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EDITORIAL

Global mental health – problem and response

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

According to the World Health Organization, 450 million people in the world currently suffer from some form of mental or brain disorder, including alcohol and substance misuse. Within this huge number, 121 million people suffer from depression, and more than 800 000 people die by suicide each year, with young people accounting for well over half of these. Projections from 1990 to 2020 suggest that, in future, the proportion of the global burden of all disease accounted for by mental and brain disorders will increase to 15%.

A significant number of mental health problems are related to the devastating effects of conflict, and the hope that the end of the Cold War would reduce the risk of actual war around the world has been cruelly shattered by the events of the past decade. Thus, in addition to the direct effects of extreme poverty in large parts of the world, there have been more than 50 million refugees and displaced people. Many have been subjected to extreme terror or have experienced sexual abuse, and all have lost, or have lost contact with, close relatives and friends. Such intense stress and trauma would threaten the mental health of the strongest and it is estimated that, among refugees and displaced people, 5 million are chronically mentally ill, whether because of illness before war or as a result of it. All would benefit from specialised care if it were available (World Health Organization, 2001; World Health Assembly, 2002).

The high health care costs and lost productivity associated with mental health problems have long been recognised and it is acknowledged that they can have a major effect on families, for example by creating or worsening poverty. Only rarely, however, are the results of such studies extrapolated to assess their impact on whole countries or, indeed, the world. In fact, there is compelling evidence that better health for the world's poor is not only an important goal in its own right, but can also act as a major catalyst for economic development and the reduction of poverty. To address the mental health needs of such large populations requires political will, international cooperation and a definitive strategy. Psychiatry can, should and must play its part in all of these areas.

Of course, psychiatry on its own cannot rectify adverse social conditions or solve the problems of mental illness worldwide, but, despite the enormity of the task, it should be acknowledged that psychiatry can play a major role in tackling it, in partnership with other disciplines and agencies. For example, psychiatrists with their background in basic biological sciences and with knowledge and experience in clinical medicine not only treat individual patients but also contribute to the de-stigmatisation of mental illness in society. Impressive developments recently in neurosciences, genetics and psychopharmacology, as well as new technologies, give hope that sound research will form the basis for new evidence-based treatments. Simultaneously, the importance of social and community care in the treatment of mental illness is increasingly being recognised.

The pace of these developments at times seems overwhelming and reaping their benefits will demand far broader training for psychiatrists and other mental health professionals than formerly, encompassing not only the traditional biological, social and psychological fields but also including public education and the social, economic and political elements of both mental illness and mental health promotion. In this context, the strong focus of the Royal College of Psychiatrists on educational activities is particularly relevant.

In addition, there is a new commitment within the College to rediscover its academic purpose and social significance, and a readiness to express this in terms of new relationships with other institutions. The College has members in many countries and, partly as a result of their efforts, the basic elements of a global response to mental health problems have begun to take shape. Simultaneously, there has been extensive reorganisation and change in the structure of the health service both in the UK and in many other countries, and this has inevitably affected the training of health care professionals. All of these factors make it

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necessary for the College to adapt so that it can be responsive to the global challenges related to mental health. It is acknowledged that the College needs to look outwards more than it has done in the past, scanning new horizons and forming new partnerships so that it can play an active role in international psychiatry for the benefit of all those suffering from mental ill health. The inauguration of the Pan-African Overseas Group of the College in Edinburgh and of the South Asian Overseas Group in Sri Lanka is evidence of the College's determination to take action to meet these needs.

The recent meeting of the European Region of the World Psychiatric Association in Vienna was very successful, and the willingness of all of the participating psychiatric associations and societies to work together was encouraging. The Royal College welcomes initiatives of this type and is ready to play a full part to ensure their success. It is hoped that such collaboration will lead to improved training to agreed standards so that people with mental illness, wherever they are in the world, can be sure of receiving high-quality care and advocacy for their rights.

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THEMATIC PAPERS – TRAUMA AND THE MENTAL HEALTH OF CHILDREN

Introduction

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Trauma can have both acute and insidious effects upon children's mental health. We present four articles, each of which offers a new perspective on this important topic. As Daniel Pine points out, in the first paper, as many as one in five children in the developed world can expect to experience a truly traumatic event, while half those in developing countries may do so. Such experiences can be either personal – such as emotional or sexual abuse – or impersonal – being shot or blown up in a conflict of which one understands little, except the misery it brings. How do children cope? We know that there are at least two important influences that moderate the impact of trauma on the developing child: the persistence and severity of the experience, and the degree of social support available. Beyond these broad generalisations, little is understood about what should be done or what could be done to minimise the long-term consequences of growing up in an environment characterised by cruelty, exploitation and death.

One of the most highly publicised conflicts involving children is that between the Palestinians and the Israelis, which has now gone on for so long that two generations have had to live with its consequences. Panos Vostanis has studied the impact of living with conflict in the refugee camps of the Gaza Strip. Remarkably, he discovered that acute post-traumatic stress had a tendency to ameliorate within a matter of months, despite the dire social circumstances of that refugee population. It is just as well that such reactions have a natural history of their own, for preliminary findings suggested a lack of benefit from formal psychotherapeutic intervention.

There are, of course, two sides to this conflict and Sam Tyano considers the plight of children in Jerusalem and their own responses. Many had first-hand experience of its effects, or of its impact upon their relatives; in fact, exposure rates to life-threatening events were amazingly high for both Palestinian and Israeli children. Post-traumatic stress disorders were disturbingly common, even among children who did not live in war zones.

Finally, Luke Dowdney considers the relatively unrecognised problem of children caught up as recruits to organised armed violence. There are many countries in which the pliability of children in early adolescence makes them attractive conscripts to those who seek to dominate communities by force, whether in warfare or – as in this example – in countries ostensibly at peace. He considers the specific case of Rio de Janeiro, a beautiful city surrounded by *favelas* in which drug factions control thousands of heavily armed child *soldados*. While subject to military discipline, such children represent cheap and expendable labour. The prospects for rehabilitating such children into society are daunting in the extreme, and the role to be played by psychiatrists in that process is a challenge yet to be met.

The effects of trauma on children: working to define roles for mental health professionals

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Interest concerning the effects of trauma on the mental health of children has grown markedly during the past few years. At least three factors contribute to this growing concern.

First, studies in the basic sciences suggest that interactions between experiential and genetic factors during particular stages of development can exert long-term influences on a set of behaviours and physiological responses related to stress regulation (Meaney, 2001; Gross *et al*, 2002). Results from studies of people with various psychiatric conditions have begun to raise important questions concerning the degree to which similar developmental relationships arise in our species (Caspi *et al*, 2002; Heim & Nemeroff, 2002).

Second, advances in assessment and epidemiological methods have facilitated a series of prospective investigations of the sequelae of childhood trauma (Pine & Cohen, 2002). Studies in this area generate concerns over the high rates of trauma exposure and the strong associations with psychopathology.

Finally, particular interest in trauma follows in the wake of the recent terrorist attacks in the United States. As with data from other recent exposures of large groups of children to trauma, these events raise basic questions about the degree to which children may be particularly vulnerable to psychological harm following trauma (Laor *et al*, 1997; Schlenger *et al*, 2002; Thabet *et al*, 2002).

Given such concerns, recent reviews have considered in detail the data from children on levels of exposure to trauma, moderators of risk, effects on physiology and available treatments (Kaufman *et al*, 2000; Breslau, 2002; Pine & Cohen, 2002). The present article briefly summarises the conclusions from these prior reports, while emphasising three aspects of the available literature:

- the prevalence of trauma exposure, the nature of associated risks for psychopathology, and the factors most consistently shown to moderate outcomes
- the results of randomised controlled treatment trials that inform therapeutics in traumatised children
- strategies for minimising risk for psychopathology following trauma.

The nature of exposure

Heterogeneity in the nature of traumatic exposure, the contexts of exposures and the nature of psychopathology complicate efforts to draw firm conclusions on the risks of psychological sequelae in children. Reported prevalence rates of childhood trauma exposure generally exceed 20% in most studies of representative samples from industrial countries, and frequently exceed 50% in studies from countries or contexts associated with various forms of political unrest or social instability (which increase risks for trauma).

Children experience trauma through exposure to a diverse array of adverse events, including episodes of domestic violence, natural disasters and political unrest, each of which has been shown markedly to increase the risk of psychological problems (Breslau, 2002; Pine & Cohen, 2002). Key aspects of traumatic experiences vary widely across this array of events. It remains unclear whether conclusions can be drawn concerning a common set of risks and moderators of outcome that apply across diverse forms of trauma, such as domestic violence as well as political violence.

Some types of trauma have a particularly heightened risk for psychopathology. In general, across the full range of traumatic exposures, two factors most consistently moderate risk in prospective investigations: overall level of exposure and the degree of social support. Data on social support appear particularly informative, in that they suggest that children experience the greatest need for intervention when trauma – such as natural disasters, domestic violence or political unrest – occurs in the context of disrupted social support networks. Findings have emerged for other potential moderators, such as age at the time of exposure or level of pre-exposure psychopathology, but these remain only suggestive, as clear associations have not emerged in all studies.

Finally, studies of diverse traumatic events consistently find strong associations between trauma and psychopathology, but disagreement persists on the degree to which risk is elevated for one or another specific condition (Steinberg & Avenevoli 2000; Breslau, 2002). Some preliminary evidence suggests that risk for various conditions may meaningfully vary across age groups and contexts. For example, adolescents may be more likely than young children to manifest the constellation of symptoms that characterises post-traumatic stress disorder in adults. Nevertheless, strong evidence has not emerged of selectively elevated risk for specific conditions associated with specific forms of trauma or particular developmental periods; strong associations appear with a wide range of conditions, including various mood and anxiety disorders, as well as various behaviour disorders (Steinberg & Avenevoli, 2000; Breslau, 2002; Pine & Cohen, 2002).

Given the complicated nature of associations between trauma and potentially comorbid mental health problems,

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Some types of trauma have a particularly heightened risk for psychopathology. In general, across the full range of traumatic exposures, two factors most consistently moderate risk in prospective investigations: overall level of exposure and the degree of social support.

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children exhibiting clearly impairing psychological problems following exposure to trauma should be assessed by mental health practitioners experienced in evaluating children with symptoms in multiple domains.

Therapeutics

Since traumatic experiences predispose to a diverse array of conditions, recent broad advances in treatment approaches for many paediatric mental disorders may address some essential questions on therapeutics. Specifically, recent large-scale randomised controlled trials (RCTs) for paediatric mood, anxiety and behaviour disorders have documented marked benefits for both psychopharmacological and psychotherapeutic interventions (Emslie & Mayes, 2001; Jensen *et al*, 2001; Research Unit on Pediatric Psychopharmacology Anxiety Study Group, 2001). In general, conclusions from these studies on the relative merits of various treatments for specific psychological problems can be applied to children exhibiting behaviour, mood or anxiety disorders within the context of trauma. Again, given the potential complexity of treatment decisions for children with comorbid problems following traumatic exposures, mental health practitioners play an invaluable role in using data from available studies to weigh the risks and benefits of particular treatments for particular children.

The psychological problems of traumatised children do clearly pose unique questions concerning therapeutics, necessitating studies that specifically examine the relative merits of interventions.

