



EDITORIAL

Mental health research publications from low- and middle-income countries

Hamid Ghodse

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World-wide, there are more than 471 000 psychiatric nurses, 165 000 psychiatrists, 147 000 psychologists and 229 000 social workers operating in the mental health field (World Health Organization, 2001). It is important that information about recent clinical, service and research developments reaches these professionals and the traditional route for disseminating such knowledge is via professional and scientific journals. However, there is clear evidence that the major journals with an international distribution are not accessible to those working in low- and middle-income (LAMI) countries.

There are several contributory factors. First, there is the important issue of affordability. The average psychiatrist working in a developing country cannot afford the subscription to even one international journal and, in many countries, very few libraries can afford to subscribe to them either. Journals with a national or regional distribution, produced in the local language, often offer an affordable alternative. Although the quality and originality of their content are variable, so that their role in the dissemination of up-to-date scientific information is doubtful, they do provide a source of information for psychiatrists who do not have access to international journals.

Second, the major international journals (i.e. those with high impact factors) focus heavily on biological psychiatry and psychopharmacology. Most are published in English, but even those clinicians who can understand and read English may find it difficult to comprehend the technical language, concepts and details of increasingly complex and sophisticated research, which anyway appears to have little relevance to the conditions in which they practise.

Unfortunately, the increasing importance attached to impact factors reinforces the trend to carry out research and publish papers on biological psychiatry. This largely excludes researchers from LAMI countries, so that the proportion of articles from non-Western countries in

international journals is inversely proportional to the percentage of publications on biological psychiatry topics. The figures speak for themselves:

- The 'rest of the world' (i.e. outside North America, Europe and Australia) contributes 6% of the articles published in the six leading general psychiatry journals (Patel & Sumathipala, 2001).
- The rate of acceptance of papers from the 'rest of the world' in three leading psychiatry journals is half that for papers from North America, Europe and Australia (Patel & Sumathipala, 2001).

Seen in this context it is unsurprising that LAMI countries do not commit scarce funding to the leading international psychiatric journals: their own contributions are likely to be rejected; the content, written by others, is largely irrelevant to local conditions; and many of the papers are difficult to understand. Further, Saxena *et al* (2003) found that only four out of a total of 530 editorial and advisory board members of the 10 psychiatric journals with the highest impact factors were based in LAMI countries. It is difficult to escape the conclusion that, currently, these journals are produced by and for mental health professionals in North America, Europe and Australia. They may be international journals but they are surely not global journals.

There are, however, good reasons to promote truly global contributions and readership – not least the enormous unmet mental health needs of LAMI countries, where 85% of the world's population lives. Teams in all parts of the world can and should contribute to advances in mental health and their findings should be easily accessible to all. More specifically, mental health research should be promoted in LAMI countries in the following areas: advocacy, policy development, and the establishment and expansion of clinical services. There is also a need to educate investigators in research skills. This in turn will contribute to greater international and multicultural understanding of mental health and ill health.

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Pragmatic action is needed at many levels to close the gap that has developed in professional journals between North America, Europe and Australia and the 'rest of the world'. It would seem sensible, in the first instance, to build on the structure and reputation of the established international journals. First, and immediately, members of their editorial boards with contacts in developing countries should be asked to pass on the message that their journal would welcome submissions. These should be further encouraged by the promise of editorial support and even coaching, with constructive feedback on weak articles and help for those concerned about the standard of their written English. A reputation for welcoming submissions from developing countries will encourage others to try. The internet may facilitate this because online submission is so much less costly. Many journals also allow free online access to the world's poorest countries so that authors and their colleagues can see their work online even if they cannot afford a print subscription; this too will encourage further submissions.

More fundamentally, perhaps, the major journals should think carefully about the nature of the research they report, as, indeed, should those who contribute to them. While it is essential to maintain a high standard of scientific merit, not all psychiatric research need be complicated or expensive. Research into mental health services, which can be carried out equally well in LAMI countries as in highly industrialised environments, is as important as the costly high-technology biological research. The results and the subsequent papers may in fact be more relevant to clinical

practice and therefore more interesting to the majority of clinicians. The publication of papers on service research offers a way of engaging clinicians and of encouraging a genuine and enriching global dialogue – through the enhanced circulation of global journals.

Different approaches to tackling some of these problems were discussed at a meeting in Geneva in November 2003, organised by the World Health Organization's Department of Mental Health and Substance Abuse. This involved 25 editors representing journals published in low-, middle- and high-income countries; other editors contributed through correspondence and papers. There was a constructive dialogue and a joint statement and catalogue of ideas were agreed (see www.who.int/mental_health/evidence/en/final_joint_statement.pdf). Obviously, it will take time to implement the necessary changes and even more time before the consequences of these changes become apparent. However, this initiative, organised by Drs Saraceno and Saxena of the World Health Organization, was an important first step in the right direction and should be commended.

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THEMATIC PAPERS – INTRODUCTION

Cultural variations in the perception of psychopathology

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For many years now there has been debate among psychiatrists concerning the specificity of diagnostic practices to particular cultures. The harmonisation of criteria for diagnostic practice, outside North America, has been one of the great achievements of the World Health Organization. Now, there seems to be a resurgence of interest in how culturally bound our ideas of psychopathology are, or should be.

In an article entitled 'How "culture bound" is "cultural psychiatry"?', Sushrut Jadhav draws the conclusion that cultural psychiatry is becoming a specialty in its own right, and provocatively challenges us to consider the possibility that this is yet another opportunity for academics to indulge their intellectual curiosity. We can detect a theme here, which is reflected in the call to action by George Hsu: the

way forward for international psychiatry is not simply to export models of psychiatry developed in the industrialised West to parts of the world where they have little direct relevance to the mental health needs of the majority. Is the profession in the UK guilty of training psychiatrists from overseas in its own image of this complex discipline, and thereby effectively laying the foundations for an ability to 'poach' them in due course, to fill the ever-expanding need for mental health professionals?

Jadhav makes the point that, in developing countries, which have a different perspective on mental distress and disorder to the North American/European one, terms like 'life events' may have quite distinct connotations. He draws our attention to the possibility that we have much to learn from anthropologically informed methods of enquiry. An eloquent example of such an enquiry comes from Elizabeth

Coker at the American University in Cairo. She gives a fascinating example of the dissonance between our Western-influenced understanding of psychopathology and a cultural tradition that has different means of expression, not easily translatable into the former framework. She points out how it is necessary to translate local meanings

of mental illness in order to fit Western-influenced international concepts of psychopathology. This process not only adds to the difficulty of assessment and treatment, but also has implications for the 'back-translation' of those international concepts into the language of the local culture.

THEMATIC PAPER – CULTURAL VARIATIONS IN THE PERCEPTION OF PSYCHOPATHOLOGY

Discursive practice and the negotiation of psychiatric pathology in Egypt

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Modern biomedical psychiatry is the product not only of scientific enterprise but also of the progressive secularisation and medicalisation of moral life in the West (Jimenez, 1987). Psychiatry is an evolving cultural product. Its diagnostic categories represent pathologies rooted in Western notions of self, identity, normality and abnormality (Gaines, 1991). Psychiatric practice in Egypt, on the other hand, is the product of two different and often incompatible world views, namely Western psychiatry and Egyptian concepts of self, identity, normality and abnormality. The task of the psychiatrist in Egypt is to negotiate symptoms and diagnoses in a way that is sensitive to the demands of these two competing cultural streams. Analysis of this process provides a unique view of the ways in which culture can have an impact on professional psychiatry in any society or ethnic context.

In Egypt, as in the West, uncovering the implicit justifications for the more obvious manifestations of psychiatric practice requires a 'cultural excavation' of sorts (Kleinman, 1980; Gaines, 1992). Medicine gains its legitimacy through not only the control of knowledge but also the creation of systems of meaning. This manipulation of meaning is carried out, in part, through one of the most important tools of psychiatric work, namely the patient chart (Hunter, 1991; Barrett, 1996). Rob Barrett (1996) described the way in which the category of schizophrenia is constructed through professional discourse and writing, and what the latter reveals about Western concepts of self and abnormality.

Likewise, in the Egyptian case it is in the construction of the patient/diagnosis through the written word that the contested nature of psychiatric hegemony is most evident. The patient charts referred to in the present paper comprise actual records of the manipulation of local meanings of mental illness in order to fit institutionalised biomedical knowledge. Through these charts, the complexities of

cultural self-processes are reduced to universal pathological phenomena, recognisable by like-minded professionals everywhere. (For a complete description of the methodology used to extract the data see Coker (2003).)

Egyptian patient charts demonstrate that the creation of the psychiatric patient in Egypt and the subsequent delineation of a causative disease represent a radical upheaval of traditional notions of personhood. Egyptian psychiatry cannot create its object in isolation from the cultural meanings encoded in the original illness presentation. In the West, the context and underlying meanings of diagnostic labels are implicit, but in Egypt they must be created anew and made explicit through professional discursive practices.

Social context and narrative

A prime example of this process is the way in which the social context is manipulated and presented in patient charts. While typical Western records give brief, third-person descriptions of social stressors that might have an impact on the disease, the Egyptian charts analysed possess a unique style that gives primacy to social context, through frequently elaborate first-person narratives, normally from the perspective of a family member of the patient. In this regard, the narrative voice of Egyptian psychiatry is discursively distanced from the official psychiatric voice prevalent in the West (Coker, 2003). This format is unique because it implies that the social environment is a direct, inherent part of the problem rather than a mere influence on it, as exemplified in the well-known biopsychosocial model (Engel, 1980). In Egypt, social relationships do not act *on* the sick individual – they exert their influence *through* that individual, who, in turn, influences social relationships. In the Egyptian context, the fragmented self that is central to traditional Western conceptions of schizophrenia, as exemplified in the work of early theorists such as Kraepelin (1919) and Bleuler (1908/1987), becomes the 'disrupted social self'.

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In the Egyptian context, the fragmented self that is central to traditional Western conceptions of schizophrenia becomes the 'disrupted social self'.

The patient is not the focal point of different and often contradictory external and internal forces, as is often the case in Western medical charts. Rather, the patient is viewed as an agent in a pathological process that does not result in a fragmented person but in fragmented relationships, social structure and society.

These narratives describe fragmentation and disunity at the level not of the individual but of the entire social environment, starting with the family. The failure of the person as a social being is emphasised. The following excerpt is from the file of a 48-year-old man with no prior psychiatric history, diagnosed with affective psychosis. The problem was presented in the chart as a verbatim quote from his brother:

A week ago he went back to his hometown and met some of his relatives. They got into a serious discussion, which he saw as an insult to him. He always thinks that people are teasing and provoking him. He feels very upset, always tense, easily provoked by the least of things. He believes that he has been cursed by magic and that his relatives served him poisoned tea. Yesterday he woke up in the middle of the night, woke everyone up with him and then went to his brother. He says, 'I hear the Koran in my ears'. When he saw his brother he burst into tears saying: 'People want to come between us'.

This excerpt provides an example of the social contextualisation of the patient-self. While the initial discussion with relatives of the patient is not specified as a cause in the typical sense, it provides a point of departure from which the subsequent disruptive behaviour can be accounted for. While it may be normal for relatives to discuss any matter, the patient's response to and misinterpretation of the event were unusual. However, this misinterpretation is meaningless from a psychiatric viewpoint. One could characterise it as suspicious, but that would place a highly individual emphasis on an event that clearly happened intersubjectively. In other words, the classic meaning of the word 'suspicious' would be inadequate to account for the complex meaning of the actual event. The fragmentation of psychosis is most often portrayed as a social disruption. This particular narrative format localises the illness in a self that extends beyond the boundaries of the individual and, at the same time, privileges local understandings of illness, represented by the primacy reserved in the chart for the voice of the family member.

