	Edgard Belford	Venezuela
5	Southern South America	Miguel R. Jorge	Brazil
6	Western Europe	Brian Martindale	United Kingdom
7	Northern Europe	Marianne Kastrup	Denmark
8	Southern Europe	Levent Luey	Turkey
9	Central Europe	Petr Smolik	Czech Republic
10	Eastern Europe	Valery Krasnow	Russia
11	Northern Africa	Tarek Okasha	Egypt
12	Middle East	Fuad Antun	Lebanon
13	Western and Central Africa	Michael Olatawura	Nigeria
14	Southern and Eastern Africa	Fred Kigozi	Uganda
15	Western and Central Asia	Haroon Rashid Chaudhry	Pakistan
16	Southern Asia	Parameshvara Deva	Malaysia
17	Eastern Asia	Jiro Suzuki	Japan
18	Australasia and South Pacific	Graham Mellsop	New Zealand

Publications and communication

These are impressive. Mario Maj, from Naples, the Secretary for Publications, has established the new WPA journal *World Psychiatry*, which is distributed free to 22 000 psychiatrists.

The WPA's book series have also been well received – 'Evidence and Experience in Psychiatry', 'Images in Psychiatry' and 'Anthologies in Psychiatry'.

The website of the WPA is www.wpanet.org

How is the WPA financed?

Financial support comes from membership fees (which are proportional to the size of the society and to its category of economic standing) as well as WPA congresses and other scientific meetings, external grants, publications and corporate supporters from industry.

As the College knows, a joint regional meeting with the WPA carries a financial risk but a co-sponsored meeting less so. The rewards, however, in terms of international exchange, heightened profile and closer links between member societies can be substantial. The Latin American countries, for example, have grouped themselves together into a Latin American Psychiatric Society and attract large numbers of participants at meetings as well as substantial sponsorship.

WPA on the web

This site (www.wpanet.org) is very active and visitors can obtain all issues of *WPA News*, *World Psychiatry*, section newsletters, the Madrid Declaration as well as the new *Electronic Bulletin*.

Ethics

Promotion of the highest ethical standards in care, teaching and research is a constitutional commitment. The WPA ethical guidelines for psychiatric practice were revised at the General Assembly in Japan and provide the ethical framework within which the Review Committee of the WPA investigates allegations of political abuse or other unethical practice. A member society is required to co-operate with the Review Committee. The WPA has a powerful sanction though the General Assembly to suspend membership of a society if it concludes that it is in breech of the Madrid Declaration.

The Review Committee is meeting with the Chinese Society of Psychiatrists and the Executive of the WPA in San Francisco to clarify some persisting ambiguities in the Chinese Society of Psychiatrists' response to the Review Committee. Plans for an educational symposium are in hand and the President of the WPA (Professor Ahmed Okasha) is meeting with the new government officials in Beijing. What is lacking at present is the possibility to meet with the patients and the clinicians face to face where there has been an allegation of political abuse. The College voice *has* been heard effectively through its President, and undoubtedly its influence has been helpful in seeking answers to the allegations. I am a new member of the Review Committee; Bob Daly was a previous consultant and Mike Shooter was able to meet the Review Committee in London. The Chinese Society of Psychiatrists has been working with the WPA on these issues but it remains possible that abuse of psychiatry at an individual or institutional level may be occurring in the hospitals that are not in the public health system.

Education

I would commend the following reports to members of the College, which can be downloaded from the website.

- *Core Training Curriculum for Psychiatry*
- *Core Curriculum in Psychiatry for Medical Students*
- WPA International Guidelines for Diagnostic Assessment (IGDA) (published as a supplement to the *British Journal of Psychiatry* in May 2003);
- *Fighting Stigma Due to Schizophrenia*.

Postlude

I hope this article will have reminded members about what is happening in the WPA and will have encouraged readers to get involved in its work.