The psychological problems of traumatised children do clearly pose unique questions concerning therapeutics, necessitating studies that specifically examine the relative merits of interventions. Unfortunately, RCTs have examined the efficacy of only a narrow range of treatments applied in a narrow range of circumstances. Specifically, at least six studies document the efficacy of cognitive–behavioural therapy (CBT) for symptoms arising following sexual abuse, and one small study documents the benefits of imipramine for acute stress disorder following a severe burn (see Pine & Cohen, 2002). Major questions in other areas remain unanswered. For example, no RCT has examined the efficacy of selective serotonin reuptake inhibitors, which have been shown to benefit adults with post-traumatic stress disorder and children with a range of mood or anxiety disorders. In fact, no RCT has examined the efficacy of any treatment directed at specific mental disorders that arise following any form of trauma beyond sexual abuse. Given concerns with tricyclic antidepressant use among children and limitations in other areas of therapeutic research, the only current, generally accepted treatment recommendation specifically for traumatised children involves targeting anxiety symptoms with CBT in initial interventions (Pine & Cohen, 2002). Decisions on other interventions should be based on the larger literature on therapeutics of paediatric mental syndromes.

Minimising risk

Insufficient data exist to inform preventive interventions, either for specific children exposed to episodes of domestic abuse or for large groups of children exposed to massive acute traumas, such as the attacks on 11 September 2001.

Insufficient data exist to inform preventive interventions, either for specific children exposed to episodes of domestic abuse or for large groups of children exposed to massive acute traumas, such as the attacks on 11 September 2001. Ideally, firm recommendations will be based on data from randomised controlled prevention trials in similarly traumatised populations. Rising concerns both with the effects of domestic abuse and with the risk for future acts of terrorism may increase efforts to implement such prevention trials.

In the absence of such data, caution seems warranted, for a few reasons. Studies in traumatised adults suggest that potential preventive interventions can exert unanticipated deleterious effects (Rauch *et al*, 2001). Similarly, prevention studies among non-traumatised children also document the potential for deleterious effects from mass interventions. Specifically, lessons from past efforts to address rising adolescent suicide rates may be relevant. In this area, initial results suggested that strategies involving the identification and treatment of those children most in need may ultimately prove more beneficial than wide-scale, non-selective, population-based interventions (Shaffer & Craft, 1999). School-based or primary care settings may employ people with limited mental health expertise to identify those children most in need of assessments by mental health professionals. Data on moderators of risk from epidemiological studies of trauma exposure can be used to inform such case-finding strategies. Specifically, parents, educators and primary care physicians should be most concerned with children who either receive high levels of exposure to trauma or who are exposed to trauma within the context of marked disruption in social support. Efforts to prevent sequelae of trauma in children might consider the merits of working to identify such children and use insights from recent research on therapeutics of various paediatric mental syndromes to provide relief of emergent symptoms. Similarly, prevention efforts might consider the merits of interventions by parents, educators and primary care providers that either limit secondary exposure, for example through media exposures, or address social disruption following trauma.

Conclusions

In closing, concern with the psychiatric sequelae of trauma follows from diverse findings in both the scientific and lay press. Accumulating knowledge from epidemiological studies generates specific concerns over the degree to which recent widely publicised traumatic events might prove particularly harmful to the psychological well-being of children. Available data document the nature of such risks and factors that moderate outcomes. While advances in therapeutics provide insights for general treatment approaches, considerable research is needed on both therapeutics for and prevention of disorders that specifically arise following traumatic experiences.

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THEMATIC PAPER – TRAUMA AND THE MENTAL HEALTH OF CHILDREN

Impact of trauma on Palestinian children's mental health: lessons from the Gaza studies

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Children exposed to violence are at high risk of developing a range of mental health problems, predominantly post-traumatic stress disorder (PTSD) and depression (Yule, 1999). Children in war zones can be affected not only directly but also indirectly, for example through their basic health needs not being met, the loss of family members, disruption of social networks, internal displacement and their parents' responses.

Since the late 1990s, we have run a number of studies in the Gaza Strip, with Dr Abdel Aziz Thabet and his research team. Our initial study, after the end of the first intifada (uprising), established a high prevalence rate (41%) of post-traumatic stress reactions among children (aged 6–11 years) and their significant association with traumatic events experienced by the children, as well as with other behavioural and emotional problems (Thabet & Vostanis, 1999*a*). The trauma experienced included injuries, death or imprisonment of family, relatives or friends, as well as day and night raids.

When we re-interviewed these children ($n=234$) 1 year later, well after the Oslo agreement and the renewal of the peace process in the region, the prevalence rate of post-traumatic stress reactions had decreased to 10% (Thabet & Vostanis, 2000). The findings suggested that most reactions were acute and resolved in the absence of further conflict, but there were also a substantial number of children who suffered chronic and resistant post-traumatic reactions, which could benefit from specialist treatment.

Palestinian children's mental health problems were compounded by their extreme adverse socio-economic circumstances, which is a common finding in research with children who are victims of political conflict. Most traumatic events occur in refugee camps in the West Bank and the Gaza Strip, where generations of children have been born for 55 years with little hope of escape. There has been a continuous growth of the population, which has now reached a density of 2300/km^2. Refugees make up 63% of the population, and 51% of refugees are under 15 years of age (Thabet & Vostanis, 1999*b*).

The second intifada (Al Aqsa) started in September 2000. Although we could not access all areas of the Gaza Strip to follow up the previous sample, we repeated the epidemiological study with a new cohort, and found that the prevalence rates of post-traumatic stress reactions had again risen dramatically, as a consequence of high exposure to new traumatic events. Children's emotional presentations were strongly correlated with maternal psychopathology (i.e. mothers' response to trauma) (Thabet *et al*, 2001). Traumatic events had changed since the previous conflict, with most children reporting watching pictures of mutilated bodies on television, and witnessing the bombing of people and houses.

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In order to understand the underlying mechanisms operating between trauma and mental health problems, in a subsequent study we compared children whose houses had been demolished with children matched for age and gender from areas indirectly exposed to other types of traumatic events, mainly through the media and adults (Thabet *et al*, 2002). Children directly exposed to war trauma reported significantly higher post-traumatic stress and fears. In contrast, children exposed to other types of traumatic events reported significantly more anticipatory anxiety and cognitive expressions of distress.

A number of factors thus appear to mediate exposure to trauma, such as:

- the duration and severity of the trauma
- the impact on adults through fear, anger or unemployment
- the children's own anger and internalisation of the conflict
- their developmental changes in relation to cognitive processing of the meaning of trauma.

A combination of these factors could lead to a state of learned helplessness and anger expressed in extreme forms. Such states are already proving difficult to resolve among the young adult generation, now even among young women, which was previously outside the cultural norms. Such coping strategies are not easy to modify by mere psychological means (Thabet *et al*, 2003).

Following the epidemiological research, we recently completed a controlled intervention trial of group debriefing (supportive psychotherapy) and school-based psychoeducation for traumatised children in refugee camps across the Gaza Strip, the data from which we are in the process of analysing and disseminating. A preliminary analysis suggests that, in the presence of ongoing conflict, neither intervention had a positive impact on children's symptoms, despite their satisfaction with the individual treatment. This by no means negates the importance of mental health services and psychiatrists in alleviating children's distress, but does indicate the limitations of making an impact on a larger scale in the absence of other measures to safeguard children's safety and basic needs (Southall & Abbasi, 1998).

Although there is some research evidence on strategies to prevent or minimise children's response to trauma in such circumstances, these are more likely to be successful through agencies operating in the area in collaboration with schools, which are the main source of stability and safety for the children. International organisations such the United Nations (under whose auspices all schools in the refugee camps operate) and the United Nations Children's Fund (UNICEF) have a major role to play in providing as much as is humanly possible in the way of socio-economic stability, education, alternative coping strategies and awareness of the impact of trauma in these sad and untoward circumstances.

The treatment of resulting psychiatric disorders, particularly post-traumatic stress and depression, needs to be viewed in the same framework, but also taking into account cultural issues and sparse specialist resources (Thabet *et al*, 2000). Children requiring interventions can be identified through schools and primary health clinics, such as those run by the World Health Organization. The nature of intervention can be informed by clinical and research evidence from work with victims of community violence, abuse, natural disasters and political persecution. Group interventions are more cost-effective, and there is evidence for the effectiveness of cognitive–behavioural (Smith *et al*, 1999) and psychodynamic therapy (Weine *et al*, 1998). These interventions need to take into account children's developmental needs and expression of psychopathology, and should not simply replicate treatment programmes originally developed for adults. They also need to take into account the diversity and comorbidity of child psychiatric disorders, instead of only targeting PTSD. In addition to assessment and treatment, child psychiatrists have an important role to play in setting-up training for non-specialist staff, to enable them to detect and manage simple cases and refer the more complex ones.

A political resolution is, of course, the only long-term option for these children, before future generations from both Palestine and Israel are condemned to more hatred, fanaticism and perpetuation of the meaningless cycle of violence.

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Post-traumatic stress disorder in Israeli children

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Unfortunately, terrorism, violence and other acute adverse life events have become a world-wide problem. There is no country today that is protected from these phenomena and people can no longer feel safe anywhere. This new situation has increased both the scientific interest in post-traumatic stress disorder (PTSD) and the amount of research conducted on this issue.

Currently, PTSD is studied in three ways:

- as a syndrome, which has to be well defined in order to be accurately diagnosed
- as a debilitating disorder which has harmful effects on people's well-being, and as such has to be cured
- as a human reaction to various stressful events, whose risk and protective factors have to be studied in an effort to elaborate means of prevention.

Although an increasing amount of research into PTSD had been conducted in the past few years, there is still much to be done. The international scientific community needs to agree well defined criteria for its diagnosis, to formulate reliable and valid scales of measurement, and to plan methods of treatment. The present lack of agreed definitions and measurement tools makes it hard, and at times impossible, to compare epidemiological research results from around the world.

The difficulty in comparing and implementing research results is compounded by the fact that PTSD, to a very large extent, is a disorder that is determined by environmental factors. Although psychiatrists are trained to deal solely with individuals, when we come to determine the severity of this psychopathology, we must take into consideration the specific environment to which the subject was exposed. Hence, we must bear in mind that the groups studied will have experienced different types of stressor and different degrees and length of exposure.

A third problem concerns the symptoms or criteria required for the diagnosis of PTSD. When we use the terms 'acute' or 'chronic' PTSD, we mean a full-blown clinical picture. Nevertheless, recent publications have stressed the impact of:

- sub-threshold clinical PTSD symptoms and their implications for the development of a full clinical picture
- partial PTSD, which can have a profound effect on the development of future impairments.

In the preceding thematic paper in this issue on PTSD in children, Panos Vostanis discusses the relationship between the intensity of stressors and the epidemiology of PTSD among children in the Gaza Strip. This important and pertinent article summarises research data accumulated during the past 10 years. Yet the fact that that particular population suffers from distinct stressors makes it hard for us to compare it with the Israeli population. The only common factors are the fact that the two populations live in the same geographical area and under a permanent existential stress.

Few studies have been conducted in Israel on PTSD reactions to the stress caused by the unstable safety situation. Three of them will be mentioned here, one concerning the general population and the others concerning children from Jerusalem. The results of an original study on PTSD in Israeli adolescents by Dr Pat-Horenczyk and colleagues will be reported at the 19th Annual Meeting of the International Society for Traumatic Stress Studies in Chicago in October (please contact Dr Pat-Horenczyk for further details: rpat@herzoghospital.org).