A study in contradictions

The Egyptian medical chart is, among other things, a study in contradictions. On the one hand, it represents a continuing evolution towards a specific disease perspective originating in the West. On other hand, it presents a subtle alternative to the total redefinition of the person in terms of disease. It represents a remarkable juxtaposition of two competing cultural notions of person and disease, namely the Western view of disease as an invading enemy and the ill person as a fragmented personification of that enemy (Barrett, 1996), and the Egyptian view that the illness resides within not the person but the social sphere

(Early, 1985; Morsy, 1993). The chart entries often recall traditional illness themes outlined in various ethnographies and cultural studies, but with a twist: these themes are now used by medical doctors to portray psychiatric illness.

The whole patient

In Egypt, diseases are named and are represented in terms of disembodied symptoms, as in the West. However, the understanding of and distinction between Egyptian and Western practices come from the chart narrative texts. It is here that the true notion of the patient in the Egyptian context becomes evident. The patient is not the focal point of different and often contradictory external and internal forces, as is often the case in Western medical charts. Rather, the patient is viewed as an agent in a pathological process that does not result in a fragmented person but in fragmented relationships, social structure and society. As such, Egyptian patient charts represent the whole patient as constructed by the physician and consisting of diagnosis and symptoms together with relationships, history and cultural roles.

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International psychiatry – an agenda for the way forward

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A news release from the World Health Organization (2003) suggested that a mere 10% of global health research is devoted to diseases that account for 90% of the global disease burden. While this comment refers primarily to research into infectious and parasitic diseases, a similar trend may well be true for psychiatry, taken from a global perspective. A cursory glance at recent issues of *World Psychiatry*, the official journal of the World Psychiatric Association, will reveal articles describing recent advances in antidepressant treatment and other pharmacotherapies, psychotherapy and psychoanalysis, personality disorders, attention-deficit hyperactivity disorder, and the genetics of mental illness. These topics are obviously important and the field cannot advance without such cutting-edge research. Most of the authors are, as expected, psychiatrists living and working in Western Europe or North America. This is also, of course, acceptable and important. The dissemination of scientific data is essential for advancing the field, and researchers who live and work in Europe and North America are generally the most qualified to do so. So, what's the problem?

The question is whether or how far this 'culture-bound' perspective will advance the field of psychiatry for 90% of the non-Western world. Psychiatrists in rural China or India or Central Africa reading a recent issue of *World Psychiatry* (to pursue that one example) will find the recent advances extremely stimulating (and that is very important for maintaining morale and motivation). However, it is extremely unlikely that they will be able actually to apply the knowledge in daily practice, except perhaps in a few cases that fit the context of these articles. Similarly, relatively few people in these geographical areas will benefit directly from the practice of psychiatry as described or presented in *World Psychiatry*.

I suggest that some of us should make an effort to channel our research towards four areas of what I suspect to be greatest need in the non-Western world. I suggest these four areas simply to stimulate debate and discussion, and I may well be mistaken in my views. Also, I am not advocating a decrease in any of our current areas of research, basic or clinical – I am suggesting that perhaps some of us can begin to shift our focus and take a slightly different perspective.

(1) Rehabilitation of the chronically mentally ill

It seems unlikely that early intervention, or the widespread use of new atypical antipsychotic drugs and active community treatment, will be available any time soon in most parts of Asia and Africa. It is therefore a lamentable fact that many patients with psychotic disorders in these areas will become chronically ill. Efforts aimed at rehabilitation – such as adaptation of the Fountain House approach (www.fountainhouse.org/) or that of the International Center for Clubhouse Development (www.iccd.org) – which de-emphasise (not challenge) the medical model may be more culturally acceptable to chronically mentally ill patients and their families.

(2) Treatment of major depression by primary care physicians

Major depressive disorder (MDD) has been identified as an important 'disease burden' (Murray & Lopez, 1996). It seems unlikely that, in the non-Western world, the need for treatment of MDD could ever be met by psychiatrists alone. The model of Katon *et al* (1995, 1996), which consists of training primary care physicians to treat MDD and using case workers to monitor antidepressant treatment and increase motivation for compliance, may be a more effective approach to lessen this disease burden. It is true that training of primary care physicians in the USA has not been particularly effective (Lin *et al*, 2001), but that alone should not deter further attempts to develop better training methods.

(3) Developing a more culturally acceptable form of psychotherapy

The psychologising of distress may be a recent Western phenomenon (Leff, 1988) but the need to share distress is probably universal. Therefore, perhaps there is a need for psychotherapy in any culture. While some efforts are being made to test whether some specific forms of psychotherapy may be effective in a different cultural setting (e.g. Verdell *et al*, 2003), clearly more should be done in this area. My own limited experience suggests that many people from the Asian subcontinent accept a problem-solving approach (D'Zurilla & Nezu, 1999) better than they do a psychodynamic approach, but this should be studied.

Psychiatrists in rural China or India or Central Africa reading a recent issue of *World Psychiatry* will find the recent advances extremely stimulating (and that is very important for maintaining morale and motivation). However, it is extremely unlikely that they will be able actually to apply the knowledge in daily practice.

Advances to identify and treat mental disorders may not be possible unless the issue of the stigma of mental illness is tackled.

(4) Stigma of mental illness

While data are lacking, those of us who have worked with different cultural groups will probably agree that the problem of stigma is greater in non-Western than in Western cultures. Advances to identify and treat mental disorders may not be possible unless the issue of the stigma of mental illness is tackled. There is almost no research into cultural differences in relation to stigma, or the reasons for such differences. Stangor & Crandall (2000) have postulated that stigma may be related to a perceived threat which is amplified by social communication and sanctioned by societal mores. Is the stigma of mental illness greater in China than in the USA because it is perceived as a greater threat, or because social communication tends more often to exaggerate such threat, or because societal customs more often sanction such beliefs? I believe the need to study the stigma of mental illness is urgent.

Conclusion

I am not suggesting that, for instance, providing a 'Balint group' experience for a trainee from the 'Third World', or training in the genetics of mental illness, would lack benefit or utility. Nevertheless, these are not the appropriate experiences needed to orientate the trainee to the 'greater' needs of the non-Western world. For all its intellectual challenges and fascinations, recent advances in

psychiatry as reflected by research and practice in the Western world cannot be applied directly to meet the mental health needs of the non-Western world. Perhaps the Royal College of Psychiatrists can champion efforts directed at the four areas I have outlined.

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THEMATIC PAPER – CULTURAL VARIATIONS IN THE PERCEPTION OF PSYCHOPATHOLOGY

How 'culture bound' is 'cultural psychiatry'?

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Stated provocatively, with a few exceptions, the discipline remains confined to the cultural boundaries of Euro-American countries, and predominantly serves the careers and social interests of their scholars.

Cultural psychiatry as a clinical specialty sprung mainly from Europe and North America, in order to respond to growing concerns of ethnic minorities in high-income countries. Academic psychiatrists pursuing comparative international studies on mental health, together with medical anthropologists conducting clinical ethnographies, contributed to its theoretical basis (Kleinman, 1987; Littlewood, 1990). What at first appeared to be a marginal specialty is no longer so. For example, the UK alone has witnessed a steady growth of the field, as evidenced by its mandatory inclusion in mental health training curricula, and the existence of several taught masters courses, academic positions in universities and three dedicated journals, as well as, more recently, lead papers in mainstream publications that have debated the cultural position of 'biology' itself (Timimi & Taylor, 2004). Additionally, with a proliferation of clinical jobs for 'ethnic minority' services in hospital trusts across the country, there is ample scope for

employment. The overall evidence indicates that 'cultural psychiatry' in the UK is now a specialty in its own right.

Stated provocatively, with a few exceptions (see *Anthropology and Medicine*, special issue, vol. 8, no. 1, April 2001), the discipline remains confined to the cultural boundaries of Euro-American countries, and predominantly serves the careers and social interests of their scholars. In most low-income countries, the specialty and its methods ironically retain the label 'cultural psychiatry' (rather than just plain standard local psychiatry). Moreover, scant teaching and research output from the latter countries is related to a more worrying scenario: psychiatry in low-income nations continues for the most part to rely on inappropriate texts, teaching and research designs imported from high-income countries. The large number of 'outsourced' mental health professionals from low-income countries working in the UK (and the ease with which they do so) is testimony to their psychiatric training, which in turn is predicated upon received wisdom from high-income countries.

Consider, for example, India – a nation of 1.4 billion people, which has produced Booker Prize winners but not yet a single textbook of psychiatry that is genuinely predicated on local psychology and social problems. The latter would include social suffering related to dowry, caste, marital and ethnic violence, corruption, kinship systems, famine and crop failures, and suicide. In such settings, phenomenologies of rich bodily experiences are commonly pushed into a black box of ‘somatisation’. Furthermore, these ‘somatic’ experiences are recorded in English by local mental health professionals on (Maudsley-derived) mental state examination pro formas. In this situation, local worlds, their core moral and cultural values, and the rich (non-English) vocabulary associated with bodily problems (Lynch, 1990) are often glossed over or pruned to fit into conventional psychiatric nosology (i.e. that espoused in ICD-10 and DSM-IV). This process of systematically acquiring a culture-blind ability is considered credible and meritorious, both locally and internationally. The exclusion of culture then systematically abolishes the ability (and sensibility) to consider the role of major social and cultural ‘variables’ that may well provide a phenomenological template to shape appropriate nosologies of distress (Kirmayer & Young, 1998).

To proceed further would entail three key stages:

First, study is needed of the lived experiences of everyday suffering and recourse to help, through local narratives and language. It would identify key constructs and examine the cultural logic of constructing illness experience in both Western and non-Western settings. The ‘semantic illness network’ is one such approach. It has revealed the local distress models of the Punjabi community in Britain (Krause, 1989) and of Shiite Muslims from Iran (Good *et al.*, 1985).

Second, such locally generated models would validate local experience on its own terms. They could then be operationalised and validated against Western phenomenology and psychopathology for congruence or goodness of fit in form, content and quality. It is likely that some patterns of distress may not fit with Western descriptions of psychopathology and disorders, and may therefore need separate and distinct class/category representation. Examples of these are: the Japanese concept of *tajjin kyofusho* (fear of embarrassing others) in the official Japanese diagnostic system for mental disorders; and the *qi-gong* (excess of vital energy) psychotic reaction and *shenjing shuairuo* (neurasthenia) as represented within the Chinese classification of mental disorders. Alternatively, some patterns (mainly the psychoses) may well reveal common universalities (but not necessarily in the same configuration), which would further enrich the debate on cultural validity.