My specific responsibilities are to ensure that the secretariat works efficiently, as well as making wider contributions to the WPA. Some may be surprised that an administrator and two and a half secretaries working from

a minute office in New York underpin the organisation. A decision has been made, however, by the General Assembly to establish a permanent secretariat by 2005 rather than a secretariat that rotates with the place of work of the Secretary General, so I am experimenting already with a new system of working. A part-time WPA secretary at Keele has helped me to keep my finger on the pulse and the College gift of a laptop when I demitted office was shrewd forward thinking!

The College has the notification and timeline of the bidding process for the permanent secretariat and the criteria against which the Executive Committee will make its recommendation to the General Assembly in 2005. The closing date for bids is 15 August 2003.

We *are* a part of a worldwide community of psychiatrists with our heart and soul in providing improved care for patients. The WPA has produced a statement drawing the attention of governments to the adverse consequences for mental health of any war and in particular a war in Iraq.

The WPA statement on Iraq was preceded by a similar statement about the mental health consequences of the Palestinian–Israeli conflict.

We must, I believe, strengthen, not undermine, existing international organisations which we need – or will need to reinvent. It would be good if members of the College can come to the World Congress in Cairo on 10–15 September 2005 to celebrate '5000 years of Science and Care'.

News and notes

For contributions to this column, please contact Brian Martindale FRCPsych, Psychotherapy Department, John Conolly Wing, Ealing, Hammersmith and Fulham Mental Health NHS Trust, Uxbridge Road, Hanwell UB1 3EU, UK, email brian.martindale@wlmht.nhs.uk

European psychiatric organisations

During recent years a number of Europe-wide psychiatric organisations have developed, each with their separate and overlapping goals. These organisations and their programmes will be fully described over time in more detail in *International Psychiatry*. As 'globalisation' and the influence of the European Union continue to increase, there are increasing consequences in Europe for psychiatry and the broader field of mental health (*BMJ*, 2002, vol. 324, pp. 991–992):

- There is now greater movement of psychiatrists between countries, both to take up employment and to attend conferences and other meetings.
- The European Union is introducing public health policies that include actions in mental health.
- The European Union has made available funds for trans-national research.
- The WHO is adopting an increased commitment to the mental health programme in all regions.
- Psychiatry in Eastern and Central European countries has been undergoing profound reform.

In July 2001, leaders of the major European psychiatric organisations met formally for the first time in London. The success of that meeting stimulated further meetings in 2002 in Stockholm, Yokohama and Copenhagen (twice). The outcome has been a clear intention to define areas of mutual concern and cooperation through task groups in order to effect a strengthening of psychiatry in Europe.

Already a working party has been set up with the aim of achieving pan-European agreement on principles and methods of approval for continuing medical education (CME) for psychiatrists. A meeting is planned for 19 June 2003 in Vienna before the World Psychiatric Association's thematic meeting. Leaders will discuss both CME and recruitment to the profession. A further meeting will take place during the Association of European Psychiatrists meeting in Geneva in April 2004.

The organisations involved in this new phase of European cooperation are the UEMS (European Union of Medical Specialists Section and Board of Psychiatry), the AEP (Association of European Psychiatrists), the WPA (World Psychiatric Association) European Region and the WHO Regional Office for Europe.

The WPA is looking for Permanent Secretariat facilities

The World Psychiatric Association (WPA) wishes to establish a Permanent Secretariat and is looking for a host organisation that can provide stable, economic and independent facilities with a minimum of 800 square feet and an appropriate ambience. If you feel that your organisation/institution would be interested in investigating this possibility further, with its enormous potential for mutual benefits, contact Brian Martindale, c/o Marion Palmer-Jones at the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, UK, for further information. Preliminary bids must be submitted by 15 August 2003.

RCPsych/VSO fellowship

Voluntary Service Overseas (VSO) enables skilled and professional volunteers to share their expertise in many of the world's poorest countries. With 40 years' experience, VSO passionately believes that such individuals can make a real difference in tackling disadvantage.

VSO and the Royal College of Psychiatrists are undertaking a joint venture for UK specialist registrars already

The VSO fellowship scheme has been developed by the Board of International Affairs at the College and is coordinated by a small subgroup.