Israeli studies of PTSD

The study concerning the general population was conducted by Bleich *et al* (2003), who examined the effect on the Israeli population of media reports of terrorist acts. Over the past two years a total of 4584 people were injured and 622 killed in Israel by such acts. In this study, the degree of exposure to stress and the frequency of PTSD were measured among a representative sample of the general population in Israel. The authors found that 44% of the sample were personally involved or had at least one relative who was exposed to a terrorist attack. This is a very high degree of exposure, in fact one of the highest described in the literature. Although only 9.4% of the sample presented full-blown PTSD, as much as 55% had at least one symptom of post-traumatic stress. Nonetheless, 82% of the sample reported feeling optimistic about their personal future. The authors also gave an overview of the coping mechanisms used by the sample. They concluded that the surprisingly moderate psychopathological impact of the violence was primarily due to a psychological process of adaptation to living in such a stressful environment, and indicates the degree of resilience of Israeli society.

The surprisingly moderate psychopathological impact of the violence was primarily due to a psychological process of adaptation to living in such a stressful environment, and indicates the degree of resilience of Israeli society.

One of the most interesting studies, in my opinion, concerning PTSD in children has been conducted by Lavi & Solomon (Solomon, personal communication, 2003), from Tel Aviv University, who examined exposure rates and PTSD prevalence rates among children from six different populations: from the centre of Jerusalem, Giloh (a suburb of Jerusalem which has suffered many casualties), Efrat (a residential area within the occupied

territories), Katif (a settlement in the Gaza Strip), from the Palestinian Authority, and Israeli-Arab children.

It is noteworthy that the authors insisted on using the term *examine*, and not *comparing*: they believe that the results obtained from the different populations are not comparable, due to differences in degrees of exposure to combat and terror, differences in culture, and differences in socio-economic status. The authors also indicated that such comparisons could raise ethical objections.

Researchers still differ on their definitions of PTSD, in the assessment tools they use and on the correlations they find.

Exposure was estimated by the number of life-threatening events that the children had experienced. Exposure rates (%) were: Katif, 11.6; Palestinian Authority, 10.0; Efrat, 8.5; Israeli-Arabs, 6.9; Giloh, 3.4; centre of Jerusalem, 2.8. Boys, in general, had been more often exposed than girls. Evidence for PTSD was found among 70.2% of the Palestinian population and 50.2% of the Israeli-Arab population. According to the authors, these results are similar to those reported by Saigh (1991) in his study in Beirut and Kuwait. Concerning the Jewish population, the proportions with a PTSD diagnosis were as follows: Katif, 27.9%; Efrat, 27.4%; Giloh, 16.4%; centre of Jerusalem, 13.9%. These results indicate that children who live in the territories show the same prevalence of PTSD as the population living in war zones. Finally, the authors attempted to link personal, religious, cultural and ideological beliefs with PTSD symptoms.

Common general findings concerning the reaction to prolonged stressors have been found, such as the fact that the degree of exposure is not directly related to PTSD morbidity. The next step is to analyse environmental factors in order to detect what protective factors are responsible for this.

Finally, in June and July of this year, Drs Galili-Weisstub and Ben-Harosh, from the Hadassah Hebrew Medical School in Jerusalem, examined post-traumatic symptoms among 163 minors who were brought to the emergency room of Hadassah Hospital, after 41 terrorist attacks. This sample consisted of 32 children (20%) and 131 adolescents (80%). Of the sample, 23.3% had to be admitted (three of whom died); the remaining 76.7% were discharged. Examination revealed that 42.9% of the children had the PTSD symptoms of re-experiencing, avoidance or hyperarousal (of whom 45.7% were boys and 54.2% girls) (Galili-Weisstub, personal communication, 2003).

Conclusions

We should be very cautious today. We are not able yet to compare research results, unless similar samples and tools are used. At the moment, researchers still differ on their definitions of PTSD, in the assessment tools they use and on the correlations they find with other variables. Nevertheless, common general findings concerning the reaction to prolonged stressors have been found, such as the fact that the degree of exposure is not directly related to PTSD morbidity. The next step is to analyse environmental factors in order to detect what protective factors are responsible for this.

Given the widespread morbidity of PTSD, we should start to think in terms of 'mass trauma', which leads us to consider 'mass treatments'. We should seek ways to use the mass media to instil resiliency in the general population. History and some form of slow 'immunisation' may be the leading horizontal factors underlying resiliency. It is important for the scientific community to find out what are the vertical, actual and practical protective components, perhaps hope and faith, which can be used both in our generation and in order to immunise the next generations from this debilitating psychopathology.

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THEMATIC PAPER – TRAUMA AND THE MENTAL HEALTH OF CHILDREN

Neither war nor peace: children and youth in organised armed violence

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The international community has been slow to appreciate the growing problem of the participation of armed children and youths in non-political disputes, encountered in both developed and developing countries, from Haiti to Northern Ireland. While there is widespread recognition of the issue of 'child soldiers' (e.g. www.child-soldiers.org/) there are also many children who participate in organised armed groups that function outside traditionally defined war zones. Nowhere

is this issue more acute than in Rio de Janeiro, Brazil. There may be more people (and specifically children) dying from small-arms fire in Rio de Janeiro than in many armed conflicts elsewhere. Most are bound up in the relentless conflicts involving factions of drugs traffickers fighting within and between Rio's *favelas*, or shanty towns, and their burgeoning drugs trade.

Drugs and arms

Rio's drug traffickers are a territorial and openly armed paramilitary presence in most of the city's *favelas*. The drug factions comprise armed groups that submit *favela* communities to their political and economic interests by means of territorial and paramilitary domination (de Souza, 2001). In recent years they have become increasingly territorial, political and military in character. Armed confrontations between rival factions and with the police are commonplace. They have arsenals of modern weapons that would make any terrorist group or legitimate security force jealous. Drug-related violence and territorial disputes between rival factions is a major causal factor in the almost 140% increase in small-arms-related deaths within the municipality between 1979 and 2000.

There are many similarities between 'child soldiers' and Rio's estimated 5000 children and youths who work for the drug factions. Children are recruited for such work from 10 years of age, and they are armed in early adolescence. They are subject to orders and punishments; they are paid for their service; they are given a weapon; they are on call 24 hours per day; and their survival is on the basis of a kill-or-be-killed reality. However, there is no military solution to this problem. Demobilisation is not a policy that can be implemented in Rio as it can be for 'child soldiers' when a conflict is settled. Furthermore, despite their characterisation within the drug factions' hierarchy as *soldados*, if we categorise these children as 'soldiers' we may legitimise the already high levels of lethal state force used against them.

Children's growing role in drugs-related armed conflicts has been facilitated by increasing access to modern weapons that are light, small and easy to use. There are great numbers of such weapons in circulation. In 1998, 10 017 illegal firearms were seized by police in Rio de Janeiro State, compared with 844 in 1960. Worryingly, in recent years drug factions have gained access to much more powerful weapons, specifically designed for warfare. Children and adolescents are now found in possession of Kalashnikov AK-47s and Colt AR-15 automatic rifles. The consequence of access to combat-grade high-powered firearms was corroborated by the surgical team at the Souza Aguiar Hospital's emergency unit, one of whom commented recently:

> Previously we would see orifices caused by the bullet entering and leaving [the body], or only entering without leaving.… Today, you no longer see orifices, you see amputations, you see the destruction of tissue and you know that this comes from a high-velocity bullet, a rifle for example.… Today you see many deformities. You see bits of feet missing, or the injury that my colleague mentioned, the boy with his hand destroyed. You see a lot of this today.

International comparisons

It is sobering to compare the danger posed to minors by gunfire in Rio de Janeiro with that of conflicts that attract considerably more publicity. For example, in the long-standing dispute between Israel and Palestine over the occupied territories, 467 Israeli and Palestinian minors were killed between December 1987 and November 2001. During the same period, in the municipality of Rio de Janeiro alone, 3937 under-18-year-olds were killed by small-arms fire. Amnesty International's report *Killing the Future: Children in the Line of Fire* (2002) calls for the UN Committee on the Rights of the Child to take notice of the fact that more than 250 Palestinian and 72 Israeli children were killed as a result of the conflict in the occupied territories between September 2000 and August 2002, a 23-month period. Between February 2000 and December 2001 inclusive (also a 23-month period) a total of 612 under-18-year-olds were killed by small-arms fire in Rio de Janeiro. The worst year for 15- 17-year-olds was 1990, when there were 274 firearm-related deaths in this age group in the city, equivalent to 100.5 deaths per 100 000 population. In contrast, in 1979, when drug factions were in their infancy, firearm-related mortality rates for children in mid-adolescence stood at 24.6 per 100 000 population.

It is sometimes said there must be similarities between recruitment of the drug factions' youth workers and the equivalent recruitment of gang members in urban centres within the United States and elsewhere. However, a drug faction differs substantially from even the most organised 'gang' in its command structure, in its quasi-military discipline, in the levels of armed confrontations, the complete territorial domination, and the almost total power exercised over the local population. The children caught up in these inter-factional disputes are far from traditional notions of delinquency. While there are 'institutionalised' gangs within some inner cities of the United States, there is no evidence that child recruits to these gangs are given war-grade weapons and paid a salary to walk openly armed within their community on defensive patrol.

Conclusions

Perhaps the biggest tragedy in Rio de Janeiro is the fact that so much of the problem is due to socio-economic marginalisation of the *favela* communities. My own research has found (Dowdney, 2002, 2003) that many children and adolescents in the *favelas* see joining a drug faction as their best option, despite knowing that death is the most likely outcome of such a 'choice'. Unless there is substantial investment in the social and material infrastructure of the

There are many similarities between 'child soldiers' and Rio's estimated 5000 children and youths who work for the drug factions. Children are recruited for such work from 10 years of age, and they are armed in early adolescence.

Unless there is substantial investment in the social and material infrastructure of the *favelas*, and a policy that brings in the rule of law, future generations of children and adolescents will continue to become involved and subsequently die while working in Rio de Janeiro's drug trade.

For more information on the COAV (Children and Youths in Organised Armed Violence) international research project, and for a daily updated news service relating specifically to children and armed violence, visit the COAV website at www.coav.org.br. A PDF version of *Children of the Drug Trade: A Case Study of Organised Armed Violence in Rio de Janeiro* (Dowdney, 2003) can also be downloaded from this site.

favelas, and a policy that brings in the rule of law, future generations of children and adolescents will continue to become involved and subsequently die while working in Rio de Janeiro's drug trade.

Furthermore, until we fully recognise the increasing role that younger children and adolescents are playing in armed groups around the world, and build a practical body of knowledge in order to design policy implementations to tackle this problem, children and youths will continue to die in alarming numbers in countries that are neither at war nor at peace.

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COUNTRY PROFILES

Introduction

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How many members of the College know about the state of psychiatry in Nigeria or Egypt? Perhaps just a few. How many would be interested in knowing more? Perhaps many. The country profiles section of *International Psychiatry* attempts to narrow this information-and-awareness gap.

Country profiles provide summary information on mental health policy, services, training and research in the country, along with key references for more details. The aim is to give a bird's eye view of the situation within about 1500 words. It is hoped that this will not only increase the awareness of the readers to distant and often forgotten countries, but also provide an opportunity for learning from others' experiences. The profiles can also open possibilities for further dialogue and even collaboration. This issue of *International Psychiatry* presents country profiles from Nigeria, Egypt and Italy, three countries that are very different in size, population and available resources. They also represent somewhat different ways of expanding the quality and coverage of psychiatric services.

If you wish to make a contribution to the country profile section, please contact Shekhar Saxena (email saxenas@who.int).

COUNTRY PROFILE

Psychiatry in Nigeria

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Nigeria is a huge country. It covers an area of 924 000 km^2 on the west coast of Africa. It has a population of about 110 million, which means that every one in six Africans is a Nigerian. It is a country of diverse ethnicity, with over 200 spoken languages, even though three of those are spoken by about 60% of the population. Administratively, it is divided into 36 states and operates a federal system of government, with constitutional responsibilities allocated to the various tiers of government – central, state and local. There are two main religions, Islam (predominantly in the north) and Christianity (predominantly in the south). However, a large proportion of the people still practise traditional religions exclusively or in addition to either Islam or Christianity.