Third, instruments need to be developed, both quantitative and qualitative, with which to measure such distress patterns. This will contribute towards the development of higher-order categories or syndromes. *Only then* can such ‘categories’ be comparable with Western psychiatric concepts, to allow an examination of their cross-cultural equivalence and validity. For example, a study of the ‘life events’ that contribute to mental health problems would

require, initially, a full picture of what ‘life events’ mean to the population under study. What is their relative perceived threat to marriage, kinship ties and integrity of the community, on the one hand, versus economic risks or unemployment on the other? Should a life event questionnaire not be recalibrated by local members of the population, who might choose to rearrange the hierarchy of events? Similarly, how healthy rather than pathological are ‘expressed emotions’ such as ‘overinvolvement’ in societies where extended kinship ties are valued and energetically pursued? Overinvolvement in this context might well be the very ‘glue’ that bonds together families with sick members.

Mental health professionals, particularly those from low-income nations, have often expressed surprise at the manner in which scholarly discourses on cultural psychiatry and medical anthropology remain confined to the academic institutions of high-income countries, and have little impact on changes in everyday clinical practice in their own settings. It is in this context that anthropologically informed methods of enquiry have the potential to help establish clearer links between personal suffering and local politico-economic ideologies. Such methods can generate alternative canons of culturally valid psychiatric theory and practice, and contextualise them in both time and space. Although ambitious in its aims, research that will critique Western psychiatric theory and practice, and reveal its ethnopsychiatric premise, will also broaden the debate on the cultural validity of psychiatric disorders in general (Jadhav, 1995). Moreover, this process could stimulate local interest in indigenous taxonomies and provide a meaningful framework within which both professionals and patients from low-income countries could reclaim their local cultural and political histories. Such a framework would also inform the development of a valid ‘text’: one that is indigenously grounded and offers a concrete solution to free this specialty from its current Euro-American confines. Until then, the debt of uncritically importing an epistemology will continue to mount and worsen existing psychiatric alienation from local suffering.

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Mental health professionals, particularly those from low-income nations, have often expressed surprise at the manner in which scholarly discourses on cultural psychiatry and medical anthropology remain confined to the academic institutions of high-income countries, and have little impact on changes in everyday clinical practice in their own settings.

Introduction

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Contributions to the country profile section are welcome: please contact Shekhar Saxena (email saxenas@who.int).

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

COUNTRY PROFILE

Psychiatry in Ethiopia

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Ethiopia, in the Horn of Africa, is one of the ancient independent nations of the world and has a rich diversity of peoples and cultures. The country covers 1.1 million km² (Central Statistical Authority, 2000a). It has a population of about 70 million people (Central Statistical Authority, 2002), 80 different ethnic groups and some 200 dialects. Ethiopia is the second most populous nation in sub-Saharan Africa, after Nigeria (Hailemariam & Kloos, 1993). Forty-eight per cent of the population are under 15 years of age and over 80% live in rural areas (Central Statistical Authority, 1995). Islam and Christianity are the main religions.

Ethiopia maintained its independence during the colonial period. Over the past 30 years the country has undergone several manmade and natural disasters, such as war and political turmoil on the one hand, and famine and drought on the other. A federal system of government is now in place: there are nine regional states in the country and elections take place every 5 years.

Ethiopia is one of the least developed and most agrarian countries in the world; its estimated per capita gross national product in 1998 was \$100 (Population Reference Bureau, 2000). About 65% of the country's people live below the absolute poverty line (World Bank, 1994). The literacy rate is estimated to be 38% for males and 23% for females (Central Statistical Authority, 2000b).

Health status of the country

The main health problems in Ethiopia are malnutrition and infectious diseases, as has been the case for many years.

Life expectancy at birth was recently estimated at 53 years (Ministry of Health, 2002). The crude birth rate is 39.9 per 1000 population per year and the crude death rate is 12.6 per 1000 per year. The infant mortality rate is 112.9 per 1000 live births and the mortality rate for the under-5s is 187.8 per 1000 live births. The maternal mortality rate is estimated at 871.0 per 100 000 live births. Only 28% of the population have access to potable water and 11% to a proper sewerage system. It is estimated that only 60% of the population are able to receive basic health services (Ministry of Health, 2002).

Health policy

The Ministry of Health, which is the government body responsible for organising, running and monitoring health services in the country, was established in 1948.

In 1993, a national health policy and strategy were implemented (Transitional Government of Ethiopia, 1993). The main objective of the policy is to provide people with an acceptable standard of comprehensive primary health care in an integrated, decentralised and equitable fashion. The emphasis is on making health services available to the rural and neglected areas of the country. A four-tier health care system has been adopted. Health centres in the rural areas, each with five satellite health posts each serving 5000 people, form the broad base of the pyramidal system, which progresses up to district, regional and specialised hospitals.

In line with the policy, autonomy has been given to the regional governments to plan, implement and manage health services in the regions through their respective health

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bureaus. The health service has been under-funded, but in recent years its share of government expenditure has increased from below 5% of gross domestic product to 7% (Ministry of Health, 2002).

Mental health services

Ethiopia still remains one of those African countries that do not have a mental health policy, national mental health programme or mental health act (World Health Organization, 2001). Most Ethiopians use traditional methods to treat mental illness and those who do seek to use modern treatments usually do so only after they have tried several traditional means (Alem, 2000).

Families and other concerned individuals are closely involved in the care of people who are mentally ill. However, many families keep relatives with an acute, severe illness at home under restraint (even in chains) until they are no longer aggressive or violent. Once their disruptive behaviour is over, many of these sufferers become vagrants. Not uncommonly such people may be seen walking naked or dishevelled in the streets of villages and towns. They typically receive any sort of care only after they have committed an offence and have been made the subject of a court order (Alem, 2000).

Modern psychiatric services are provided by Amanuel Mental Hospital (the only mental hospital in the country), the out-patient clinic at the University Department of Psychiatry and the psychiatric unit at a military hospital. All these institutions are located in the capital city, Addis Ababa. The military hospital has 30 beds for psychiatric patients. However, until late 1986 there were only two indigenous psychiatrists in the country, one working in the university and the other in the army. In 2003, there were 11 Ethiopian psychiatrists in the country (all of whom had trained abroad): nine working in the above-mentioned institutions and two in private practice. This gives a psychiatrist : population ratio of 1 : 6 000 000.

The Amanuel Mental Hospital was built by the Italians to serve as a general hospital during their occupation of the country in the 1940s. After the Italians left, it was converted to a mental asylum because it was far from the centre and deemed appropriate for the isolation of 'insane' people from the rest of the community. Now, as the city has increased its geographical size, the hospital is no longer on its outskirts but it is still located in an impoverished neighbourhood.

Initially the hospital had very few beds and its prime function was as a place of incarceration for mentally ill offenders. Gradually more buildings were added and the number of beds increased, to the current level of 360, although for many years the hospital accommodated over 500 in-patients. In those days the hospital was run by expatriate psychiatrists from Eastern Europe. From 1984 Ethiopian doctors gradually took over the responsibility for running the hospital and the situation started to change. The number of Ethiopian staff has increased and the patient : bed ratio has become 1 : 1.

The Amanuel Mental Hospital is the only mental health institution in the country to provide a forensic service.

However, until hospital beds become available for the close observation and careful examination of alleged offenders by psychiatrists, they stay in the central prison in Addis Ababa. At any given time, one will find about 100 such persons in the central prison awaiting psychiatric assessment (Alem, 2000), sometimes for as long as a year, without any treatment. They are kept in crowded prison cells and are probably maltreated by prison guards and other inmates because of their disruptive behaviour.

The Ethiopian Psychiatric Association was established late in 2002, but formal meetings have not yet begun.

In 1985, the Ministry of Health and the University Department of Psychiatry, in collaboration with the World Health Organization, decided to train psychiatric nurses as the best alternative to provide a primary mental health service in the country. A training programme started in 1987. General nurses are recruited to it from the regional and district hospitals. The training takes one year and is designed to enable the nurses to identify and treat common psychiatric disorders. On completion of the training, the nurses go back to the institution from which they were recruited and set up psychiatric units.

Psychiatrists and general doctors working in psychiatry do most of the teaching of psychiatric nurses. A total of 232 nurses have been trained so far and currently there are 43 psychiatric units in the regional and district hospitals and two health centres outside Addis Ababa, each operated by two psychiatric nurses who graduated from the programme. The nurses receive periodic supervision at their place of work and refresher training by psychiatrists from Addis Ababa. Despite many difficulties, the services run by these nurses are very impressive.

In some regional hospitals the psychiatric nurses are able to admit patients to the medical wards and to provide an in-patient service for them. When they are faced with particularly difficult cases, the psychiatric nurses refer patients to Addis Ababa. After a treatment plan has been decided, the patients are referred back to the psychiatric nurses for follow-up and maintenance treatment. Periodic shortages of the necessary drugs are the greatest problem these nurses face in their practice (Alem, 2000).

Education

For many years Addis Ababa University was the only one in Ethiopia. It had the country's only medical school until 25 years ago, when the Gondar School of Health Sciences started training doctors, followed by the Jima Institute of Health Sciences a few years later.

The teaching of psychiatry to medical students was started in Addis Ababa University in 1966 by Professor Robert Giel from the University of Groningen, The Netherlands, who established a psychiatric unit in the Department of Internal Medicine. Dr Fikre Workneh, the first Ethiopian psychiatrist, came from the USA (where he had trained) and joined the university in 1972. In 1973 the Department of Psychiatry was created and the teaching was done by one person for many years, although expatriate psychiatrists sometimes assisted him. Expatriate psychiatrists also taught psychiatry to medical students at

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External funding sources and collaboration with universities abroad have contributed greatly to mental health research in Ethiopia.

the other two medical schools for some time, but for the past 15 years psychiatrists from Addis Ababa are the ones who have done most of the teaching in those institutions.

Since there was no postgraduate training programme for psychiatry in Ethiopia, doctors had to go abroad to do their training. Currently there are five trainees abroad – two in the UK, two in South Africa and one in Russia; they are expected to return to Ethiopia within 1–2 years to practise psychiatry.

In January 2003 the Department of Psychiatry, Faculty of Medicine, Addis Ababa University, started a 3-year postgraduate training programme with a first intake of seven doctors. The department has only three academic staff, all of whom are general adult psychiatrists: one Associate Professor and two Assistant Professors. The department has been able to solicit assistance for the teaching of its postgraduate students from universities and individuals abroad. The Department of Psychiatry at the University of Toronto, Canada, has committed itself to assisting the programme by sending two teachers for three 1-month blocks every year for 3 years. This is part of the University of Toronto's commitment to developing international partnerships for collaborative education and research. In addition to the Toronto-based faculty teaching in Ethiopia, psychiatrists from the University of Addis Ababa will visit Toronto to present research papers and to teach. The programme is also an opportunity to share expertise in mental health service delivery, research and education, and advocacy for mental health issues in both countries.

Volunteers from The Netherlands, England, Australia, Sweden and the USA also have contributed greatly in the postgraduate training programme, which is proving a success. More institutional collaborations are being sought to strengthen the programme until the department becomes self-sufficient.

Research

Despite the facts that the number of psychiatrists in Ethiopia has always been minimal, the resources are limited

and the infrastructure is poorly developed, quite a few research papers have been published in international and local journals since the 1960s. Particularly over the past 10 years, mental health research in the country has changed significantly. Epidemiological studies in different population groups such as children, adults, islanders, semi-nomads, displaced people and women have been conducted in towns and rural settings. Some of these studies are ongoing. For example, a cohort of patients with schizophrenia and bipolar disorder is being followed in Butajira District, a rural setting, to describe the course and outcome of these disorders, which is one of the few such studies in the world in these settings (Kebede *et al*, 2003). A good number of publications have appeared in international and local journals from these studies. External funding sources and collaboration with universities abroad have contributed greatly to mental health research in Ethiopia.