For an information pack, contact the VSO Enquiries team on 020 8780 7500, email enquiry@vso.org.uk, explaining that you are interested in applying for a RCPsych/VSO fellowship.

VSO
317 Putney Bridge Road, London SW15 2PN
Email: enquiry@vso.org.uk
Website: www.vso.org.uk

enrolled on a higher specialist training programme in psychiatry to spend their second or third year in a developing country as a VSO volunteer. This will be recognised as part of their CCST programme. A similar fellowship scheme for paediatricians is in its third year.

Although day-to-day support will come from their employer, the College will assist them both professionally and personally in numerous ways including:

- an in-country mentor, closely linked and known by the College, who will make regular contact with the volunteer
- distance learning and support via a UK mentor
- a comprehensive training course before departure
- a full evaluation and assessment of the placement upon return to the UK.

These fellowships will be unique and rewarding experiences. Volunteers will live and build friendships at the heart of a different culture. Professionally they will face many challenges and their skills will be tested in a variety of ways in a very different working environment, enabling them to make a difference by strengthening local health services.

Psychiatrists do not need to provide their own funding, as a comprehensive package exists. This includes:

- return airfares
- a living allowance and accommodation
- a language and cultural orientation course on arrival
- guidance and advice on health matters plus comprehensive health cover while overseas
- medical and personal accident insurance.

Violence in the Middle East

The WPA issued a statement in August 2002, and approved by the WPA General Assembly, concerning the escalation of violence in the Middle East. This reflects the great concern about the serious threat to the mental health of persons in all affected areas, in terms not only of the serious post-traumatic stress disorders but also of many other acute and chronic emotion- and stress-related disorders in children and other vulnerable groups exposed to chronic trauma, violence, danger and humiliation. The statement expresses concern about the multi-generational consequences of the violence and the insecurity and the deep distrust engendered. The WPA is also concerned about access to mental health care and the safety of mental health professionals.

The WPA statement makes a number of requests:

- to participants in the conflict to bear in mind the mental health consequences
- to the local WPA societies to raise public awareness of the psychological consequences of the war and violence, to make reports on the mental health situation in affected areas and to make recommendations
- to all members and sections of the WPA to report on other situations in the world.

The WPA will organise an international forum and a network of international mental health and humanitarian organisations to review mental health reports from this region and to find helpful situations in collaboration with local societies.

WHO reports – details from *Mental Health Europe Newsletter*, 2002, vol. 9.

World Report on Violence and Health

On 3 October 2002, the WHO launched the *World Report on Violence and Health*. Violence is one of the most important public health issues of our time. This groundbreaking report demonstrates that violence is predictable and preventable. It provides a public health prescription for preventing violence before it occurs.

For information on the report, visit www.who.int/violence_injury_prevention. To order a copy of the report, contact bookorders@who.int.

WHO European report links poverty to widening gaps in health

On 16 September, the WHO Regional Office for Europe released *The European Health Report 2002* at the 52nd session of the WHO Regional Committee for Europe. The report confirms the strong links between socio-economic development, health and equity in the WHO European region. It analyses a decade of evidence on health in the region, which comprises 51 WHO member states, with a combined population of about 870 million. While, overall, levels of health in the region are among the highest in the world, the report describes widening gaps between and within countries.

The *European Health Report 2002* describes trends in health and the most important health problems, lifestyle and environmental determinants of health, and health care systems. Among many other facts, the report states that mental health problems are increasing. Some European countries register up to 6% of the population as having serious mental disorders and mental ill health accounts for up to 30% of consultations with general practitioners in Europe.

The full report in English, including the annex of statistical tables comparing all countries in the European region, can be found on and ordered from the website of the Regional Office (http://www.euro.who.int/document/e76907.pdf). French, German and Russian versions are in press.

Project Atlas

Project Atlas is a WHO project to map mental health resources around the world. The findings are disturbing. Of the countries studied, 25% have no legislation on mental health, 41% have no mental health policy, 28% have no separate budget for mental health, and 36% allocate less than 1% of their health budget to mental health. Moreover, 37% have no community care facilities and 41% do not have treatment facilities for severe mental disorders in primary health care. More than 660 million people in the world have access to less than one psychiatrist per million population. Find out more on http://mh-atlas.ic.gc.ca.