In spite of its abundant natural and human resources, Nigeria is still a poor country, and nowhere is that status indicated better than in its health indices.

In spite of its abundant natural and human resources, Nigeria is still a poor country, and nowhere is that status indicated better than in its health indices. About 170 out of every 1000 children die before the age of 5 years and life expectancy is 46.8 years for men and 48.2 years for women (World Health Organization, 2000). It spends about 3% of its gross domestic product on health (World Health Organization, 2001) and in a rating of the overall health performance of all 191 member states of the World Health Organization in 2000, Nigeria was ranked 187 (World Health Organization, 2000).

A brief history

Available records suggest that the first asylum had been established in the southern city of Calabar by 1904. It was

followed by the Yaba asylum, also in the south, which was opened in 1907 with 48 patients. Before that, some patients with mental illness were sent to Sierra Leone. However, the seeking of orthodox care for mental illness must have been very uncommon at the time, for a British army physician claimed in 1845 that insanity was rare in Nigeria (Anumonye, 1976). The asylums relied on the services of general medical officers, since there were no psychiatrists and those there were provided essentially custodial management.

When the Aro Mental Hospital was opened in Abeokuta in 1954, it was to respond to the need for improved mental health care identified by the British colonial government. Since Dr Thomas Adeoye Lambo had arrived back in the country from England in 1952, the establishment of Aro Mental Hospital was also an opportunity to make the best use of the services of this first Nigerian psychiatrist. The hospital, later to be known as the Aro Neuropsychiatric Hospital, was to play a central role in the development of psychiatry in Nigeria (Asuni, 1967, 1972)

Clinical practice

From a total of 5 in 1963, 25 in 1975 and 35 in 1981, today there are about 100 psychiatrists working in Nigeria (Jegede, 1981). Most of these are based in departments of psychiatry in the 12 medical schools and the eight psychiatric hospitals in the country. The provision of psychiatric beds amounts to about 0.4 per 10 000 persons, while that of both psychologists and social workers is 0.02 per 100 000 persons (World Health Organization, 2001). Thus, the country is severely underserved in these respects. Psychiatric care is almost entirely located within the public health sector – there is virtually no private psychiatric practice in the country. Since the available resources are also all located in urban centres and predominantly in the southern parts of the country, some sections of the community experience an even worse shortage of resources than others.

Traditional antipsychotic drugs and tricyclic antidepressants are available and relatively affordable. However, the newer formulations are either unavailable or too expensive for most of those in need. For example, a month's supply of risperidone would cost more than twice the minimum monthly wage in the public service.

Traditional healing practices and faith healing, much of which are poorly understood and some of which are quite clearly harmful, are the common resort. The lay view of mental illness is generally still rooted in supernatural beliefs; moreover, given the restricted access to adequate orthodox psychiatric care, few members of the public get even a chance to be convinced of its effectiveness.

Training

The first generation of Nigerian psychiatrists – those who trained in the early 1960s – received their training almost exclusively in England or Scotland. Most started off with an introduction to the field in Nigeria and, with encouragement and support from Dr Lambo, completed their training in the UK. In later years, Nigerian psychiatrists also trained in places such as North America and Australia (Jegede, 1981).

Most of the psychiatrists currently working in the country received their training locally. The West African Postgraduate Medical College, part of the West African Health Community, was constituted in 1976. Incorporating Anglophone countries in the West African sub-region (i.e. Nigeria, Ghana, Liberia, Sierra Leone and Gambia), it regulates and conducts postgraduate diploma examinations (termed 'fellowship' examinations) for specialist qualifications. Soon after its inauguration, the West African Postgraduate Medical College was complemented by the National Postgraduate Medical College, which was established by a Nigerian government decree in 1979. The Faculties of Psychiatry of both Colleges run broadly similar courses of training that span a minimum of 4 years. The examinations are conducted in three stages: primary (mainly basic sciences and psychology), part I (consisting of clinical, written and oral examinations) and part II (consisting a supervised research project, the results of which are reported in a bound dissertation and a viva). In practice, the average time taken to complete training is 5 years.

Traditionally, attracting doctors to psychiatry had been difficult. Poor conditions of service in the public sector made it unattractive and led doctors to seek specialisation in areas where lucrative private practice could be expected. Psychiatry was and is still not one of these. However, with the recent improvement in the conditions of service for doctors in the public health service, the number of doctors wishing to specialise in psychiatry has increased dramatically in the past few years. Currently, there are about 110 doctors at various stages of training. Whether improved service conditions will also translate into better retention of psychiatrists in the country is not yet clear. Many trainee psychiatrists have obtained training positions overseas (particularly in the UK) in the past and have not shown a willingness to return home to practise after qualifying.

Research

The contribution of Nigerian psychiatrists to the international psychiatric literature contrasts with their small number on the ground and the general lack of institutionalised support for research in the country. Nigerian psychiatry is known to many for the influential work of Dr Lambo on the Aro village treatment system and his pioneering community epidemiological study (Leighton *et al*, 1963). It is also known for its involvement in such landmark studies as the International Pilot Study of Schizophrenia, the 10-country study of the incidence and manifestations of schizophrenia and, more recently, the Psychological Problems in General Health Care project.

Part of the reason for this is the strong academic orientation of Nigerian psychiatry, with most professionals working at some point in their careers in universities. However, beyond these remarkable achievements, the range of research activities is actually relatively narrow. Most are small-scale surveys and descriptive clinical studies. Many of these address subjects such as drug use in schools and

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phenomenological studies of psychoses, among others. Intervention studies are rare and cohort studies few. Research addressing special groups such as children and the elderly is very much in its infancy.

Mental health policy

The first mental health policy for the country was launched in 1991 (Federal Ministry of Health, 1991). Its laudable 14 declarations include:

> The mental health policy shall be based on the national philosophy of social justice and equity.
>
> Individuals with mental, neurological and psychological disorders shall have the same rights to treatment and support as those with physical illness and shall be treated in health facilities as close as possible to their own community. No person shall suffer discrimination on account of mental illness.

It also recommends a revision of laws relating to the mentally ill in Nigerian statutes. The policy is backed with a National Mental Health Programme and Action Plan, which, unfortunately, has hardly been implemented.

The legal provisions in the Nigerian statutes are obsolete. For example, the country still operates within the framework of the Lunacy Act Cap. 112 (Cap. 81 Lagos) of 1916, which in turn was based on the Lunacy Acts 1890–1908 of the United Kingdom. Accordingly, the Act recommends certification for 'lunatics', including 'an idiot or any person of unsound mind'. These provisions fail to recognise the present-day view of severe mental disorders as treatable conditions, or to give special consideration for actions that breach the laws of the land but that are committed when the individual is unable to make a reasoned judgement. However, there is some hope that, in the new democratic political dispensation, there may be some positive changes, as attempts at revising these laws are currently under way.

Professional groups

The Association of Psychiatrists in Nigeria, formed in 1969 at a meeting in Ibadan attended by seven members, has grown such that there are now over 130 members and associate members. Its annual general and scientific meeting has become an established annual event. The Association was a strong member of the now defunct African Psychiatric Association. Several of its members were also instrumental in the formation and nurturing of the *African Journal of Psychiatry*, which, unfortunately, is also now defunct. Indeed, the involvement of Nigerian psychiatrists in international professional associations started with the organisation in 1961 of the first Pan-African Psychiatric Conference by Dr Lambo. Participants at the conference had come from several African countries, as well as Europe and North America. Currently, Nigerian psychiatrists are fully involved in the activities of the World Psychiatric Association and newly established Association of African Psychiatrists and Allied Workers.

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Several Nigerian psychiatrists are members or fellows of the Royal College of Psychiatrists. At present, there is no organised forum for them in which to meet and deliberate on College affairs, even though Nigerian members and fellows are often present at the annual College conference. The story is different for Nigerian psychiatrists working in the UK. Several of these have played active roles in the activities of the College and some have held important leadership positions in training and examination programmes.

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COUNTRY PROFILE

Psychiatric services in Egypt – an update

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For over a thousand years, the Hippocratic system of medicine prevailed in Europe. It went into oblivion during the Dark Ages, when there was a reversion to the demoniacal theories of mental illness. Hippocrates' works survived, however, in the library at Alexandria, where they were

translated into Arabic. These and other classical works were retranslated into Latin and Greek from the 12th century on, ushering in the Renaissance.

Around 1284 CE, the Sultan of Egypt, Al Mansour Kalawoon, bequeathed one of his palaces in Cairo for the construction of a general hospital with a department of psychiatry. It soon became one of the most famous hospitals throughout the Islamic world. It was, and still is, known as Dar Al Shefa, literally the House of Healing (Okasha *et al*, 1993). Two features were remarkable for that era: the care of mental patients in a general hospital, and the involvement of the community in the welfare of the patients, which foreshadowed modern trends by six centuries (Baasher, 1975).

The mentally disturbed usually received baths, fomentation, compresses, bandaging and massage with various oils. Blood-letting, cupping and cautery were also widely used. A familiar term for an antidepressant in the medieval period was *mufarrih an-nafs*, 'gladdening of the spirit'. Those suffering from insomnia would be placed in a separate hall to listen to harmonious music and to hear skilled story-tellers recite their tales (Buergel, 1975; Dols, 1992).

Mental health resources

Today, the population of Egypt is around 61 000 000 (National Information Centre, 1997). There is one psychiatric bed for every 6000 citizens; psychiatric hospital beds represent less than 10% of the total. These are largely concentrated in Cairo, bringing the ratio there to 1 bed per 2200 – the four public psychiatric hospitals in Cairo provide 5800 beds, and the remaining 1200 beds are distributed over the rest of Egypt (Ministry of Health, 1998). Psychiatric hospitals are currently experiencing difficulties in the provision of care, treatment and rehabilitation, as they have limited resources.

Egypt has one psychiatrist for every 130 000 citizens, compared with one physician for every 500. Clinical psychologists total around 250 in the whole country, most of them also concentrated in the capital. The nurses working in the mental health field are general nurses – most have little or no training in psychiatric care. The more highly qualified nurses graduating in Egypt generally prefer to work abroad, often in the Gulf, where remuneration is much higher. There are many social workers practising in all psychiatric facilities, but they are mostly generic social workers, who have minimal graduate training in psychiatric social work. There is no training for occupational therapy in Egypt (Okasha & Karam, 1998).

Training

There are 13 medical schools in Egypt, each with a department of psychiatry (mainly providing out-patient services). Undergraduate training in psychiatry is often limited to a few days in the curriculum. There is a 4-year postgraduate psychiatric training programme in several of these schools. In 1948, Cairo University started a diploma in psychological medicine and neurology.

Health expenditure

According to United Nations Development Programme (UNDP), health expenditure, estimated as a percentage of gross domestic product (GDP), is 1% in Egypt. This is far below the minimum expenditure of 5% of GDP recommended by the World Health Organization, and may be compared with 13.7% in the USA (World Health Organization, 1996). The Ministry of Health budget constitutes 1.9% of the national budget (Ministry of Health, 1998). The allocation of resources is directed towards endemic problems such as malnutrition, parasitic infestations (e.g. bilharzia), tuberculosis and maternal and child morbidity.

In a postal survey conducted by Okasha & Karam (1998) looking at psychiatric services in several Arab countries, there was a consensus among Arab psychiatrists about the need for:

- public mental health education
- an increase in the number of psychiatrists
- upgrading of the training and education of mental health professionals
- the development of preventive and community mental health care services.