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COUNTRY PROFILE

Mental health services in Israel

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Israel is a multicultural society in a state of permanent change. The population, of about 6.5 million, comprises the following religious groupings: Jews (77.5%), Muslims (15.3%), Christians (2.1%), Druzes (1.7%) and others (3.4%). The organisation of and the approaches used by the country's health services have been determined by this socio-

cultural plurality, and also by a continuous influx of immigrants (among whom, 882 600 and 44 200 arrived from countries of the former USSR and Ethiopia, respectively, between 1990 and 2001), as well as by the precarious security situation (the country has seen several wars with its neighbours in addition to the long-standing conflict with

the Palestinians). The patterns of care of the population reflect both Western psychiatry and traditional systems. Because of such complexity, the present brief overview is necessarily selective.

Health indicators

The description of mental health services that follows will be better understood against a background of selected public health indicators and socio-demographic variables. Mean life expectancy in the year 2000 was 76.7 years for men and 80.9 for women. The infant mortality rate was 5.1 per 1000 live births in the year 2001. The coverage for immunisation for poliomyelitis reached 93% during the first year of life (1998 figure). The chief causes of mortality are the chronic disorders, an area of health that calls for closer linkage with the mental health professions. With regard to age, 28.5% of the population are under 15 years and 9.8% are 65 years old or more. The median time spent in education for people aged 15 and over was 12.3 years by the year 2000. All these figures refer to the combined Israeli population; however, there are some notable differences between specific population groups (Central Bureau of Statistics, 2002).

National health insurance

By law, all residents are insured for health care and contribute to a national fund according to income. Most of the population is served by one of the four health maintenance organisations, the largest of which was established in the pre-State years (before 1948) by the labour unions.

Importantly, the law that established this health system did not include either psychiatric care or geriatric and nursing services. In 2002, the government decided to transfer all responsibility for mental health care (see below) to the health maintenance organisations; implementation of this decision is expected in 2005.

Care provided by a general practitioner is free. A visit to a specialist (other than a psychiatrist) carries a nominal fee (less than US\$5). Visits to a psychiatric clinic, care in a psychiatric hospital or hostel, and certain specified drugs are free of charge. Preventive maternal and child health services are provided free by the municipalities and by the Ministry of Health.

Policy principles guiding the provision of mental health care

Israel has not yet developed a national mental health plan, but the first steps are being taken and the political will exists to formulate one. Once adopted, the plan will be based on the following policy objectives, which are endorsed by almost all stakeholders:

- to promote the mental health of the population
- to integrate mental health care within the general health system
- to ensure equity of access to services in all parts of the country
- to provide high-quality evidence-based and cost-effective care to persons with mental disorders

- to promote the psychosocial rehabilitation of persons with mental disability
- to strengthen and expand community-based care and reduce both hospital admission rates and length of stay
- to ensure the availability of emergency and crisis services, specially in security-related situations.

The organisation of mental health care

The government is responsible for the overall planning, budgeting and monitoring of the mental health care provided to all the population. Two multi-sectoral national advisory councils, one on mental health and the other on community-based mental health rehabilitation, assist the government in this.

The national fight against addictions, including health promotion and prevention activities, is the responsibility of an autonomous council. The services, such as methadone supply, however, are the responsibility of the Ministry of Health, in association with the welfare system.

The Ministry of Health allocates 5.9% of its budget to mental health services (2002 figure). This is not all the budget available for public mental health care, since this percentage does not include sums from other public-sector organisations. As noted above, curative care is provided by the government, although some services are offered by the health maintenance organisations. The responsibility for psychosocial rehabilitation services is shared with the welfare services and, especially, with the National Insurance Institute (see section on legislation, below).

Any inhabitant can freely access any mental health curative service (Feinson *et al*, 1997). Although referral by a general practitioner is preferable, any resident can attend mental health services directly, without such a referral. The country has 114 clinics and day-care centres, 12 psychiatric wards in general hospitals and 20 mental hospitals.

Since the early 1950s, Israel has run a psychiatric case register. All admissions and discharges are cumulatively entered into a database. Of late, this database has incorporated additional sources of information (e.g. clinic-originated information). The confidentiality of the database is specifically protected by law (Department of Information and Evaluation, 2002).

Table 1 highlights some statistics relating to in-patient care in Israel. The rates of hospital admission per

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Table 1. In-patient psychiatric services, 2001

Beds (number per 1000 persons aged 15 and above)	1.17
Annual rate of first admission, per 1000 persons aged 15 and above	
Total	0.92
Jews	0.99
Muslim Arabs	0.70
Others	0.34
Annual rate of readmissions per 1000 persons aged 15 and above	2.96
Annual admission rate per 1000 persons aged 15 and above to in-patient and hospital-based day care	
Men	3.4
Women	2.3
Average length of hospital stay (days)	131
Proportion of all admissions that are voluntary	74.2%

1000 are lowest for Muslims (men 2.50, women 1.19), intermediate for Christian Arabs (2.48 and 1.69, respectively) and highest for Jews (3.49 and 2.50, respectively). Similarly to most countries, 51.8% of admissions are for schizophrenia or delusional disorders. Five per cent of psychiatric beds are in general hospitals. The number of beds has fallen over time.

Consumer and family organisations

These organisations are highly visible and active in both advocacy and mutual support. (A special issue of the *Israel Journal of Psychiatry*, vol. 39, no. 3, 2002, was wholly devoted to the consumers of mental health services.) They have representation on the national councils and have a strong voice in the efforts leading to the transfer of mental health care to the health maintenance organisations. The Ministry of Health recognises their important role in the humanisation and democratisation of mental health care by contributing to their support. These organisations were consulted in the process of drafting the laws alluded to below and their representatives take part in the quality-control activities that have recently been initiated.

In addition, several non-government organisations are active in mental health care, such as ERAN, which offers telephone first-aid assistance nationally, and another that provides initial guidance to foreign workers.

Legislation on psychosocial rehabilitation

Perhaps the single most important piece of legislation that facilitates the ongoing – but slow – process of psychiatric reform is that adopted in 2000. This is the Community-Based Rehabilitation of the Mentally Disabled Act, whereby all consumers whose degree of mental disability reaches 40%, as established by the National Insurance Institute, are fully entitled to receive a set of rehabilitation services in the community. This law has enabled the mental hospitals to discharge people who would otherwise remain merely for custodial reasons and to promote their social reintegration. Funds have thus become available to contract out to private and social enterprises running hostels with different levels of supervisory services for their clients. To avoid recreating the atmosphere of mental institutions, these hostels are periodically inspected by staff from the Ministry of Health.

The range of rehabilitation services is wide: they include dental care, for example – an item often neglected in psychiatric health plans – and supported education. With regard to the latter, special efforts are being made to help consumers to complete their educational cycle within the regular system of education for adults.

Health services and the security situation

The unstable security situation has led the country to devote considerable resources (in services, research and teaching) to help the civilian population overcome the

stress resulting from both open warfare and acts of terrorism. This section alludes to the 1991 Gulf War, when areas of the country were subjected to missile attack by Saddam Hussein's Iraq, and to the current second Intifada, which began in October 2000.

In the Gulf War, studies covered a number of health issues among adults, such as mortality (the early elevated cardiovascular mortality rate that was found was presumably linked to the use of gas masks and extended stays in sealed rooms – Kark *et al*, 1995); self-appraisal of physical health (worsened health status); health behaviour (increased smoking, diminished physical activity, changed eating habits); and psychological distress (higher in the exposed areas) (Nakar *et al*, 1996; Soskolne *et al*, 1996). Other studies explored reactions in children (Laor *et al*, 1996) and among the elderly (Solomon & Prager, 1992), and acute stress in evacuees (Solomon *et al*, 1993).

Soskolne *et al* (1996), in addition to the measures noted above, enquired into the use of tranquillisers and the use of services. They found higher use of tranquillisers compared with the preceding month but no differences in service utilisation.

Nakar *et al* (1996) compared the 2-week consulting load in a family practice of an area that was highly exposed to SCUD missile attack with the equivalent period during the previous year. The authors reported that the total rate of visits was cut by half, but with a relative and absolute increase in psychological consultations and a decrease in consultations for infectious and respiratory conditions. Apparently, worries about the attacks led to a reduction in consultations for trivial disorders, but to an increase in the anxiety level of the population.

During the second Intifada, the Ministry of Health and several non-governmental organisations have established mental health activities that are provided as early as possible in the emergency rooms and wards of general hospitals that treat casualties. The Ministry has trained several teams of eight mental health specialists, who are attached to a general hospital. Half of them are trained to care for children and adolescents, and half for adults. Immediately following an attack (or other disaster), they are expected to report to their hospital. Their task is to examine all persons who are lightly injured and those suffering from a stress reaction. Following first-aid treatment, everyone is transferred to another area near the emergency room for individual and group intervention. The intervention includes an explanation about the nature of psycho-trauma, the provision of emotional support and the giving of information about psychological and social security assistance. This information is offered in five languages – Hebrew, English, Russian, Arabic and Amharic. An additional role of the mental health team is to provide emotional support to doctors and nurses who are involved in the care of the wounded.

Hospital social workers are responsible for meeting the family members and friends of the injured, and helping them to locate the casualties, assist with their grief, and accompany the family members to the hospital morgue to identify victims.

The Ministry of Health's system for emergency intervention and treatment with regard to psychological trauma

Nakar *et al* (1996) compared the two-week consulting load in a family practice of an area that was highly exposed to SCUD missile attack with the equivalent period during the previous year. The authors reported that the total rate of visits was cut by half, but with a relative and absolute increase in psychological consultations and a decrease in consultations for infectious and respiratory conditions.

also includes activities that take place at the community level. Trained personnel in out-patient clinics are entrusted with the care of persons affected by acute stress disorders or post-traumatic stress disorder. At the time of a national emergency, these out-patient clinics are open 24 hours a day.

Research

Much mental health research has been and is being conducted both in the universities and in the services. National and international funding sources support Israeli research. For the sake of brevity, the main areas of research are briefly summarised below. The studies cited here are merely examples – a national database is available at www.szold.org.il.

Epidemiology

Studies have been conducted with regard to the mental health of communities both in peace and in war. Currently, the national authorities are conducting household surveys of the young and adults, the latter as part of epidemiological studies in a number of countries, run jointly by the World Health Organization and Harvard University. A large survey exploring emotional distress (common mental disorders) among Arabs and Jews has concluded relatively recently. The fact that many early immigrants were Holocaust survivors provided the substance for studies on the mental health status of first- and second-generation immigrants (Levav, 1998).

Social psychiatry

The cultural mosaic of Israel has prompted investigators to explore the knowledge, attitudes and practices of different Arab and Jewish groups of the population.

Health services research

The Ministry of Health supports a relatively large staff, who are entrusted with the responsibility of providing data for planning, monitoring and evaluation. These efforts are buttressed by studies conducted by university staff and students.

Biological psychiatry

This area, in consonance with the current psychiatric zeitgeist, is flourishing and making significant contributions in a number of respects, particularly with regard to schizophrenic, obsessive and depressive disorders and post-traumatic stress disorder.