The full text of the WPA statement is available on http://www.wpanet.org/home.html

Monthly WPA *Electronic Bulletin*

This has been launched with the aim of reaching all psychiatrists in WPA organisations. In it, you will find the latest *WPA News*, *World Psychiatry* (the official journal of the WPA) and the WPA section newsletters plus a list of the latest WPA publications, institutional and educational programmes, meetings, contributions from the sections and more. There will be thematic and institutional forums, changing every month, to encourage active participation.

You can also access the WPA website. It is recommended that all psychiatrists register in order to receive the monthly *Electronic Bulletin* – http://www.wpanet.org/sectorial/bulletin/suscript.php

What's your line?

Why not make contact with international colleagues in your area of interest? The WPA has 55 sections, each with a range of activities from meetings to publications. Names of sections and current contact email addresses are listed opposite. If there are communication queries, contact wpasecretariat@wpanet.org.

Teaching and learning about schizophrenia

'Teaching and Learning About Schizophrenia' is a WPA educational programme and is available on WPA online for use in teaching programmes. Professor Nancy Andreasen has been central to the current production, which is a useful tool for routine use. The document is divided into four modules: Clinical Presentation, Pathophysiological Mechanisms, Treatment, and Case Vignettes. The first three modules consist of text and accompanying PowerPoint slides. Through the combination of text and slides, lectures can be developed of variable complexity, length and sophistication. They can be used for a one-hour lecture or a course lasting for several weeks or months. Thus these materials can be used to teach a variety of audiences: nurses, general practitioners, medical students, trainees in the speciality of psychiatry, or even lay audiences. The case vignettes illustrate the clinical presentation in a human way, and provide training in differential diagnosis and in the complexity and diversity of psychotic disorders. Because of their multiple national origins, the case vignettes also illustrate cross-cultural aspects of psychotic conditions. For those with high-speed connections: http://www.wpanet.org/sectorial/edu4c1.html, for those with a 56 kbit/s connection or lower: http://www.wpanet.org/sectorial/edu4c2.html

Please send feedback whenever you use this programme on forms that can be obtained from Professor Dr Roger Montenegro, email rogermontenegro@wpanet.org.

Teaching graduate psychiatry

The Core Training Curriculum for Psychiatry is a recently published WPA document that contains guidance for didactic and clinical content for the postgraduate training of psychiatrists. With more than 125 organisational members in 105 countries it is intended to provide a contemporary framework for the knowledge and skills necessary for psychiatric training around the world. It can be accessed from http://www.wpanet.org/sectorial/programs.html.