Research in Egypt

Egypt is the most productive country in the Middle East in terms of the number of articles published per year over the past 30 years (176 articles). However, using another method of measuring research productivity – the number of articles per million of the population – Egypt would rank average to low (1.5 articles per million).

The region seems to lack a strategic, policy-oriented position on the research agenda. Furthermore, funding for academic research is limited and depends on the interests of the different financing organisations. On the other hand, collaboration between different centres at the Arab, regional or international level will doubtless contribute to the development of research in the Arab world (Okasha & Karam, 1998).

Policies and future directions

Egypt has a Mental Health Act dating back to 1944 and a documented health policy. Four years ago, the Ministry of Health adopted a new strategy, of centralisation of mental health services. In collaboration with several international agencies, this has facilitated the implementation of several projects to upgrade mental health services:

- a Finnish project on human resource development and the introduction of community-based services
- a UNDP project that concentrates on improving treatment services and rehabilitation for addiction
- a World Health Organization project on the inclusion of psychiatry in primary care services, as well as support for community-based services.

Mental health and culture

As in the majority of developing countries, patients tend to present with somatic psychological symptoms. This

Around 1284 CE, the Sultan of Egypt, Al Mansour Kalawoon, bequeathed one of his palaces in Cairo for the construction of a general hospital with a department of psychiatry.

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presentation of mental ill health is reflected in the pattern of consultation. Patients tend to pass through different health care 'filters' before they reach psychiatric clinics and hospitals. According to Goldberg & Huxley (1992), almost two-thirds of patients with psychiatric symptoms attend only their general practitioner, and only 50% of those would be recognised as having a psychiatric disorder.

In this context, traditional and religious healers play a major role in primary psychiatric care in Egypt. They deal with minor neurotic, psychosomatic and transitory psychotic states using religious and group psychotherapies, suggestion and devices such as amulets and incantations (Okasha, 1966). It was estimated that 60% of out-patients at the university clinic in Cairo, which generally serves people from low socio-economic classes, have been to traditional healers before attending a psychiatrist (Okasha & Hassan, 1968). In rural areas, community care is implemented without the need for health care workers. Egyptians, especially those living in the countryside, have a special tolerance of mental disorders and an ability to assimilate those with a chronic mental illness. For example, these patients, and those with mild or moderate learning disabilities, may cultivate crops along with, and under the supervision of, family members.

Traditional and religious healers play a major role in primary psychiatric care in Egypt. They deal with minor neurotic, psychosomatic and transitory psychotic states using religious and group psychotherapies, suggestion and devices such as amulets and incantations.

Thus, the real challenge for mental health professionals is the first filter, that is, patients acknowledging their mental health problems. However, this challenge cannot be met without a reorganisation of both the health-providing structures and the approach to medical education and training. The latter cannot be systemically tackled without the guidance of action-oriented and policy-oriented research.

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COUNTRY PROFILE

Italian psychiatry – 25 years of change

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Italian psychiatry is probably more debated than known in the international arena. Law 180 of 1978, which introduced a radical community psychiatry system, has drawn worldwide attention and debate, with comments ranging from the enthusiastic to the frankly disparaging (Mosher, 1982; Jones *et al*, 1991). More recently, this interest was marked by a well-attended symposium 'Lessons Learned from Italian Reforms in Psychiatry' held at the 2003 annual meeting of the Royal College of Psychiatrists in Edinburgh.

Historical analyses of how the reform movement took momentum, produced a law and how it was enacted can be found elsewhere (Perris & Kemali, 1985; Saraceno & Tognoni, 1989; Mangen, 1989; Fioritti *et al*, 1997). In this article we try to outline the general social context in Italy, its health and psychiatric services, their organisation, functioning and culture.

Italian communities at a glance

Italy is a country of 56 995 744 inhabitants (census of 21 October 2001) and its economy is the world's seventh largest in terms of gross domestic product (GDP) (World Bank, 2003). It has the world's fifth highest life expectancy at birth (76.9 years for men and 83.3 years for women) (World Health Organization, 2003).

Administratively, the country is divided into 20 regions and 109 provinces. Because of its historical fragmentation until reunification in 1870, striking social and economic

differences persist across the nation. Per capita income, economic activities, distribution of wealth, rates of unemployment and the development of welfare services are still very different in northern–central compared with southern regions. In acknowledgement of this, a policy of devolution is now transferring most administrative powers to regional councils; notably, this includes all functions related to planning and management of health services. This explains the remarkable differences in models and implementation of psychiatric services, whose landscape has been described as 'patchy and confused' (Freeman *et al*, 1985).

Although rapid demographic changes are occurring (in particular, massive immigration is compensating for a decrease in the native population, which presently has a low birth rate), Italian society is still based on strong family links and demographic stability. Recent comparative studies (Warner *et al*, 1998; Fioritti *et al*, 2002) have shown that over 70% of patients with psychosis live with their family, in accommodation they own and in which they have typically lived for about 20 years. Patients are usually well protected from certain psychosocial stresses (e.g. housing and financial problems) but quite dependent on significant others, whose involvement in the care process is almost always required. Families are fundamental stakeholders in health administration and their associations have become very influential on national and regional mental health policies (e.g. becoming providers of mental health services or supporting bills to reform current legislation).

Health care and psychiatric services

Italy has had a National Health Service (NHS) since 1978, when a comprehensive public health policy was adopted. The NHS absorbs about 6% of the nation's GDP, while an additional 2–3% of it is spent on private health services. About 5% of NHS resources are allocated to child and adult psychiatry, excluding services for drug misuse and learning disabilities. It is generally held that the implementation of the NHS has achieved good results in the northern regions but failed most of its promises in the south, mostly because of pre-existing social and economic factors (Putnam, 1993).

The NHS is organised through 401 local health trusts (*aziende unità sanitarie locali* – AUSL), each caring for a geographically defined population of 200 000–500 000 inhabitants. They have full economic accountability and reasonable autonomy in planning, managing and evaluating services. Each AUSL has one mental health department (*dipartimento di salute mentale* – DSM), which provides comprehensive psychiatric care for the local population and manages on a unitary basis the full set of necessary services (as stipulated within national policy documents):

- community mental health centres (CMHCs)
- day-hospital/day-care rehabilitation centres
- psychiatric wards within a general hospital (*servizio psichiatrico di diagnosi e cura* – SPDC)
- non-hospital residential medium- and long-term facilities (NHRF).

Regional and local differences can be found as to standards (i.e. number of beds, allocation of resources to each unit within the department), integration of private services within the DSM and integration with child psychiatry, drug misuse and learning disabilities services.

This system is the end-point of a process started by Law 180 of 1978, which had five key effects:

- all mental hospitals were gradually phased out, with a halt to all new admissions
- general hospital psychiatric wards (SPDCs) were established, each with a maximum of 15 beds
- severe limitations were set on procedures for compulsory admissions and on their length (maximum 7 days, renewable weekly)
- the CMHCs were established to provide psychiatric care to geographically defined areas
- all new and old public psychiatric services were integrated within the NHS.

The 1980s saw the establishment of the CMHCs, the deinstitutionalisation of patients from the mental hospitals, who were usually moved into small NHRFs, and the establishment of the network of SPDCs by the general hospitals. The 1990s saw the establishment of the co-ordination of all these facilities under the DSM and the adaption of existing services to the new chronic population that was emerging. Only in 1999 were the last mental hospitals closed, thereby bringing a 21-year process to an end. A critical issue of the 1990s was also the integration of economic and quality assurance elements within the management of clinical teams, as required by policies and laws affecting all health services. Throughout that decade, the actual number of professionals employed by the NHS in psychiatry decreased by about 10% (from 34 000 in 1992 to 30 711 in 2002) and so did the number of psychiatrists (from 6276 in 1992 to 5561 in 2002).

Italian psychiatry today represents a multifaceted and complex system (see Table 1). CMHCs are well established all over the nation; their multi-professional teams ensure general psychiatric evaluation and care, and often good assertive outreach. These services are grounded in an interesting mix of phenomenology, psychodynamics, and clinical and social psychiatry. The actual number of hospital beds and facilities is among the lowest in Europe. One recent comparison of the psychiatric laws of all European Union countries acknowledged that the Italian law and

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Table 1. The composition of Italian mental health services

	Number	Rates per 100 000 population
Community mental health centres	707	1.24
Psychiatric wards in the general hospital		
Number	321	0.56
Beds	3 997	7.01
Private clinics		
Number	56	0.09
Beds	3 950	6.92
Non-hospital residential facilities		
Number	1370	2.40
Beds	17 138	30.06
Day centres	921	1.61

Data from Ministero della Salute (2001) and, for the non-hospital residential facilities, de Girolamo *et al* (2002) (these facilities comprise supported housing with four or more beds with any degree of staff supervision, therapeutic communities and facilities set up as alternative to mental hospitals).

system pose the lowest level of formal coercion over the patient (Fioritti, 2002). In seven regions, additional hospital beds are acquired from private clinics under 'allowance schemes', but the total number of beds in hospitals remains low. The area of medium- to long-term NHRFs saw a large expansion during the 1990s and now accounts for more beds than the hospital sector (de Girolamo *et al*, 2002).

Challenges currently on the agenda include: collaboration with primary care; the integration with drug misuse services; and the integration (or reform) of the forensic psychiatry sector, which is still a separate system, run by the Ministry of Justice, with very few points of contact with the NHS (Fioritti & Melega, 2000).

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Education and training

Psychiatry is part of the compulsory undergraduate training of every medical student on a degree course in medicine and surgery at any Italian university. It is usually organised as formal teaching (i.e. lectures and seminars), and it is then followed by an oral examination.

Psychiatry is now taught in its own right at postgraduate level as well, having been separated from neurology in the mid-1970s, but still in the 1980s the psychological sciences had little place in medical curricula. At the beginning of the 1990s Italy had to conform to European educational standards and universities adapted very rapidly to these requirements. To become a psychiatrist, the student (who has already registered with the Medical Council before applying to the Psychiatry Residency School) must attend courses for four academic years and must discuss his/her own dissertation at the end of training. Today, residents are fully integrated within the teams of teaching psychiatric clinics or of public health services. They attend theoretical lessons and receive a broad range of practical experiences in general hospital and community psychiatry, consultation–liaison, psychotherapy, rehabilitation and research.

Other mental health professionals do not receive specific training before employment and their education is based on practical experience and educational programmes set up by their employers. In 2000 a formal system of continuing medical education based on credits was set up and has served to greatly improve local educational programmes at both public and private psychiatric institutions.

Research

Research in mental health has achieved mixed results. Italian psychiatry ranks ninth internationally in terms of the number of papers published and eleventh in terms of their impact (Fava & Montanari, 1998); these contributions largely come from a few distinguished centres (Verona for social psychiatry and epidemiology, Pisa, Milan and Cagliari for biological psychiatry, Bologna for psychotherapy) (Fava & Tansella, 2002). This is not an adequate representation of the intensive national and international scientific life of Italian universities, scientific societies and DSMs. Some research projects whose formal bibliometric impact is low have none the less yielded very significant results and shown that good organisation and commitment can produce good research within very limited budgets (e.g. the 'Progres Project'; de Girolamo *et al*, 2002). Finally, Italian research teams are currently involved in all major collaborative studies financed by the European Union in psychiatry (e.g. EUNOMIA and EQOLISE).

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Professional bodies

The Italian Psychiatric Association (Società Italiana di Psichiatria – SIP) has about 6000 members and has 25 thematic sections. It is very active and supports several educational and research programmes.