Training

Graduate, postgraduate and in-service education is a vibrant area. The country trains all the range of mental health professionals (clinical psychologists, nurses, etc.). There are 16.4 psychiatrists per 100 000 population. The register of the Child and Adolescent Society numbers about 150 specialists (Apter, 1998). In addition, there are approximately 200 residents in training. To be recognised

as a specialist, the resident has to complete four years of postgraduate education in a variety of services and pass two examinations.

Looking back, moving forward

Throughout the country's history, the mental health services in Israel have had to face the challenge of how to provide care to persons from very different cultural and religious backgrounds – Jewish, Muslim, Druze and Christian – see Al-Krenawi (1999) and Al-Krenawi & Graham (1999) with regard to the Arabs, and Bilu & Witztum (1997) and Greenberg & Witztum (2001) with regard to different Jewish Israeli groups, who emigrated from 70 or so countries, wherein many had endured severe persecution and the traumatic loss of their significant others, and whose lives since the dawn of the State have been punctuated by war and terrorism.

A judgement on how well the services have performed is beyond the scope of this report. However, it is fair to say that mental health care is increasingly recognised by decision makers and the public as an important link in the chain of efforts that the health system makes towards the health of the nation. Mental health services are free and open to all, and the service users and their families are being sought as natural partners of mental health professionals.

In the field of research, Israel is contributing its share to the global pool of scientific knowledge, as has been noted by Patel (2002).

Admittedly, not all is well. Psychiatric reform, which involves deinstitutionalisation, community-based care and the humanisation of services, is progressing more slowly than is wished by many. Mental hospitals still remain the main axis of care, command an unusual amount of power and authority, and consume most of the mental health budget. A large proportion of their personnel, although less fearful of community-based care than they were, remain ambivalent at best about the psychiatric reform that is leading to the transfer of mental health care to the health maintenance organisations. Despite the free access to care, equity has not been achieved, and the barriers to care for foreign workers, particularly those without papers, have not been lowered. Child and adolescent mental health services and services for the elderly, although available, are probably less than are needed (an ongoing survey will identify needs among the young). A last limitation worth noting is that the services have yet to balance their efforts in care and rehabilitation with health promotion and illness prevention.

In conclusion, the Israeli mental health services are genuinely attempting to upgrade the mental health care for the whole population. To overcome the remaining and still formidable obstacles, both internal and external, to the system, will require, much as in other nations, the support of many stakeholders, and a successful blend of political and social will, the application of scientific and technical know-how, the involvement of service users and their families, and the dedication and commitment of mental health workers.

A database of Israeli mental health research is available at www.szold.org.il.

Mental hospitals still remain the main axis of care, command an unusual amount of power and authority, and consume most of the mental health budget.

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COUNTRY PROFILE

Mental health services in Albania

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Albania, situated in the western Balkans, has an area of 28 748 km² and a population of 3 069 275 (year 2001), almost one-third of whom are aged 0–14 years. Life expectancy is estimated to be 70.4 years for both sexes (World Health Organization, 2003a). According to the World Health Organization's classification, Albania is a country with low child and low adult mortality rates. The nation's total expenditure on health in 2001 amounted to 3.7% of gross domestic product.

For more than a decade Albania has been undergoing a transitional process of democratisation of its society and decentralisation of its systems, including systems of care in general. However, its relatively recent totalitarian past had created a culture of lack of community initiative, participation and decision-making, and the care system remains prey to financial and regulatory rigidity. The system is still highly centralised and lacks a focus on the social welfare of citizens. Decentralisation and open governance within a framework of comprehensive reform are prerequisites for better services. Furthermore, any intervention to improve the health system will need to take into account the fact that Albania is not a rich country and health is not the

top priority when it comes to the allocation of national resources.

Education in psychiatry

Formal psychiatric education is provided by the only university department of psychiatry in the country; it is part of the Faculty of Medicine of the University of Tirana. Education in psychiatry has had to be transformed in order for it to meet international standards. While psychiatry constitutes 1.4% of the overall training hours in the university curriculum for medical doctors, in 1994 postgraduate psychiatric education was extended from 9 months of internship to 4 years of residency in the university clinic.

Residents annually discuss their training plan with their supervisors. They attend to and follow clinical cases in their charge. The professional qualification for psychiatrists involves several yearly examinations across the entire residency period, and one final examination (oral and written). While the curriculum offers satisfactory training in biological psychiatry, it is difficult to train young residents properly in the psychosocial aspects of practice, as there are few supervisors with sufficient experience and

The care system remains prey to financial and regulatory rigidity. The system is still highly centralised and lacks a focus on the social welfare of citizens. Decentralisation and open governance within a framework of comprehensive reform are prerequisites for better services.

knowledge in this area. Psychotherapy is taught only theoretically – there is no opportunity for practice and supervision – and psychosocial rehabilitation is missing from formal residency training because the university clinic has no facilities for it.

A curriculum for a residency in child and adolescent psychiatry has recently been approved. This means that the academic year 2004–05 will mark the initiation of a 4-year programme that will cover general paediatrics, neuro-paediatrics, general psychiatry, and child and adolescent psychiatry. It is a step forward in giving to the population better access to more appropriate services.

There are no formal specialisation courses for psychiatric nurses or for clinical social workers, although psychology students in the last year of their undergraduate studies can choose to specialise in clinical psychology or organisational psychology. There is no formal training for occupational therapists.

With an increasing awareness of the need for continuing medical education, including in psychiatry, there are formal negotiations going on between the Ministry of Health and the Ministry of Education in order to establish a responsible body.

Clinical practice and services

Clinical practice in psychiatry in Albania is exceedingly demanding because so few resources are dedicated to mental illness. For example, within community mental health facilities for children and adults (psychiatric wards in general hospitals, ambulatory clinics, community mental health centres, day centres), there are, nationally, 69 neuropsychiatrists (who have a combined neurology–psychiatry postgraduate qualification, which was abolished in 1974) and psychiatrists (2.2 per 100 000 population), of whom 54% are psychiatrists; 130 nurses (4.2 per 100 000); 6 psychologists (0.2 per 100 000); 12 social workers (0.4 per 100 000); and 8 occupational therapists (0.3 per 100 000). These figures suggest that psychiatrists (and other professionals) working in ambulatory settings will confront a demand that is impossible to respond to properly in either quantitative or qualitative terms. Except where community mental health centres are already established, the ambulatory clinics are staffed by only one psychiatrist and one nurse, who mostly do diagnostic work and prescribe psychotropic drugs. Psychiatric home care is seldom supported, and visits to a patient's home are made (if at all) only when the patient is not compliant with aspects of psychiatric care.

Albania's in-patient facilities comprise two psychiatric hospitals (Elbasan and Vlora) and two psychiatric wards within general hospitals (Tirana and Shkodra). Except for some administrative/budgetary differences, the approach to service provision is the same for these psychiatric hospitals and wards. The hospitals and wards have a total of 840 beds. This is not a very low figure for the country's population but because half the beds are used for long-stay patients the demand for in-patient services cannot be met.

The two mental hospitals in Elbasan and Vlora have 12 psychiatrists, 93 nurses and 5 occupational therapists.

There are no psychologists or social workers at these hospitals.

Psychiatric hospital care involves diagnostic work and free medication – there are few activities available to patients. There is little in the way of rehabilitative work, as it would require a budget and human resources but at present is not a priority.

Legislation

The Albanian Parliament approved the Mental Health Act in 1996. It provides a framework for compulsory examinations, admissions and treatment, but pays little attention to the establishment of comprehensive, deinstitutionalised services. However, the main problem of the Act is in its implementation. Lack of community services means that institutions continue to be used to segregate people with a mental illness. Efforts are being made to redress the situation, and to build up supportive alternatives, through the drafting of a national mental health policy.

Developments in mental health

Many actions were taken during the 1990s by international organisations to improve aspects of Albania's psychiatric services, including training and education, day centres and the rehabilitation of institutionalised patients. Unfortunately, these initiatives had little long-term effect. This brought the realisation that it is essential to involve the national authorities in any such work, as this will improve the chances of implementing a break with tradition and establishing new practices. This would be true anywhere in the world, but is particularly pertinent to the Albanian case, where systems are still managed centrally and so where any important, radical change needs the commitment and influence of central authorities in addition to the initiative and will of local professionals or community groups. Thus, based on the lessons learnt, national professionals have more recently drawn on international expertise in an effort to establish a reform process oriented towards the delivery of comprehensive community mental health services by multi-disciplinary teams.

In 1999 the Ministry of Health embraced a proposal by the World Health Organization for a comprehensive reform of the entire psychiatric system. This was made the responsibility of a national organisation when, in 2000, the Minister of Health established the National Steering Committee for Mental Health. Moreover, the Committee was given the powers necessary to implement the changes required. With technical input from the World Health Organization, the main focus of the Committee has been on elaborating the mental health policy referred to above. This should provide the political framework for change. The Policy for Mental Health Services Development in Albania was approved by the Minister of Health in March 2003. It defines the national goal as the 'establishment and development of a national community mental health care system', and describes two main tools to reach the goal: the downsizing of the psychiatric hospitals and the decentralisation of services.

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With an increasing awareness of the need for continuing medical education, including in psychiatry, there are formal negotiations going on between the Ministry of Health and the Ministry of Education in order to establish a responsible body.

As mandated by the policy document, the National Steering Committee is currently elaborating a strategy for the implementation of the mental health policy, assisted by the World Health Organization.

In addition, pilot projects are now being run to show the feasibility and benefits of community-based mental health care.

Considering all the above, there are at present better chances than ever before of achieving comprehensive and accessible mental health services in Albania.

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SPECIAL PAPER

Current ethical issues for African psychiatry

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One of the challenges of medical practice is to resolve the conflicts that arise when a professional is required to choose between competing ethical principles. This is especially true in psychiatry. The answers to ethical issues are not necessarily right or wrong. Ethics in psychiatry is complex, and numerous dilemmas may confuse the picture. Clinicians and researchers bring their own values to the scenario, but they must also deal with the values of their colleagues and their patients, as well as those of the wider (multi-cultural) community. These conflicts traditionally concern confidentiality, informed consent, involuntary hospitalisation, the right to treatment, the right to refuse treatment and the regulation of psychiatric research, among others. These are universally encountered but present differently across the regions of the world.

Principles of the debate and the African perspective

The principles usually addressed in bioethics debates are particularly applicable to the practice of psychiatry in Africa. For example, the principle of autonomy is prominent in the changes from tribal or colonial dominance to democratic governance. Human dignity and respect, and the principles of beneficence and non-maleficence require consideration in the discussion. Patient confidentiality needs to be addressed in professional training and the formulation of policy. Respect for the patient is shown in the efforts made to restore or maximise the mentally ill patient's competence or other capacities. The more we aim to restore capacity, the nearer we come to the ideal of respect for persons. The principle of justice is probably

the most important, however, in light of the scarcity of resources.

Since ethics involves a set of principles, doctors are tempted to seek answers in law or in professional codes of ethics when they encounter problems. These approaches do not necessarily solve problems – certainly not in Africa.

The themes are common but some of the ethical issues for African psychiatry are different from those in developed countries and the approach needs to be somewhat less Western. The emphasis in Africa should be on the ethical educational input and general sensitisation, on ongoing training and thus on the circumstances of professional practice. Public sanction and support are essential, as are the involvement of the community and concern for the safety and well-being of its members. Indigenous healers (as an example of a cultural factor) must be carefully considered. Their involvement is being formalised in many countries and is a topic of discussion in itself.