Sections and contacts for the World Psychiatric Association

Section	Email address of section secretary
Addiction Psychiatry	tarek58@menanet.net
Affective Disorders	isad@soton.ac.uk
Anxiety and Obsessive–Compulsive Disorder	eric.hollander@mssm.edu
Art and Psychiatry	thomashoff@utanet.at
Biological Psychiatry	crc-mh@online.be
Child and Adolescent Psychiatry	jbsikor@itsa.ucsf.edu
Classification and Diagnostic Assessment	claudio@lexxa.com.br
Clinical Psychopathology	giostan@libero.it
Conflict Management and Resolution	rataems@doh.ofs.gov.za
Eating Disorders	kah29@cornell.edu
Ecology, Psychiatry and Mental Health	s.d.kipman@wanadoo.fr
Education in Psychiatry	amemus@dinamico.com.ar
Emergency Psychiatry	piermaria.furlan@unito.it
Epidemiology and Public Health	vkovess@mgen.fr
Family Research and Intervention	info@orienthalsan.nu
Forensic Psychiatry	barel@isdn.net.il
Genetics in Psychiatry	sekretariat.psychiatrie@uniklinik-saarland.de
History of Psychiatry	phoff@ukaachen.de
Humanities in Psychiatry	m.broome@iop.kcl.ac.uk
Immunology and Psychiatry	manfred.ackenheil@ psy.med.uni-muenchen.de
Informatics and Telecommunications in Psychiatry	boll001@pol-it.org
Interdisciplinary Collaboration	urielh@acsu.buffalo.edu
Mass Media and Mental Health	materazzi@intramed.net.ar
Measurement Instruments in Psychiatric Care	ajanca@cyllene.uwa.edu.au
Mental Health Economics	moscarelli@icmpe.org
Mental Retardation	22245rna@comb.es
Military and Disaster Psychiatry	alvarog@terra.es
Neuroimaging in Psychiatry	luann-godlove@uiowa.edu
Occupational Psychiatry	tshimo@tokyo-med.ac.jp
Old Age Psychiatry	vincent.camus@inst.hospvd.ch
Personality Disorders	birgit.bork.mathiesen@psy.ku.dk
Pharmacopsychiatry	angj@gentoftehosp.kbhamt.dk
Preventive Psychiatry	sadanand.rajkumar@mwahs.nsw.gov.au
Private Practice	hakiskal@ucad.edu
Psychiatric Law and Ethics	marijo@eunet.yu
Psychiatric Medicine and Primary Care	fahrer@ciudad.com.ar
Psychiatric Rehabilitation	taintz01@popmail.med.nyu.edu
Psychiatry and Human Sexuality	psiquiatria.fmp@mail.telepac.pt
Psychiatry and Sleep Wakefulness Disorders	jmonti@mednet.org.uy
Psychoanalysis in Psychiatry	mbotbol@wanadoo.fr
Psychological Consequences of Torture and Persecution	drthomaswenzel@web.de
Psychoneurobiology	Not available
Psychoneuroendocrinology	cnemero@emory.edu
Psycho-oncology	hollandj@mskcc.org
Psychopathology of Expression	psquit@hcsc.insalud.es
Psychophysiology	wald@psych.waw.pl
Psychotherapy	mark_erickson@health.state.ak.us
Public Policy and Psychiatry	herrmahe@svhm.org.au
Quality Assurance in Psychiatry	lolasf@chi.ops-oms.org
Religion and Psychiatry	brian_ladds@nymc.edu
Research Methods in Psychiatry	marcantoine.crocq@forenap.asso.fr
Schizophrenia	rae@sun.ac.za
Suicidology	abotsis@compulink.gr
Transcultural Psychiatry	nfumita@attglobal.net
Urban Mental Health	sasanto@attglobal.net
Women's Mental Health	donna.stewart@uhn.on.ca

Forthcoming international events

4–6 July 2003
Psychoanalytic Psychotherapy in Our Time. When, Where and for Whom?
5th EFPP conference (European Federation for Psychoanalytic Psychotherapy in the Public Sector). For those who work with adults, children and adolescents and in groups.
Stockholm, Sweden.
Contact: efpp.stockholm2003@enigma.se
www.efpp.org

5–7 July 2003
Psychiatry and Primary Care.
A WPA co-sponsored conference with the Psychiatric Society.
Rio Grande do Sul, Porto Alegre, Brazil.
Contact: Dr Rogerio Wolf de Aguiar
Email: wolfaguiar@vol.com.br

3–5 August 2003
A Better Future for Those with Mental Illness: Rehabilitation for Those Without Success.
WPA Section on Rehabilitation and the World Association for Psychosocial Rehabilitation.
New York City.
Contact: Dr Zebulon Taintor. Email: office@wapr.net.