Important acknowledgements to Italian psychiatry have come from appointments to international bodies of highly representative psychiatrists: Dr Benedetto Saraceno is currently Director of Mental Health and Substance Dependence at the World Health Organization in Geneva; and Professor Mario Maj is President of the European Association of Psychiatrists.

Conclusions

As early as 1950, Italian psychiatry was mentioned in international scientific papers for its obsolete and repressive institutions (Lemkau & de Sanctis, 1950). This went on until the reform law of 1978. Deinstitutionalisation has probably met in Italy its more radical form and produced a complex and multifaceted system of community psychiatry which is now actively looking for international comparison.

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The Association of European Psychiatrists' programme of itinerant CME courses

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According to the most recent data provided by the World Health Organization (2001), there are presently in Europe more than 77 000 psychiatrists, more than 46 000 clinical psychologists active in the mental health field, more than 285 000 psychiatric nurses, and more than 91 000 social workers operating in the mental health sector. Are these professionals being adequately updated on recent clinical and service developments in mental health? What is the role of international channels (in particular, those of international professional associations) in this process? These are difficult questions to answer, in the absence of a European systematic survey (which, of course, would be a very worthwhile initiative). I try, however, to provide here a framework for a discussion of these issues, as a background to the presentation of the programme of itinerant educational courses run by the Association of European Psychiatrists (AEP).

The main channels

The main international channels of professional update in the mental health field are scientific meetings, traditional publications (i.e. professional journals, books and other printed materials), the internet and the direct channels used by drug companies.

Scientific meetings

A well-organised international meeting offers a variety of opportunities for update, from state-of-the-art lectures to workshops and educational courses. Several international meetings offer a programme of continuing medical education (CME) courses, with provision of credits.

The problem is, however, that the average European psychiatrist is often unable to afford the registration fee, so that his or her participation often depends on sponsorship by a drug company. This means that psychiatrists who do not have relationships with drug companies are penalised in their access to professionally relevant information. This is the case for virtually all psychiatrists of some European countries which are not very attractive to drug companies, in particular in eastern Europe. For instance, during the AEP CME course held in Almaty, Kazakhstan, on 6 June 2003, the participants were asked to complete a questionnaire concerning their previous participation in international psychiatric congresses. Out of the 56 participants on the course, who were likely to represent a selected group of highly motivated psychiatrists, only two had ever participated in a World Congress of Psychiatry, and none had ever attended a Congress of the AEP, the European College of Neuropsychopharmacology (ECNP), the Collegium Internationale Neuropsychopharmacologicum (CINP) or the American Psychiatric Association (APA). For those who may think that this is a marginal problem, it is useful to point out that the number of psychiatrists who are currently active in Kazakhstan is about 1000.

The European audience of international psychiatric meetings is represented by a restricted elite, mostly consisting of psychiatrists from 'group A' countries of the World Bank classification (i.e. those with the highest income per capita). Moreover, the participation of European mental health professionals other than psychiatrists is usually very limited.

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Traditional publications

In psychiatry and related mental health disciplines, there are presently 89 journals for which the Institute of Scientific Information reports an impact factor, of which 76 are produced in English. Most of these journals have an international distribution, but the vast majority and sometimes the totality of their subscribers are from North America, Western Europe and Australia. The average European psychiatrist (especially from a group B, C or D country) cannot afford the cost of the subscription to even one international journal. Moreover, in many European countries, libraries where international psychiatric journals can be found are few and difficult to access; in several group C or D European countries, no such library is available. Furthermore, many academic centres, even in group A European countries, are currently reducing the number of journals to which they subscribe.

Financial and logistic difficulties are not the only obstacles to the access of European psychiatrists to international journals. Many European clinicians, even if they are able to read English (which is not the case for several thousands of psychiatrists in Europe), experience increasing difficulties in understanding the technical details of some papers published in international journals – indeed, the contents of some international journals are becoming less and less accessible to clinicians.

Finally, few clinical psychologists and other mental health professionals have access to international mental health journals in most European countries.

The offer of books in the mental health field is rich and varied. However, access to books is even more limited than to journals. The cost of books is often prohibitive for the vast majority of professionals. Even many academic centres in group B, C or D European countries cannot afford to purchase them. Access to individual chapters of published books is much more difficult than to papers published in international journals. This is one of the reasons why books are increasingly becoming a vehicle for theoretical essays or reviews of the literature rather than for new information.

It is useful to emphasise that the majority of international psychiatric journals largely depend for their survival on advertisements by drug companies, and that many publishing companies require the author of a book to ensure that a certain number of copies be purchased by a sponsor, which is usually a drug company.

The internet

The role of the internet in the dissemination of information in the mental health field is becoming more and more significant. The main problem with this information is its very varied quality and credibility. International professional associations have a very important role to play here, not only by providing information and educational materials on their own websites, but also by developing rules with which their members have to comply in the provision of information, as well as a system of accreditation of the information which appears on-line, as a guide for users.

The drug companies

Besides funding, directly or indirectly, the majority of the above-mentioned channels by which information is disseminated in the mental health field, drug companies are increasingly developing their own, direct channels. In addition to traditional leaflets focusing on their products, they often distribute proceedings of symposia they have sponsored, reprints of articles published in international journals and other printed materials. Moreover, several companies now invite internationally renowned researchers with whom they have good relationships to deliver seminars in several centres, with the participation of many hundreds of psychiatrists, including many who do not usually attend international scientific meetings.

The role of international professional associations

In this situation, what should be the role of international professional associations? Can they do more than organise scientific meetings for a small minority of European psychiatrists, or publish journals and books for an even more limited audience, or make attempts to harmonise national CME programmes (which in several cases exist only on paper)? Can these associations do more for psychiatrists of those European countries which are currently almost forgotten by the international psychiatric community? I believe that not only can they do so, but they have the duty to do so, and that the crucial step is the establishment of a close collaboration with national psychiatric societies. These societies should be provided not only with rules and guidelines, but also with concrete support, for example in the form of internationally renowned teachers and high-quality educational materials, following their own priorities rather than those of any sponsor or of any European body.

What should be the role of international professional associations? Can they do more than organise scientific meetings for a small minority of European psychiatrists, or publish journals and books for an even more limited audience, or make attempts to harmonise national CME programmes (which in several cases exist only on paper)?

Table 1. Calendar of AEP itinerant CME courses for the second half of the year 2003

Date	Location	Collaborating body	Title	Director(s)
2 June	Tel Aviv, Israel	Israeli Psychiatric Association	How to set up and evaluate a community mental health service	G. Thornicroft, UK
6 June	Almaty, Kazakhstan	Kazakh Association of Psychiatrists and Narcologists	Trends in drug treatment of schizophrenia	F.-A. Wiesel, Sweden
11 June	Oviedo, Spain	Spanish Association of Neuropsychiatry	How to set up and evaluate a community mental health service	G. Thornicroft, UK; M. Tansella, Italy
13 August	Reykjavik, Iceland	Icelandic Psychiatric Association	Cognitive–behavioural therapy in anxiety disorders	L.-G. Ost, Sweden
8 September	Tblisi, Georgia	Society of Georgian Psychiatrists	ADHD through the life span	S. Tyano, Israel
15 October	Antalya, Turkey	Psychiatric Association of Turkey	Alcohol dependence	K. Mann, Gernmany
20 October	Bologna, Italy	Italian Psychiatric Association	Liaison psychiatry: identifying and treating psychiatric problems in a medical population	F. Creed, UK
19–23 November	Berlin, Germany	German Society of Psychiatry, Psychotherapy and Neurology	Teaching general practitioners about depression Alcohol dependence	J. Cooper, UK K. Mann, Germany

The AEP programme of itinerant CME courses (Table 1) represents a first step in this direction. Our starting point has been the programme of CME courses delivered at the 11th Congress of the Association in Stockholm in May 2002. This programme included 36 CME courses, all developed under the guidance of an ad hoc committee. These courses were formally evaluated in Stockholm by three groups of assessors: the participants, the teachers and a group of observers appointed by the AEP and the host society, the Swedish Psychiatric Association. Among the courses which received the best ratings, the AEP Executive Committee selected those whose topics were most likely to be of interest to psychiatrists of all the various European countries. The list was then submitted to the presidents of all national psychiatric societies, asking them to host one or more of the courses within their national congresses, as a joint initiative of their society and the AEP, providing the same kind of evaluation which took place in Stockholm. Local expenses, including those of simultaneous translation, were to be covered by national societies, whereas the travel expenses and the honoraria for the teachers were to be covered by the AEP. No drug company was to be involved in any way in the organisation of the courses.

To date, concrete agreements have been made with 18 national psychiatric societies for the co-organisation of the courses (the Czech Psychiatric Society; the Danish Psychiatric Association; the Finnish Psychiatric Association; the German Society of Psychiatry, Psychotherapy and Neurology; the Icelandic Psychiatric Association; the Israeli Psychiatric Association; the Italian Psychiatric Association; the Kazakh Association of Psychiatrists and Narcologists; the Kyrgyz Psychiatric Association; the Lithuanian Psychiatric Association; the Luxembourg Society of Psychiatry, Neurology and Psychotherapy; the Maltese Psychiatric Association; the Polish Psychiatric Association; the Portuguese Psychiatric Association; the Psychiatric Association of Slovenia; the Psychiatric Association of Turkey; the Society of Georgian Psychiatrists; the Spanish Association of Neuropsychiatry). The list of the courses scheduled for the second half of the year 2003 is presented in Table 1.

Of course, this is just a beginning, and many things can be done to extend the initiative in terms of countries involved, of courses provided, and of participants in each country. However, several principles on which the initiative is based deserve attention:

- the collaboration of an international psychiatric association with national psychiatric societies in Europe in a concrete educational activity
- the implementation of the initiative in individual European countries
- the coverage of all areas of Europe, without exclusion;
- the possibility offered to national societies to choose the topics and teachers of interest
- the coverage of part of the expenses by the international association
- the decision not to request the sponsorship of a specific drug company.

In the future, the possibility may be considered of building up a consortium of drug companies covering part of the costs of the initiative. This consortium should not have any role in the selection of the topics, the teachers, or the countries in which the courses have to be implemented. What we are especially exploring, however, is the possibility to submit to the European Union a comprehensive European educational programme, jointly promoted by the AEP, the European Region of the World Psychiatric Association, the European Union of Medical Specialists and the European region of the World Health Organization, in collaboration with national psychiatric societies in Europe.

What we are especially exploring, however, is the possibility to submit to the European Union a comprehensive European educational programme.

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NEWS, NOTES, FORTHCOMING INTERNATIONAL EVENTS

News and notes

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Report on the annual meeting of the Royal College of Psychiatrists, Edinburgh International Conference Centre, 30 June–3 July 2003

I had spent the best part of a year helping to plan a balanced, scientifically stimulating conference, which also could:

- give delegates an opportunity to participate in interactive sessions and training courses
- give all the different concerns of Faculties, Sections and Special Interest Groups in the College a place in the metaphorical sun
- and, not least, be financially successful for the College.

One would have expected that, by the time of the opening ceremony, I would have been a bundle of nerves in trepidation that, by trying to address all these agendas, we were in real danger of pleasing no one.

Nothing was further from the truth. To my admittedly biased but none the less critical eye, the programme looked like it was going to be a success, and the wonderful city of Edinburgh could offer the guarantee that it would lend its Gaelic magic to the conference. On top of all of this, with the traditional hospitality of our hosts and the efficiency of the College Conference Office, I was as cool as a cucumber. I could then switch off from being the organiser to just one more delegate taking advantage of the annual get-together.