What of international standards? Although universal principles are accepted, care must be taken to avoid the trap of imposing 'their' views and solutions on 'our' situations. The Madrid Declaration drawn up by the World Psychiatric Association attempts to meet this need for its smaller member countries. The 2000 revision of the Helsinki Declaration recognises the vulnerability of developing countries with a poor resource base in research.

The essence of an ethical dilemma is that there is no simple correct solution. Africa has raised key ethical issues, from apartheid, genocide and pandemic illnesses to the role of women, AIDS, poverty and tribal wars. All these have had an influence on the mental health of its populations. Certain issues need to be focused on in an approach to the dynamic area of ethics in Africa – a large and complex continent. These are discussed below.

Since ethics involves a set of principles, doctors are tempted to seek answers in law or in professional codes of ethics when they encounter problems. These approaches do not necessarily solve problems – certainly not in Africa.

Mental health legislation

Laws change and different circumstances may govern their application. The law and ethics are different in approach and often in conflict. This becomes evident in the revision and formulation of new mental health law. Do rules as postulated internationally have equivalent application to African psychiatry? Mental health legislation must always be reviewed and updated, in line with a contemporary understanding of human rights. Each problem has to be analysed individually and the solution directed towards the interests of patients and of others, including the community.

Many countries, but particularly African ones, have obsolete, archaic or non-existent mental health legislation. However, most of those that do have such legislation, or that are in the process of revising it, have achieved very high standards. Consultation has proved important. In most cases the psychiatric profession is driving the process and this must be encouraged, in keeping with modern psychiatry.

National mental health policy

Mental health policies are being most keenly promoted in areas where they were often previously non-existent. The focus of policy is pleasingly also moving to preventive aspects of mental health. Treatment of the more serious mental illnesses is being addressed, together with the development of psychosocial rehabilitation programmes involving the communities. The standards of care include consideration of the cultural influences of the patient's background.

The professionals comprising the multi-disciplinary team are all in short supply. Projects of support between regional countries are underway. For example, there are placements of supernumerary registrars at the University of Cape Town for training as psychiatrists. These professionals will return to apply their skills and knowledge in their home countries. This programme has proved very successful, in that the nature of the disorders and circumstances of the population are similar. Further initiatives are needed to ensure the future provision of psychiatric practitioners.

Research into the countries' specific needs is being undertaken. More attention should be given to the subject of domestic abuse and violence and the increasing problem of substance misuse. Planning is required to provide mental health services to post-conflict societies, including the needs of children in these traumatised populations. The importance of an awareness of the severe psychological reactions to trauma cannot be overemphasised.

Resources (justice principle)

The justice principle, in relation to resources, is probably the most relevant to the ethics of mental health policy in Africa. In this context it can be understood as the fair distribution and application of psychiatric services. Treatment choice for persons with mental illness is greatly limited by economic restrictions in the public sector and by

the introduction of managed health organisations in the private sector. Effective treatments are available but are not always accessible. The lack of human and economic resources makes it particularly difficult to deliver efficient interventions. The lack of facilities, and especially those allocated to mental health, is well known in developing countries. The lack of psychiatrists on the continent is a cause for concern. It is distressing that there are programmes of active recruitment and 'head-hunting' of young psychiatrists (e.g. from South Africa) on the part of developed countries. A focus on delivering mental health services at primary care level has been one of the solutions sought.

Human rights

Can there be a right to effective treatment in psychiatry? Is this absolute in all areas?

The right to treatment of patients who have been hospitalised involuntarily (as opposed to mere custodial care in adequate and acceptable facilities) does not require further debate but its application in developing countries requires a different approach. However, a shift is underway from large custodial facilities to community-based programmes, many of which are unique and in themselves could be examples of progressive mental health policy.

Anti-stigma campaigns have been introduced and accepted in various African countries. The World Health Organization's initiative in 2001, with the theme 'Destigmatisation', was launched on World Mental Health Day in Africa, in Nairobi, Kenya. Progressive patients' rights charters have been adopted or are being drafted, with international guidance and support. The inclusion of patients' rights in mental health legislation, as in the new Mental Health Care Act in South Africa and in other countries, is significant. These often appear to be more advanced than those of more developed countries.

Psychiatric research ethics

Research ethics has achieved a high profile in international circles in recent years and an understanding in the African context is important. Updated guidelines were issued in the revised Helsinki Declaration, of October 2000. A link to a universal standard is important in psychiatric research, because of the nature of multi-centre drug trials. Exploitation (often termed 'research imperialism') and conflicts of interest are high in profile. Financial, professional and business interests are evident. The Helsinki Declaration refers to vulnerable populations, especially economically or medically disadvantaged groups, including those with a mental illness. Those incompetent to consent or who may consent under duress are specifically mentioned, as are those for whom research is combined with care.

Research in developing countries by wealthy industrialised countries for their own benefit has been around for some time but must be accepted only with caution. Research in developing countries needs to be of benefit to the people concerned. Two key questions arise:

The lack of psychiatrists on the continent is a cause for concern. It is distressing that there are programmes of active recruitment and 'head-hunting' of young psychiatrists on the part of developed countries. A focus on delivering mental health services at primary care level has been one of the solutions sought.

A shift is underway from large custodial facilities to community-based programmes, many of which are unique and in themselves could be examples of progressive mental health policy.

The most difficult issue is whether a global standard can be accepted as the 'best' treatment. The debate continues regarding whether there should be one global standard for all or local standards.

Health care systems need the influence of appropriate research to extend their approach towards the social constructs of disease and suffering, and to develop an approach to mental health that could complement and enhance the physical health care of individuals in the developing continent.

- Are drug trials serving the interests of the investigator or company, rather than those of the population?
- What about the influence of incentives and payments to investigators and subjects?

The research must benefit participants as well as non-participants in the developing country. The risk of exploitation and conflicts of interest remain. Experience has demonstrated that the potential for abuse is significant when local circumstances cannot support the research initiatives that may be advantageous to the needs of the population. The result is that the investigator is easily seduced by the attraction of research support and participation.

The most difficult issue is whether a global standard can be accepted as the 'best' treatment. The debate continues regarding whether there should be one global standard for all or local standards.

Teaching of psychiatric ethics

The training of psychiatrists for practice within the region should be attempted in the region itself. Currently, medical ethics is attracting much public and professional interest, but it is generally not taught to trainees in a satisfactory manner. It has until recently been given little or no attention in training programmes. The traditional view is that the trainees model themselves on the consultant to whom they are apprenticed, and assimilate an appropriate system of values for application in their subsequent careers. The aim is not to convert students into amateur moral philosophers and ethicists, but to sensitise them to the complex and intricate ethical issues that commonly face mental health professionals. The topics and concepts which have a bearing on day-to-day professional practice in Africa have been introduced into training. Students need to appreciate that no ready-made solutions are available to overcome all problems. With increased awareness progress can be made.

Social dysfunction, poverty and disaster

The effects on the practice of psychiatry of social disruption from a variety of causes is seen in modern-day Africa. This topic embraces bioethical principles and illustrates the problems facing the provision of mental health care in Africa. Although comparable conditions may occur elsewhere, they are generally more severe in Africa. Social circumstance and its relevance to mental health need not be stressed. However, mental health care professionals need to broaden their understanding of the influence of such stressors on mental health.

The term 'social suffering' describes the human suffering, group and individual, associated with the social conditions thrust upon them. Unlike physical suffering or more formal mental illness, it is largely unrecorded. New measures, such as disability-adjusted life years (DALYs), neglect most of what is at stake for African populations. Awareness of the effects of social suffering on the mental health of the population requires extensive discussion and

attention. Social suffering evolves from poverty, illiteracy, natural disasters and climatic influences, as well as the earlier years of colonial exploitation.

The Universal Declaration of Human Rights and international law were expected to reduce human suffering at the end of the last century, but not sufficiently so in Africa. Unprecedented population growth, ethnic and gender conflict and global economic trends have rendered millions vulnerable to poverty, disease, genocide, torture and sexual abuse. Suffering is now present to a greater degree than in the past through poverty and deprivation, and has been increased both by diseases, including AIDS, and by the use of military force. These have, unfortunately, become accepted as inevitable aspects of modern life in the communities affected. The suffering linked to violence is built into the lives of many African societies. The tragedy of Rwanda has been evident from descriptions of health workers; in that modern tribal war populations were brutally victimised.

What of traumatised children? International indifference is seen towards Africa, while the people of the continent suffer debt burdens, famine and cruelty (often that of their own governments). This is without even considering the relationship of economic and other factors to diseases such as AIDS, malaria and tuberculosis. The oppression of parts of society during the apartheid era in South Africa has, through the testimonies at the Truth and Reconciliation Commission, become well known; that Commission has shown the importance of public acknowledgement in dealing with human suffering.

Conclusion

While medicine has done much to advance health and prolong the lives of individuals, an improvement in the mental health of many of the populations of Africa will require profound social, economic, political and cultural changes. All mental health professionals have a challenge to broaden their understanding of health, disease and suffering, and of their role in society. Health care systems need the influence of appropriate research to extend their approach towards the social constructs of disease and suffering, and to develop an approach to mental health that could complement and enhance the physical health care of individuals in the developing continent. Respect for human rights is essential.

The social and legal environment is changing and requires professional accountability. The main principle of ethical practice is the autonomy of the person. Autonomy has replaced paternalism, but to what degree can this be applied in vulnerable mentally ill or handicapped persons and more especially in undeveloped areas and populations of the continent of Africa?

Are ethical issues for psychiatry in Africa really any different? Ethical issues receive a great deal of attention in developed countries when publicity is given to scandals concerning malpractice or sexual violations, or to public fears of people with mental illness who are homeless and who are perceived as dangerous. In Africa the emphasis is on promoting ethical standards of professional practice.

None the less, ethical conflicts often relate to social suffering arising purely as a consequence of severely limited resources.

Ethical issues necessarily relate to what is acceptable in our own societies, and to our responsibilities to those societies. The issues are not really different in principle in Africa but the emphasis is different. The culture of the

individual and multiple groupings must be respected in the planning and provision of psychiatric services. A continual process of seeking the highest ethical standards of care for everybody in mental health care must be the aim, without any differences regionally or within health care provision – that is, no discrimination for psychiatric patients, wherever they may be.

ASSOCIATIONS AND COLLABORATIONS

The World Health Organization's Mental Health and Substance Abuse Programme

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There has been a rapid rise in the number of people with mental disorders. These disorders represent a major challenge to global development. The burden will be higher in developing countries, which have the least resources to respond. World-wide, 450 million people are affected at any given time. No group is immune to mental disorders but the risk is higher among: the poor; children and adolescents; abused women; the unemployed; persons with little education; neglected elderly people; victims of violence; migrants and refugees; and indigenous populations.

Mental disorders can result in substantial disability, as well as social and occupational disadvantage, in both developed and developing countries. They impair psychological and social functioning, and individuals with mental disorders and disability end up in more socially disadvantaged circumstances.

We can say that mental ill health is a significant contributor to poverty. In addition, the poor have been shown to be more likely to have a mental disorder than those with higher incomes. People in socially disadvantaged situations are exposed to more adverse life events than those in more advantaged environments. We can say that poverty is also a significant contributor to mental ill health.

Finally, poor provision of mental health care results in poor outcomes, avoidable relapses and insufficient rehabilitation. We can say that poor mental health service provision is a significant contributor to the perpetuation of mental ill health and poverty.