17–20 August 2003
International Conference of the UK Chapter of South Asian Psychiatrists Forum on Mental Health and Psychiatry.
A WPA co-sponsored conference.
Colombo, Sri Lanka.
Contact: Prof. R. N. Mohan. Tel. +44 (0)121 685 6574
Email: c.mohan@blueyonder.co.uk

23–28 August 2003
17th World Congress on Psychosomatic Medicine.
Waikoloa, Hawaii, USA.
Contact: Pr. Jon Streltzer, Queen's Office of Continuing Medical Education, Harkness 117, 1301 Punchbowl Street, Honolulu, Hawaii 96813, USA.
Tel: 808 537 7009
Fax: 808 547 4031
Email: icpm2003@aol.com
Website: hawaiiresidency.org/icpm2003

22–25 September 2003
Reconciliation, Reform and Recovery – Creating a future for psychological interventions in psychosis.
14th International Symposium for the Psychological Treatments of Schizophrenia and other Psychosis (ISPS).
Melbourne Convention Centre, Australia.
Contact: ISPS,C/-Conference Strategy Pty Ltd, Post Office Box 1127, Sandringham Victoria 3191 Australia.
Tel: +61 39 521 8881
Fax +61 39 521 8889
Email: isps@conferencestrategy.com.au
Website: www.conferencestrategy.com.au

25–27 September 2003
World Congress on Depressive Disorders and International Symposium of Cognitive Disorders.
Mendoza, Argentina.
Contact: Professor Jorge Nazar.
Tel/Fax: 54 261 429 5662/431 1209
Email: orge_nazar@hotmail.com
Website: www.mendoza2003.com

29 September–1 October 2003
12th International Congress of the European Society of Child and Adolescent Psychiatry.
A WPA co-sponsored conference.
Paris, France.
Contact: Prof. Philippe Jeammet
Email: philippe.jeammet@imm.fr

2–4 October 2003
Mental Health Alliances.
A WPA regional meeting.
Caracas, Venezuela.
Contact: Prof. E. Belfort, Colegio de Medicos del Estado Miranda. Ur. 'El Bosque' Av. El Golf Qta 76, Caracas, Venezuela.
Fax: 58 212 232 11 04/58 212 763 11 84
Email: secretariaapal@cantv.net/belfort.ed@excite.com

31 October–3 November 2003
Third International Conference on the Synthesis of Psychotherapy and Pharmacotherapy.
Amsterdam, Holland.
Contact: Dr Rob M. W. Smeets. Email: mmoalem@kenes.com

9–13 November 2003
Psychiatric Care Across Cultures.
WPA Section on Transcultural Psychiatry in collaboration with the University of Malta.
Malta.
Email: charles.pace@um.edu.mt or cpace_malta@hotmail.com

14–18 April 2004
European Psychiatry: Evidence and Experience.
12th AEP Congress.
Geneva, Switzerland.
Call for abstracts ends 30 October 2003.
Contact: aep12@kenes.com
Website: www.kenes.com/aep2004

1–6 May 2004
Annual Congress of the American Psychiatric Organization.
New York.
Contact: apa@psych.org
Website: www.psych.org

6–9 July 2004
Annual Meeting of the Royal College of Psychiatrists.
Harrogate (UK) International Centre, Harrogate, UK.
Contact: College Conference Office. Tel: +44 (0)20 7235 2351 x 142. Fax: +44 (0)20 7259 6507
Email: mbraithwaite@rcpsych.ac.uk

28 September–1 October 2004
Translating the Evidence.
International Early Psychosis Association.
Vancouver, Canada.
Contact: congress@venuewest.com
Website: www.iepa.org.au

24–27 October 2004
XVIII World Congress of Neuropsychiatry.
Kobe, Japan.
Contact: Nagasaki University School of Medicine. 1-7-1 Sakamoto, Nagasaki 852-8501, Japan. Fax: +81 95 849 72 96
Email: yonakane@net.nagasaki-u.ac.jp

10–13 November 2004
Treatment in Psychiatry: An Update.
An International Congress of the WPA
Florence, Italy.
Contact: Prof. Mario Maj, Institute of Psychiatry, University of Naples, Largo Madonna Delle Grazie, I-80138, Italy.
Fax: +39 081 56 66 523. Email: majmario@tin.it

10–15 September 2005
Five Thousands Years of Science and Care.
XIII World Congress of Psychiatry of the World Psychiatric Association.
Cairo, Egypt.
Contact: Pr. A. Okasha, 3 Shawarby Street, Kasr El Nil, Cairo, Egypt.
Fax: +202-74 81 786
Email: aokasha@internetegypt.com