A conference with no less than 63 sessions, 32 workshops, 10 keynote addresses, 5 training courses and 4 poster sessions, with nearly 350 speakers.

He suggested that psychosis was specific to *Homo sapiens* precisely because of its connections to the acquisition of language.

We were given a good start in the welcoming ceremony by Malcolm Chisholm, SMP and Minister for Health and Community Care, indicating the commitment of the Scottish Parliament to mental health issues, no doubt made real by the example, as Dr Mike Shooter, the President, indicated, of the common sense the Scots had adopted in the process of modernising its mental health legislation, in contrast to the tortuous and somewhat ludicrous steps undertaken by their colleagues south of the border.

In a conference with no less than 63 sessions, 32 workshops, 10 keynote addresses, 5 training courses and 4 poster sessions, with nearly 350 speakers, it would be invidious to single out highlights, so I will simply report those that were of particular interest to me.

Having recently read of and been involved in the controversy about the role psychiatrists in the UK play in the management and treatment of people with personality disorders (National Institute for Mental Health in England, 2003) I attended the session on the development of psychopathology of borderline personality disorders and was disturbed, if not surprised, to hear from Professor Peter Hobson how distorted and insensitive relationships could already be detected between mothers who have a diagnosis of borderline personality disorder and their infants, and wondered how early interventions could perhaps change the course of the development of such disorders.

The Distinguished Guest Lecture was delivered in scholarly fashion by Tim Crow, who described a fascinating hypothesis that attempted to explain, in evolutionary terms, why the genetic predisposition to schizophrenia remained prevalent and universal in mankind, despite not offering any perceptible survival advantages. Linking the evolution of language to the point in which species transition occurred and which separated us from our pre-hominid ancestors, he suggested that psychosis was specific to *Homo sapiens* precisely because of its connections to the acquisition of language, which in turn determined asymmetries in our brain structures, leading to lateralisation of functions. Psychosis and what makes us human are so inextricably connected, according to this view, that one cannot exist without the other.

The Psychotherapy Lecture was delivered by Professor Sydney Bloch, who reminded us of the importance of a balance between scientific and alternative evaluations of the effectiveness of psychotherapies, particularly those that rely on creative functions.

In a session on depersonalisation, I learned how surprisingly prevalent this condition is: it has been found in up to 18% of clinic attenders, yet often goes unrecognised, particularly in psychiatric populations. Psychotherapeutic and psychotropic interventions have not been found to be particularly helpful in a syndrome that probably reflects a protective neural response, aimed at buffering the effects of high levels of arousal.

On the following day I decided to concentrate on the stream focusing on schizophrenia, and so listened to the findings of the Scottish studies led by Professor Eve Johnstone on early clinical and neuroimaging manifestations of the disease, and then a fascinating and controversial session, led by Professor Robin Murray, that looked at the association between schizophrenia and marijuana use, and the growing evidence of the role of cannabis in the presentation and continuation of psychotic symptoms. A masterful keynote lecture by our invited and distinguished speaker Professor Jeffrey Lieberman, from the University of North Carolina, described in optimistic terms the possibilities for the treatment of first-episode schizophrenia and the opportunities to change the course of the illness.

My afternoon was spent attending sessions on treatment approaches, from cognitive–behavioural therapies to early intervention teams, novel pharmacological strategies focusing on relapse prevention, and finally the important and sometimes dispiriting topic of treatment-resistant schizophrenia. I ended the day feeling well nourished and certainly less pessimistic than I anticipated.

The following day presented me with a difficult but pleasant dilemma: should I go to a session on psychological interventions in pain management, women patients in secure settings, anti-stigma campaigns, specialist management of affective disorders or a workshop on the unlicensed use of licensed psychotropic drugs? I decided to go and learn about something I knew little about, and was rewarded by three very useful lectures on the link between psychological states and pain. The highlight was the Psychiatry of Old Age Lecture, delivered by Professor Lawrence Whalley, who examined how life course, cognitive ageing and dementia could be related, a lecture that, in fact, was of interest not only to psychiatrists dealing with the elderly, but to all of us concerned about how our lifestyles, stress and nutritional behaviours can affect the presentation of dementia in old age.

In keeping with the membership of the College in the UK and abroad, the final day contained a series of impressive sessions on mental health issues in Africa, looking at training and appropriate forms of culturally relevant psychotherapies; presentations from the Middle Eastern group, debating early detection of mental illness in primary health care and cultural adaptation of questionnaires for Arab-speaking populations; and hot topics from the USA, including the psychological after-effects of the attacks of 11 September 2001 and controversial physician-assisted suicide proposals. I attended the session led by the Critical Psychiatry Group, which examined the values and roles of psychiatrists in modern society, the politics of psychiatric drug treatment and institutional racism. The session on asylum seekers, a worryingly increasing problem for psychiatric services, was also very revealing and apposite to the practice of most psychiatrists working in large conurbations. On the topic of institutional racism, Professor Kamlesh Patel, in his plenary lecture, took on the gauntlet presented to him by the Royal College to examine its own institutional discriminatory practices, and gave a critical account of mental health services for ethnic minorities in the UK.

In this highly and unfairly selective account of what I thought was a thoroughly enjoyable, wide-ranging and informative experience, I have not mentioned the high quality of the training courses available – a new departure for College annual meetings – the variety of interactive

workshops or poster presentations, let alone the fun we had at the Gala Dinner at the Hub, on the Royal Mile, in the shadow of Edinburgh Castle. But if it serves to whet the appetite of the reader, why not book early for next year's psychiatric jamboree? It takes place in Harrogate, and promises to deliver much of the same, only better!

Finally, I am particularly grateful to Professor David Cunningham Owens for shouldering the unenviable burden of putting the scientific programme together, Kevin Healy for coordinating the workshops, Denise Coia and the Scottish Division for hosting the event, the Officers of the College, in particular the President, Mike Shooter, and Professor Richard Williams, the Director of Conferences, and, last and definitely not least, the sterling Conference Organisers for all their efforts, without whom I am sure the conference would not have been the success it proved to be.

Reference

National Institute for Mental Health in England (2003) *Personality Disorder: No Longer a Diagnosis of Exclusion*. London: NIMHE.

Dr Leonard Fagin
Conference Organiser, Annual Meeting, Royal College of Psychiatrists; Consultant Psychiatrist and Clinical Director, North East London Mental Health NHS Trust, Honorary Senior Lecturer, University College London; South Forest Centre, 21 Thorne Close, London E11 4HU, UK, email leonard.fagin@nelmht.nhs.uk

European psychiatric leaders meet in Vienna

The third annual meeting of the leaders of European and national psychiatric organisations was held in Vienna in June 2003, on the day before the World Psychiatric Association (WPA) held its International Thematic Conference on Diagnosis in Psychiatry. The purpose of the meeting was to facilitate improvements in psychiatric societies' organisational and inter-organisational functioning in our increasingly interdependent European environment. That the meeting is clearly growing in importance in the calendar of leaders is reflected in the high attendance rate among: representatives of the WPA's executive and European zones; members of the Section and Board of Psychiatry of the European Union of Medical Specialists (Union Européenne des Médecins Spécialistes; UEMS); members of the executive of the Association of European Psychiatrists (AEP); WHO European National Counterparts; members of the Board of the European Federation of Psychiatric Trainees; and, most importantly, a considerable number of persons from the leadership of national psychiatric organisations, including the Royal College of Psychiatrists.

At the 2002 annual meeting, in Stockholm, there had been much concern about the contemporary identity of the European psychiatrist and the fact that some countries have recruitment problems. The morning of the 2003 meeting was therefore devoted to discussing these overlapping themes. The issues were brought alive by two excellent presentations from Professor Wolfgang Maier from Bonn and Professor Jeremy Holmes from the UK. Professor Maier gave an excellent overview of the evolving understandings of mind–brain paradigms, and highlighted the excitement of contemporary understandings for the modern academic psychiatrist. Professor Holmes stressed the attractions of the psychiatrist as, potentially, the epitome of the modern doctor, capable of listening to the subjective experience of the patient, bearing emotions, listening to and making narratives. These engaging talks on the interaction between subjectivity and objectivity led to a lively discussion in the now traditional small work groups that followed. In these settings, leaders could discuss practical ways of attracting high-quality doctors to our discipline.

The afternoon was spent listening to and discussing the complex issues related to European-wide quality standard-setting for continuing medical education in psychiatry.

Thanks are especially due to Wolfgang Fleishhacker for the excellent local arrangements and to Marion Palmer Jones at the Royal College of Psychiatrists for administrative support. (Editor's note: Particular thanks to Brian Martindale for his tremendous energy and enthusiasm in organising this collaborative venture.) Next year's meeting will be on 13 April 2004, just before the AEP Congress.

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Section and Board of Psychiatry of the Union Européenne des Médecins Spécialistes (UEMS)

The planned expansion of the European Union (EU) has brought new members and new perspectives into the discussions of the UEMS. There is now striking diversity across cultures, particularly within psychiatric training and in the implementation of psychiatric health policies. In addition, common standards of quality assurance need to be addressed urgently.

No one doubts the difficulties. Meaningful international comparisons are not always readily made. None the less, agreements have already been reached on some fundamental issues, such as the supervision of trainees and the need to create a standard system of accreditation for postgraduate training schemes. Success in these has also encouraged the Section and Board to move forward to consider, for example, undergraduate training in psychiatry on an EU basis and postgraduate recruitment and entry into the profession.

One of the more ambitious projects is to try to define a common role for the psychiatrist or at least to provide a profile recognisable within different cultures. There has also emerged the need for the development of a charter on training and for the delineation of skills-based objectives for training.

Information supplied by
Dr James G. Strachan, UK representative, UEMS

AEP Research Prizes 2004

The AEP offers three research prizes, of €5000 each, for the young psychiatrists who publish the best scientific papers in the years 2002/2003 in the following areas:

- clinical psychopathology and refinement of psychiatric diagnostic categories
- biological correlates and treatments of mental disorders
- psychiatric epidemiology, social psychiatry and psychotherapeutic interventions in mental disorders.

Entrants must be:

- a psychiatrist or trainee working in Europe
- under 40 years old (on 31 December 2003)
- the first author of a scientific paper published in 2002 or 2003 in a journal indexed in *Current Contents* in one of the above-mentioned areas.

Applicants should send documentation of the above with 10 copies of the paper. This must be received by 31 January 2004 by the President of the AEP, Professor Mario Maj, Clinica Psichiatrica, Primo Policlinico Universitario, Largo Madonna delle Grazie, 80138 Napoli, Italy.

Prizes will be awarded during the AEP Congress in Geneva, 14–18 April 2004. Further information is available at the website www.aep.lu.

Psychiatry books (less than 10 years old) and journals (less than 3 years old) are urgently required in Cambodia. Please send donations to Professor Ka Sanbaunat, Chairman, Department of Psychiatry, Psychiatric Outpatient Clinic, Preah Bat Norodom Sihanouk Hospital, Phnom Penh, Cambodia.

The 2004 WPA International Congress: 'Treatments in Psychiatry: An Update'

Next year's WPA Congress in Florence, Italy, 10–13 November 2004, is expected to be one of the main psychiatric events of the year and to have some 5000 participants. The Congress aims to provide a comprehensive and high-quality update on all evidence-based treatments for mental disorders. The Congress will feature:

- 14 plenary update lectures
- 36 interactive symposia
- 12 advanced courses
- 6 forums
- symposia organised by the various components of the WPA (sections, zones, committees)
- sessions for the reporting of new research
- poster sessions
- sponsored events.