However, effective (in some cases cost-effective) interventions are available for almost all mental disorders. These interventions often do not cure the disorders but substantially improve symptoms or decrease relapses, or lead to social (not clinical) recovery, or improve quality of

life. Programmes of mental health promotion and mental ill health prevention can reduce a population's overall vulnerability to disorders and improve its general mental health, through improved individual skills and resources, the empowerment of communities, and improvements in the socio-economic environment. Nevertheless, cost-effective interventions are not always implemented and there is a huge gap between treated and untreated (World Health Organization, 2003).

Closing this gap is therefore a clear obligation: otherwise no discourse around new classifications, concern about more sophisticated diagnosis, or the development of innovative psychopharmacological research can be credible, at least not from the global and moral perspective of the World Health Organization (WHO).

2001 was the Year of Mental Health. The WHO World Health Day in 2001 was a resounding success. Over 150 countries organised activities, including the delivery of major addresses by political leaders and the adoption of new mental health legislation. At the 2001 World Health Assembly, over 130 ministers responded positively, with a clear and unequivocal message: mental health, neglected for too long, is crucial to the overall well-being of individuals, societies and countries. The theme of the *World Health Report 2001* was mental health, and its 10 recommendations have been positively received by all member states (World Health Organization, 2001).

As a result of these activities in 2001, a Mental Health Global Action Programme (mhGAP) was created (World Health Organization, 2002a) to put strategic directions in place for addressing the findings presented in the *World Health Report*.

GAP logic is based on four strategies:

- *Increasing and improving information for decision-making and technology transfer.* We should know

For contributions to the 'Associations and collaborations' column, please contact John Henderson, email john.henderson53@btoopenworld.com

Programmes of mental health promotion and mental ill health prevention can reduce a population's overall vulnerability to disorders and improve its general mental health, through improved individual skills and resources, the empowerment of communities, and improvements in the socio-economic environment.

The areas of promotion of mental health and prevention of mental disorders are being investigated systematically for evidence-based programmes; a comprehensive report is being developed.

Good information is a prerequisite for better decisions, for both the WHO and member states. The WHO will bridge the information gap by developing a set of indicators to monitor mental health systems and services at country level.

more about the magnitude and the burden of mental disorders around the world, and know more about the resources (human, financial, sociocultural) that are available in countries to respond to the burden generated by mental disorders. We should increase and improve the transfer of technologies related to mental health.

- *Raising awareness about mental disorders through education and advocacy for more respect of human rights and less stigma.* We should address not only the general public but policy makers, politicians and other sectors.
- *Assisting countries in designing policies and developing comprehensive and effective mental health services.*
- *Building local capacity for public mental health research in poor countries.*

At the WHO Executive Board meeting in January 2002 a resolution on mental health was adopted. It strongly supports the mhGAP and urges action by member states. The resolution was endorsed unanimously by the World Health Assembly in May 2002 (World Health Organization, 2002b).

However, the WHO is aware that mhGAP risks remaining a merely theoretical exercise, with limited impact at country level unless further action is initiated. Therefore, the WHO Department of Mental Health has strengthened the normative work on information and policy, by developing the *Atlas* project and the WHO Mental Health Policy and Service Guidance Packages. The *Atlas* provides basic information on the mental health resources of all countries, while the Health Policy and Service Guidance Packages are a series of comprehensive, interrelated, user-friendly modules, designed to address the wide variety of needs and priorities in policy development and service planning.

Good information is a prerequisite for better decisions, for both the WHO and member states. The WHO will bridge the information gap by developing a set of indicators to monitor mental health systems and services at country level. The indicators are drawn from the 10 recommendations included in the *World Health Report 2001*: they suggest actions addressed to all parts of the mental health system, from treatment to prevention and promotion, and to research. The indicator scheme focuses on countries with low- and medium-level resources and goes far beyond the basic information available in the *Atlas*. Through these indicators, countries will be able to monitor their progress in the implementation of their reform policies, provision of community services and activities, and involvement of communities, consumers' and families' associations, and that of other governmental sectors in mental health promotion, prevention, care and rehabilitation. Countries will thus receive a clearer and more comprehensive picture of the main mental health issues and be able to assess improvement over time.

To make the implementation of the 10 recommendations feasible, the WHO has adapted the nature of the implementation to the general level of resources of the

country. In the particular case of developing countries, where the mental health gap is greater, the WHO will offer differentiated packages of 'achievable targets' for implementation (gap-reduction achievable national targets, or GRANTs).

The achievement of the targets will influence both health and social outcomes, namely mortality due to suicide or to alcohol/illicit drugs, morbidity and disability due to the key mental disorders, quality of life, and, finally, human rights. With progress, the standards will be upgraded until countries move up in continuous pursuit of excellence. Relying on sentinel communities in each group of countries and using one or more sentinel disorders (suicide risk, depression, schizophrenia, epilepsy, alcohol misuse, illicit drug use), the WHO will evaluate the impact of the package according to suitable parameters of change.

Of course, the assistance to countries through the GRANTs approach has not stopped WHO core normative and knowledge transfer functions in many key areas. These are discussed under separate headings below.

(1) Mental health prevention and promotion

The areas of promotion of mental health and prevention of mental disorders are being investigated systematically for evidence-based programmes; a comprehensive report is being developed. The WHO Programme is also implementing a large project on the prevention of substance use among young individuals in eight countries spread across four WHO regions.

(2) Mental health policy and service development

A Mental Health Policy and Service Guidance Package is being designed to address the wide variety of needs and priorities in policy development and service planning. The guidance package consists of a series of interrelated, user-friendly modules. These modules include: Mental Health Policy, Plans and Programmes; Legislation and Human Rights; Financing; Advocacy; Quality Improvement; Organisation of Services; and Planning and Budgeting for Service Delivery.

(3) Suicide prevention

The department has launched a global suicide prevention programme called SUPREMIS. The aim is to contribute to a reduction in suicidal behaviour, particularly in countries whose suicide rates are above the regional average. Its main activities are:

- monitoring and surveillance of mortality rates due to suicide
- production and dissemination of information
- technical assistance to member states
- a multi-site intervention study on the prevention of suicidal behaviours (for Brazil, China, India, Estonia, South Africa, Sri Lanka and Vietnam).

(4) Depression

As part of the activities related to the management of mental disorders of public health importance, the department regularly disseminates information and guidelines on the management of depression. It is currently conducting a project on the comorbidity of depression with alcohol use, cardiovascular diseases, cancer, HIV/AIDS and tuberculosis, in order to identify those factors dependent on depression that result in reduced compliance and adherence to the treatment of the comorbid condition. Appropriate management of depression improves both adherence rates and the outcome of those diseases.

(5) Schizophrenia

The department promotes a balanced approach to the management of schizophrenia, one that includes biological treatment, psychosocial rehabilitation, empowerment of consumers and support for families. A multi-site intervention study based on this approach is being conducted in India.

(6) Global campaign against epilepsy (GCAE)

The GCAE is a joint initiative of the WHO and leading non-governmental organisations (NGOs) in this area – the International League Against Epilepsy and the International Bureau for Epilepsy. There is a two-track strategy for the GCAE:

- providing a platform for general awareness
- assisting government departments of health in the development of national programmes on epilepsy.

More than 90 countries are currently involved in the various GCAE activities via the NGOs' chapters and WHO collaborating centres. Large demonstration projects are being carried out in Argentina, Brazil, China, India, Zimbabwe and Senegal.

(7) Substance dependence

The WHO Programme has prepared a report on the neuroscience of psychoactive substance use and dependence, with the aim of overcoming misconceptions and stigma associated with substance dependence, thereby improving access to treatment for those in need.

The Programme promotes strategies for the early identification and management of substance use disorders in primary health care, which have proved to be cost-effective with regard to alcohol problems. To improve our knowledge about the feasibility and effectiveness of screening and brief intervention for illicit drug use, we have developed and validated a screening instrument for drug use and have recently initiated a multi-site randomised controlled study on the effectiveness of brief interventions for illicit substance use in general medical settings.

In the area of the epidemiology of substance use, a global alcohol database (GAD) is being maintained. It is a

single source of global information on alcohol consumption and associated morbidity, mortality and country responses. Several research projects are being conducted in developing countries on alcohol involvement in injuries (12 countries), alcohol and gender (7 countries) and unrecorded alcohol consumption (4 countries).

(8) Comorbidity and adherence issues in infectious and non-infectious disease

It is well documented now that persons suffering from mental disorders have poorer physical health. Mental disorders affect the course and outcome of comorbid chronic conditions, such as cancer, heart disease, diabetes and HIV/AIDS, disorders that are associated with a heightened risk for diminished immune functioning, poor health behaviour, non-compliance with prescribed medical regimens, and unfavourable disease outcomes. For example, it has been shown that depressed patients are three times more likely not to comply with medical regimens than non-depressed patients, and that depression predicts the incidence of heart disease. The reverse relationship also holds true: people suffering from chronic physical conditions have a heightened probability of developing mental disorders such as depression. The Programme has developed a number of projects to address comorbidity and adherence issues.

The effects of drug dependence treatment, including substitution maintenance therapy of opioid dependence with a community-based directly observed therapy (DOT) approach, are being assessed to see whether it improves access and compliance to treatment for HIV/AIDS and for opportunistic infections among drug-dependent people with HIV/AIDS. Substance use, and injecting drug use in particular, is a driving force of HIV/AIDS epidemics in many parts of the world. Dependent drug users are at particular risk of HIV and hepatitis C transmission, as they have impaired control over their lifestyles and behaviours.

To address these problems the Programme has implemented the WHO Drug Injection Study Phase II – the largest epidemiological study of injecting drug use, involving 14 developing and transitional countries in all six WHO regions. Finally, we are carrying out a multi-site project on drug dependence treatment and HIV/AIDS in five countries in South East Asia and Eastern Europe. It aims to evaluate substitution maintenance treatment, and the capacity of services to prevent HIV among service clients, and to assist in the management of HIV-positive clients.

References

- World Health Organization (2001) *World Health Report 2001*. Geneva: WHO.
- World Health Organization (2002a) *mhGAP*. Geneva: WHO.
- World Health Organization (2002b) *Strengthening Mental Health. Resolution of the Executive Board of the WHO, EB109.R8*. Geneva: WHO.
- World Health Organization (2003) *Investing in Mental Health*. Geneva: WHO.

The department promotes a balanced approach to the management of schizophrenia, one that includes biological treatment, psychosocial rehabilitation, empowerment of consumers and support for families. A multi-site intervention study based on this approach is being conducted in India.

News and notes

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

The Royal College of Psychiatrists is having a stand at the American Psychiatric Association's 157th Annual Meeting in New York, 1–6 May 2004. The College will be selling Gaskell books, demonstrating online journal features and displaying information about its various activities. Please visit Booth 1708 in the Publishers Book Fair.

Sessions for International Regional Groups

There will be specially dedicated sessions for the International Regional Groups (Divisions) at the Annual Meeting of the Royal College of Psychiatrists in Harrogate, 6–9 July 2004:

- *Middle Eastern International Group* – increasing awareness of differences in training in the Middle East from that in the West due to differing cultural and ethical contexts.
- *South Asian International Group* – the influence of poverty and social change on mental health in South Asia.
- *Pan-African International Group* – mental health in Africa: challenges and opportunities. (Presentations will range from transforming traditional mental hospitals, reducing the impact of the apartheid era in South Africa to personal accounts of working as a psychiatrist in different African countries and of being a refugee.)
- *North American International Group* – serving the underserved in North America. (Themes will include rural children, comparing the severely mentally ill in New York City and London, and the plight of the elderly mentally ill in nursing homes.)