Abstracts (no longer than 250 words) can be submitted by email to the Scientific Secretariat: secretariat@wpa2004florence.org. For further information contact the Chair of the Organising Committee, Professor Mario Maj, email: majmario@tin.it.

5th WPA Co-sponsored Eastern Africa Regional Scientific Conference

This meeting of African psychiatrists was held in Kenya in April 2003. It had 150 participants, which is the largest number of African psychiatrists and other mental health workers to meet in recent times. Psychiatrists from Kenya, Uganda, Tanzania, Sudan, Ethiopia, South Africa, Nigeria, Malawi and the UK were present.

The sense of social and professional isolation can be daunting to those psychiatrists who work alone or in very small groups and the meeting served an important function that might be little understood by colleagues from countries with many psychiatrists.

The dangers of 'intellectual inbreeding' in the leadership of psychiatry can also be mitigated and challenged through such meetings.

Information supplied by
Dr F. G. Njenga, Conference Chairman and President,
African Association of Psychiatrists and Allied Professions.
Email: fnjenga@africaonline.co.ke

'Estates General' of psychiatry

In Montpellier, June 2003, for the first time in France, all the country's professional and scientific mental health organisations met together for a meeting called 'Estates General' of psychiatry (the title is a reference to the assembly that launched the French revolution in the 18th century). The initiative for this exceptional event was taken by the French Federation of Psychiatry, with the aim of defending the French model of psychiatry, which has recently been under attack for economic reasons. In summary, French psychiatry is being hit by government attempts to import 'managed care' into France, but this has the attendant risk of deleterious consequences similar to those seen by colleagues in America. In France the consequences will be even worse because of:

- the balance of services in the public sector in psychiatry and the scarcity of independent in-patient facilities
- the reliance of most public social agencies on the public psychiatric system to deal with the psychological component of their users' problems
- the importance given to psychotherapy within French psychiatry.

More than 2500 participants and the presence of WPA officers (Juan Mezzich, WPA President-Elect, and Brian Martindale, Western European Zonal Representative) ensured the success of the meeting. The French media gave a large amount of coverage to the main concern of the Estates General: the dramatic cut in public financing of psychiatry in spite of ever growing demand.

Information supplied by
M. Botbol

Australia, New Zealand, South East Asia and the Pacific

The Royal Australian and New Zealand College of Psychiatrists has a Regional Issues Committee to work with, and support, psychiatrists and other mental health stakeholders in South East Asia and the Pacific. It intends to respond to what is wanted or requested in the wider region, rather than having preconceptions about what it should offer. The Committee's chair is Professor Graham Mellsop (also WPA representative for Australia, New Zealand, Papua New Guinea, and the South West Pacific Zone). Members or Fellows in the Region are encouraged to make contact via email (g.mellsop@auckland.ac.nz) or fax (+64 9 276 0066).

WPA forums in psychiatry

The following are available via the publication section of the WPA website (www.wpanet.org):

- *The Declaration of Madrid and Current Psychiatric Practice: Users' and Advocates' Views*
- *Psychiatrists and the Death Penalty: Some Ethical Dilemmas*
- *Psychiatry in Medical Education*
- *Managed Care and Psychiatry*
- *Culture, Spirituality and Psychiatry*
- *Mass Media and Psychiatry*
- *Psychiatry and Human Sexuality.*

Eating disorders

A sixth volume in the WPA's very successful series 'Evidence and Experience in Psychiatry' has been published, entitled *Eating Disorders* (eds M. Maj, K. Halmi, J. J. López-Ibor & N. Sartorius. Chichester: Wiley, 2003). World-wide, eating disorders may be one of the major areas of clinical psychiatry in which the gap between research evidence and clinical practice is most dramatic. The six chapters deal with diagnosis, epidemiology, physical complications, pharmacological treatment, psychological interventions and social/economic burden. Each consists of a systematic review of the research evidence, followed by many commentaries from virtually all the renowned experts in the field.

Classification and diagnosis

Work progresses towards the next revisions of the world's current classification systems. A successful major WPA International Thematic Conference took place in Vienna in June in collaboration with the Austrian Society of Psychiatry and Psychotherapy. In May, the WPA Section on Classification, in collaboration with the WHO Classification Office, organised the Symposium on Philosophical and Methodological Foundations of Psychiatric Diagnosis in New York. A diversity of first-rate contributions, from philosophers, psychiatrists and other health scientists, addressed the complex issues. The *Newsletter* featuring this symposium is available on the Section's website: www.wpanet.org.

The WPA Section of Affective Disorders

The Section has adopted the *Journal of Affective Disorders* as its house journal. A fruitful collaboration has also been established with the International Society for Affective Disorders (ISAD). Both the Section and the ISAD are chaired by Professor Chris Thompson. The ISAD had a very successful inaugural meeting in Taormina, Sicily, in March 2002. Its next meeting is in Cancun, Mexico, 5–10 March 2004. ISAD members receive a personal subscription to the *Journal of Affective Disorders* as part of their membership. Details of membership and of the Cancun meeting can be found on the website www.isad.org.uk.

Albert Schweitzer Medal

Professor Henry Walton, Professor Emeritus of Psychiatry and of International Medical Education, University of Edinburgh, has been awarded the Albert Schweitzer Grand Gold Medal of the Albert Schweitzer World Academy of Medicine. This was for humanitarian services with respect to his international medical education work over numerous decades and was presented at a ceremony in the Royal Castle of Warsaw on 15 May 2003. Professor Walton was the foundation President of the Association for Medical Education in Europe, and subsequently the long-term President of the World Federation for Medical Education. He initiated the Global Curriculum in Psychiatry programme of the World Psychiatric Association.

All psychiatrists can obtain extensive up-to-date information about international news, publications and conferences (and much more) by subscribing electronically to the monthly e-bulletin of the WPA. Subscriptions are available through the website www.wpanet.org/

The Pan-African Group of the Royal College of Psychiatrists was inaugurated at the College annual meeting in Edinburgh in July. Dr Frank Njenga was elected Chairman for a period of 1 year. The position will be reviewed at the 2004 annual meeting of the College, when the decision of the Privy Council about converting the Group to a Division will have been received.

Forthcoming international events

31 October–2 November 2003
15th National Conference of the Indian Association for Social Psychiatry
Trichy, India.
Contact: Dr Savita Malhotra.
Email: savitam@sancharnet.in.

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

9–13 November 2003
Psychiatric Care Across Cultures: A Conference Week
WPA Section on Transcultural Psychiatry in collaboration with the University of Malta.
Malta St Julian's, Republic of Malta.
Email: charles.pace@um.edu.mt; cpace_malta@hotmail.com.

27–30 November 2003
XI Congreso de la Sociedad Dominicana de Psiquiatria
WPA co-sponsored conference. In collaboration with the Latin American Psychiatric Association.
Melia Caribe Tropical Hotel, Dominican Republic.
Contact: Dra. Daisy Acosta .
Email: daisyacosta@codetel.net.co.

29 January–2 February 2004
International Conference on Schizophrenia
WPA co-sponsored conference. Schizophrenia Research Foundation (SCARF) in collaboration with the WHO.
Chennai (Old Madras), India.
Contact: Dr R. Thara.
Email: scarf@vsnl.com.
Website: www.scarfindia.org.

1–28 February 2004
Fifth Virtual Congress of Psychiatry (interpsiquis 2004)
Palma de Mallorca, Spain.
Contact: Dr Pedro Moreno.
Email: secretaria@psiquiatria.com.
Website: www.interpsiquis.com/2004/particiption.html.

5–10 March 2004
Second Biennial Conference of the International Society for Affective Disorders (ISAD)
WPA co-sponsored conference in collaboration with the WPA Section on Affective Disorders.
Cancun, Mexico.
Contact: David Beck.
Email: d.k.beck@soton.ac.uk.
Website: www.isad.org.uk.

17–20 March 2004
Second World Congress on Women's Mental Health
WPA Section on Women's Mental Health and the WPA Section on Interdisciplinary Collaboration.
Washington, DC, USA.
Contact: Dr Donna Stewart; Dr Uriel Halbreich.
Email: donna.stewart@uhn.on.ca; urielh@acsu.buffalo.edu.
Website: www.womenmentalhealth.com.

29 March–2 April 2004
Congreso Panamericano de Salud Mental Infanto-Juvenil
Organised by the Cuban Society of Psychiatry in collaboration with the WHO and the Latin American Psychiatric Association.
Palacio de Convenciones, Havana, Cuba.
Contact: Dr Cristobal Martinez Gomez.
Email: crisma@informed.sld.cu.
Website: www.sld.cu/eventos/psiquiatria/felices; www.loseventos.cu/saludmental2004.

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

1–6 May 2004
American Psychiatric Association Annual Congress
New York, USA.
Contact: apa@psych.org.
Website: www.psych.org.

14–19 May 2004
History of Psychiatry: 18th Congress of the Hellenic Psychiatric Association
In collaboration with WPA Sections on History of Psychiatry and Humanities in Psychiatry.
Island of Kos, Greece.
Contact: Prof. George Christodoulou, Hellenic Psychiatric Association, 11, Papadiamandopoulou str., 11528 Athens, Greece.
Fax: +30 210 724 2032.
Email: gnchrist@compulink.gr.

10–13 June 2004
National Conference of the Czech Psychiatric Society
Spindleruv Mlyn, Czech Republic.
Contact: Dr Jiri Raboch.
Email: raboch@beba.cesnet.cz.

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

17–19 September 2004
WPA Regional Meeting
Mental Health Resource Center (MHRC) in collaboration with the Pakistan Psychiatric Society.
Lahore, Pakistan.
Contact: Dr Haroon Rashid Chaudry.
Email: pprc@wol.net.pk.

22–26 September 2004
14th World Congress of the World Association for Dynamic Psychiatry (WADP)
WPA co-sponsored conference.
Cracow, Poland.
Contact: Dr Maria Ammon.
Email: wadp.congress2004@dynpsych.de.

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

6–9 October 2004
8th Congress of the International Association for the Treatment of Sexual Offenders (IATSO)
WPA co-sponsored conference.
Athens, Greece.
Contact: Dr Orestis Giotakos.
Email: giotakos@tri.forthnet.gr.
Website: www.iatsoathens.gr.

7–10 October 2004
Mental Health Perspectives in Public Health Conference
WPA co-sponsored conference in collaboration with the Armenian Association of Psychiatrists and Narcologists.
Yerevan, Armenia.
Contact: Dr Armen Soghoyan.
Email: majoria@arminco.com.

24–26 October 2004
3rd World Congress on Men's Health
WPA co-sponsored conference. International Society for Men's Health in collaboration with the International Forum of Mood and Anxiety Disorder and the Austrian Association of Neuropharmacology.
Vienna, Austria.
Contact: Dr Siegfried Kasper.
Email: sk@akh-wien.ac.at.
Website: www.wchm.info.

24–27 October 2004
XVIII World Congress of the World Association for Social Psychiatry
The Japanese Society of Social Psychiatry in collaboration with the WHO.
Kobe, Japan.
Contact: Dr Yoshibumi Nakane.
Email: yonakane@net.nagasaki-u.ac.jp.
Website: www.congre.co.jp/18wasp.

10–13 November 2004
Treatment in Psychiatry: An Update
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: +39 081 566 6523.
Email: majmario@tin.it.

12–15 March 2005
Advances in Psychiatry and Meeting of the WPA Scientific Sections
WPA Regional Meeting.
Athens, Greece.
Contact: Prof. George Christodoulou, Athens University Department of Psychiatry, Eginition Hospital, 74, Vasilissis Sophias, 11528 Athens, Greece.
Fax: +302 10 724 2032.
Email: gnchrist@compulink.gr.