News of the North American Group of the College

The annual reception of the Group will be held at the Annual Meeting of the American Psychiatric Association in New York City on Sunday 2 May 2004 in the New York Hilton Hotel from 6.30 to 8.30 p.m. All members and friends of the College are invited.

The Group has also organised a symposium and a workshop with international members of the Royal College. The symposium is entitled 'Psychiatric services around the world with a shortage of psychiatrists' and will feature speakers from Kenya, Pakistan, Egypt, England and New York. The workshop (with video) is on psychiatry in Afghanistan and Afghan refugees, and will feature speakers from Pakistan and Afghanistan. The workshop is scheduled for the Thursday morning (6 May) and the symposium for that afternoon, both at the Marriott Marquis Hotel (all functions should, however, be rechecked in the official programmes).

Presidents of National and European Psychiatric Organisations

The Fourth Annual Meeting of the Presidents of National and European Psychiatric Organisations will take place on

Wednesday 14 April in Geneva, before the conference of the Association of European Psychiatrists. The theme will be 'Psychiatric services focused on a community: challenges for the training of future psychiatrists'. This annual meeting considers not only the content of a theme such as training, but also how psychiatric organisations can learn from one another how best to develop in such a way as to support the profession and the continuing development of their members.

The role of health economics in mental health policy in low- and middle-income countries

A joint conference held on 30 May 2003 in London by the Office of Health Economics, Institute of Psychiatry and London School of Economics, and funded by the Department for International Development, has been published as a briefing paper (and is on the web at www.ohe.org).

The purpose of the conference was to locate and promote the role of health economics in mental health policy in low- and middle-income countries. Health economists have a growing voice in health policy development. But just as it is only recently that mental health policy specifically has been highlighted on the global stage, with the WHO's 2001 *World Health Report*, so too has the economics of mental health only comparatively recently started to claim attention on the global policy stage.

The conference brought together approximately 100 economists, health professionals and policy makers from a great many countries. The participants heard and discussed presentations from prominent practitioners in the field of mental health economics and policy in a global context. Highlights from those presentations and discussions are set out in the briefing paper. Together, they amount to a primer in mental health economics and policy in low- and middle-income countries.

Information supplied by Professor Rachel Jenkins

The second annual conference of the British Pakistani Psychiatrists Association (BPPA)

The conference was held in Watford in October 2003 and had delegates from the UK, the USA and Pakistan. Representatives of the British Indian Psychiatric Association, the British Sri Lankan Psychiatrists Association and the British Arab Psychiatrists Associations also attended.

Dr Mateen Durrani (BPPA Secretary) welcomed the delegates. The keynote address was followed by an address from the President of the Royal College of

Psychiatrists, Dr Mike Shooter. The chairperson of the BPPA, Dr Akmal Makhdum, presented his report on the progress of the organisation during the past year.

On the first day, chaired by Professor Bhugra, interesting and original scientific papers were presented by Dr Atif Rahman, Dr Safi ullah Afghan and Dr Ahmed. Dr Rahman presented results of his project from rural areas of Pakistan on maternal mental health and its effect on the newborn's physical health. Dr Afghan discussed the economic evaluation of mental health needs in developing countries. Other eminent speakers in this session were Professor Allan Young and Professor R N Mohan.

The second day of the conference was dedicated to trainee members of the BPPA. Issues related to the MRCPsych examination, job interviews and the preparation of a curriculum vitae were discussed. Special interest was expressed by participants in the research session for psychiatric trainees.

A well attended banquet and musical evening were also witnessed by Dr Maleeha Lodhi, High Commissioner of Pakistan to UK, and Dr and Mrs Mike Shooter.

The BPPA will meet again in 2004 in London.

Report prepared by Dr Tayyeb Tahir

Early interventions in psychosis

Early interventions are now a focus of international attention and the next international conference on this topic, in Vancouver in September 2004, will highlight continued advances in the full spectrum of biological, epidemiological, psychological and sociological research into early psychosis, with the aim of translating the new evidence into clinical advances that will enhance prevention, care and recovery, and into the necessary changes in mental health care delivery internationally. See 'Forthcoming international events'.

Jean Delay Prize

The Jean Delay Prize is the most important award of the World Psychiatric Association (WPA). Jean Delay was the President of the first World Congress of Psychiatry (Paris, 1950) and the first President of the Association. He introduced chlorpromazine in the treatment of psychotic disorders and was the first to describe the antidepressant effect of isoniazide, both in 1952. Jean Delay was a great scientist and humanist. He was followed by very eminent disciples, such as Pierre Pichot, Pierre Denicker and Raymond Sadoun.

The Jean Delay Prize is awarded to any individual who has made a major contribution to the biological, psychological or social aspects of psychiatry or to building bridges between them.

The prize consists of a diploma, a medal and a cheque for €40 000 and the awardee has to commit him-/herself to deliver a plenary lecture at the World Congress

of Psychiatry. Nominations for the 2005 Prize must be returned by 1 November 2004 and can be found on the WPA website (www.wpanet.org).

Previous winners have been Sir David Goldberg (UK) (1999) and Hagop Akiskal (USA) (2002).

The Sri Lankan Forum on Mental Health in Old Age

The Forum was launched as a collaborative project in August 2003, at the South East Asian Psychiatric Conference, as a partnership between the Department of Health, medical faculties, the Sri Lanka College of Psychiatrists, the Royal College of Psychiatrists in the UK and governmental organisations. The aims of the Forum are to promote positive mental health, to promote awareness of mental illness, to support all training initiatives and to develop a comprehensive high-quality mental health service for older people and their carers.

The demographic changes in Sri Lanka closely mirror what has happened in the UK in the past quarter of a century. At present there are no specific services for the elderly. Dr T. Elliott, Member of the Faculty of Old Age Psychiatry in the UK, Dr B. Somasunderam, Chairman of the Sri Lankan Psychiatric Association UK and I as Chairman of the Forum will be leading the work over the next 5 years on a voluntary basis.

*Report prepared by Pearl Hettiaratchy OBE FRCPsych
email pearlhet@globalnet.co.uk*

Medicinal plants in psychiatry

An international conference on the use of medicinal plants in psychiatry was held in Brazil in December 2003. This was the first conference on this particular issue and was very well attended by psychiatrists, pharmacologists and other mental health and health care professionals. The organiser was Professor Elisaldo Carlini. For many centuries medicinal plants have been used in medicine and psychiatry and there is continuing use in many parts of the world, although data are lacking on their effectiveness. The conference examined this and many other related issues.

VSO placements for consultants

A mental health unit in Sri Lanka, which already has an occupational therapist and a psychiatric nurse, is seeking senior medical support under the auspices of VSO. The unit would like one 6-month volunteer for September 2004, followed by another for a further 6 months. This may be an attractive opportunity for retired consultants. Applications/enquiries should be made to: margaret.english@vso.org.uk

These placements are in addition to 1-year Fellowships currently available for specialist registrars in psychiatry (approved for training).

Forthcoming international events

1–6 May 2004

American Psychiatric Association Annual Meeting
New York, USA.
Contact: apa@psych.org.
Website: www.psych.org.

27–29 May 2004

International Conference on Education and Promotion in Mental Health

The annual conference of Mental Health Europe.
Ljubjana, Slovenia.
Contact: Mental Health Europe, Boulevard Clovis7, B-1000 Brussels, Belgium.
Tel: +32 2 280 0468.
Email: info@mhe-sme.org.

10 June 2004

Poder de la Resiliencia en el Desajuste Social Actual.

WPA Section on Mass Media and Mental Health in collaboration with Hospital Psiquiatrico Jose T. Borda. Buenos Aires, Argentina.
Contact: Dr Miguel A. Materazzi.
Email: materazzi@arnet.com.ar.

25–27 June 2004

XVIII Peruvian Psychiatric Congress and III Regional Meeting of the APAL

WPA co-sponsored conference.
Lima, Peru.
Contact: Dr Elard Sanchez Tejada.
Email: app@amauta.rcp.net.pe.

26–27 June 2004

The Great Partnership

Joint conference of the British Indian, Pakistani, Arab and Sri Lankan Psychiatric Associations. These associations together have a membership exceeding 700 and the opening theme of the conference is therefore 'Mainstreaming'.
NEC Hilton Metropole, Birmingham, UK.
Contact: Dr M. Akmal Makhdum, Chair, British Pakistani Psychiatrists Association and Co-chair, Joint Steering Committee.
Email: makhdum@ntlworld.com.

6–9 July 2004

Caring for the Carers: Royal College of Psychiatrists Annual Meeting

International Centre, Harrogate, UK.
Contact: College Conference Office.
Tel: +44 (0)20 7235 2351 ext. 142.
Fax: +44 (0)20 7259 6507.
Email: mbraithwaite@rcpsych.ac.uk.

4–8 August 2004

Solidarity/Moral Displacement

Stockholm Group Conference on Social Issues (International Association of Group Psychotherapy).
Email: Soci2004@hotmail.com.
Website: www.psykoterapisallskapet.se.

4–8 September 2004

16th International Congress on Addiction

Center of Interdisciplinary Addiction Research, Hamburg University, with the Medical University of Vienna.
Vienna, Austria.
Contact: Dr Alexander Friedman.
Email: information@addiction.at.

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.

20–23 September 2004

South African Society of Psychiatrists (SASOP), XIII National Psychiatric Congress
Drakensberg, South Africa.
Contact: Dr Ian Westmore.
Email: westmore@shisas.com.

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.

7–10 October 2004

Mental Health Perspectives in Public Health Conference

WPA co-sponsored conference. Armenian Association of Psychiatrists and Narcologists.
Yerevan, Armenia.
Contact: Dr Armen Soghoian.
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 World Association for Social Psychiatry

The Japanese Society of Social Psychiatry in collaboration with the WHO.
Kobe, Japan.
Contact: Dr Yoshiyumi Nakane.
Email: yonakane@net.nagasaki-u.ac.jp.
Website: www.congre.co.jp/18wasp.

28–31 October 2004

XI Scientific Meeting of the Pacific Rim College of Psychiatrists, Hong Kong

Contact: Meeting Secretariat, c/o Meeting Planners International (HK) Ltd, 22/F, Pico Tower, 66 Gloucester Road, Wanchai, Hong Kong.
Tel: +852 2509 3430.
Fax: +852 2667 6927.
Email: PRCP@mphk.com.

2–3 December 2004

Regional Conference on Psychotraumatology

Jointly organised by the European Society for Traumatic Stress Studies and the Turkish Neuropsychiatric Association.
Istanbul, Turkey.
Contact: Professor Sahika Yuksel (local organising committee).
Email: sahikeyuksel@turk.net.

12–15 January 2005

Facing the Challenges, Building Solutions

WHO Ministerial Conference on Mental Health. An invitational conference of all 52 member states in the WHO European Region and of selected organisations.
Contact: Mental Health Programme, Regional Office for Europe, Scherfigsvej 8, DK 2100, Copenhagen, Denmark.
Fax: +45 39 17 18 65.
Email: jke@euro.who.int.