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EDITORIAL

Rational prescribing of psychotropic medicines

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The progressive development of effective psychotropic medicines over the past 50 years has undoubtedly revolutionised the care of people with a mental illness, so that they now have a very important role in modern health care. Increasingly, however, concern is being expressed in a number of countries about the excessive use of these medications (International Narcotics Control Board, 2001, 2004).

It is perhaps worthwhile to analyse why the increasing use of psychoactive drugs arouses so much concern among the public when the increased prescription of non-psychoactive drugs rarely provokes such strong reactions. The difference in response arises predominantly because the symptoms for which psychoactive drugs are prescribed – such as insomnia, depression, anxiety and inability to cope – often result from underlying personal or social problems rather than from a recognised medical condition (Fombonne *et al*, 1989). Thus, medical professionals, and particularly psychiatrists, find themselves providing a pharmacological response to non-medical problems. This situation has profound implications for society as a whole, and leads to a deep unease, which is exacerbated by the knowledge that these drugs are associated with a number of ill effects, some long term.

The validity of such concern is highlighted by the different treatment practices in different countries. For example, the consumption of central nervous stimulants is on average ten times higher in the USA than in European countries, whereas the consumption of benzodiazepine-type sedative hypnotics and anxiolytics in Europe is three times higher than that in the USA. Even within the European Union, despite efforts to harmonise prescribing policies, the consumption of benzodiazepines in France was for many years more than twice that in Germany or Norway (Ghodse, 2003).

Such large discrepancies in use in different countries can hardly be explained away by different prevalence rates of mental illness, and other reasons must therefore be sought. These include the economic and social conditions in a country, together with the importance accorded to health care, the availability of medicines in general and the effective functioning of regulatory control. Most low- and middle-income countries, for example, lack the resources and expertise required to determine medical needs and to adjust drug supply accordingly. At the same time, newly gained wealth in countries experiencing rapid economic growth is often associated with rapidly increasing drug consumption. Thus, the 'pill-popping' culture of many countries in the developed world is spreading fast to developing countries (International Narcotics Control Board, 2001).

Excessive reliance on pharmacotherapy is often associated with polypharmacy, that is, the use of multiple drugs, often in irrational combinations, at inadequate dosages and for excessively long periods. This is contrary to the principles of rational, evidence-based therapy and cannot be cost-effective. The medical profession (particularly psychiatry) bears an important responsibility to prescribe appropriately; in this light, national medical associations and other professional bodies have, in the past, undertaken useful initiatives to promote good practice.

The pharmaceutical industry is equally important in curbing excessive drug consumption and most manufacturers exhibit responsible and ethical behaviour in the promotion of all medicinal products. None the less, certain psychotropic medicines continue to be promoted even when better treatment options are available. In addition, direct financial support is provided to associations and other advocacy groups by drug manufacturers, which also disseminate promotional material for certain psychotropic drugs. Furthermore, contrary to the provisions of the 1971 United Nations Convention on Psychotropic Substances, some of these drugs are directly advertised to the consumer.

Despite all this, the role of the individual prescribing clinician is of paramount importance. A well-founded therapeutic decision is based on a good clinician–patient relationship, accurate assessment and diagnosis by the clinician, and careful consideration of the available

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therapeutic options, including the expected benefits and risks. The clinician–patient interaction involves responsibilities on the part of both, the extent of which is influenced by the culture of the country in question. In an age of wider access to health-related information, of 'concordance' and of joint decision making, the patient is seen as an increasingly important contributor to the entire therapeutic process and it is hoped that this 'therapeutic alliance' will improve compliance with treatment (Ghodse & Khan, 1988; International Narcotics Control Board, 2001).

In the midst of concern about the excessive use of psychotropic drugs, it is easy to ignore or forget the important facts about their therapeutic usefulness. However, the scientific evaluation of a drug should not be influenced by attitudes and value judgements, and psychotropic drugs should be assessed using the same tests and standards that are applied to non-psychotropic drugs. Within this context it is important to remember that a lack of appropriate drugs deprives patients of their fundamental right of relief from suffering. At the same time, excessive use and over-medication leads to suffering of a different kind. The problem is that there is no universal consumption standard for psychotropic medication and no country or even region can be held up as an example of best practice.

The prescription of psychotropic medicines may be inappropriate if it is: uninformed; inconsistent or lax; knowingly done for misuse of the drug by the patient; for self-administration. The underlying causes of such behaviour appear to be: inadequate training; shortage of information; lenient or lax attitudes; lack of sense of professional responsibility; unethical behaviour; personal drug addiction; criminality or corruption (Ghodse & Khan, 1988).

Psychiatrists can and should play an important role in educating doctors and other health care professionals as well as the public at large to achieve a culture of rational prescribing of psychotropic medicines. However, there is a wide range of policy makers, including government, health authorities, universities, postgraduate colleges, medical professional organisations and the pharmaceutical industry, all of which have an important influence on the education of health care professionals and so must also acknowledge and implement their collective responsibilities in this area.

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THEMATIC PAPERS – INTRODUCTION

Patient satisfaction with psychiatric care

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We are enjoined nowadays to be ever more cognisant of the views of patients about the care they receive, in all forms of health service. From the point of view of psychiatry, there is a small but growing literature on this subject and we have three opinions from around the world in this issue. First, Australian colleagues from psychiatric nursing (Brenda Happell and Monica Summers) surveyed patients with mental health problems who attended an accident and emergency department. One important issue, which is reflected in many such departments around the world, is the length of time spent waiting for an assessment. Despite the fact that a triage process was available, which presumably did increase efficiency, the wait was too long for many clients, who left before being seen. (Most had attended after self-harming behaviour.)

A second article, from the United States, also from colleagues in psychiatric nursing (Patricia Howard *et al*) considers patient satisfaction with the quality of service received, and with treatment outcomes, in public sector psychiatric hospitals. Increasingly, the quality of care provided is being measured, in part, by how satisfied patients are with it. We anticipate these considerations will soon motivate care widely in the developed world. Noting that the majority of patients in this survey had been involuntarily confined, it is fascinating to learn what they felt had been the greatest sources of satisfaction during their confinement (mainly the opportunities to talk to other patients and to staff). The sources of dissatisfaction appear to be related to a failure of staff to listen sufficiently carefully to the needs of the patients.

Finally, we have a survey from the Swedish health care system. Håkan Johansson points out that there is a structural problem with the very idea of measuring satisfaction. Outcome measures vary from survey to survey, and there is no clear relationship between satisfaction with care and treatment outcomes. The style of this survey was quite different to that of the previous two, for

it was essentially qualitative in character. The patients who were most satisfied with the care they had received were those who were able to form a warm, empathic relationship with staff, whether this was in an out-patient or an in-patient setting. There was a fascinating dissonance between the perceptions of patients, for whom time was elastic and who wished to have more contact with staff, and the availability of those staff.

These three reviews, covering aspects of care from attendance at an emergency clinic to involuntary admission, recognise that there are many sources of patients' satisfaction with their care, especially in the domain of patient–staff relationships. They also bring to our attention the continuing need to consider the most appropriate structural arrangements for the provision of psychiatric care.

There was a fascinating dissonance between the perceptions of patients, for whom time was elastic and who wished to have more contact with staff, and the availability of those staff.

THEMATIC PAPER – PATIENT SATISFACTION WITH PSYCHIATRIC CARE

Satisfaction with psychiatric services in the emergency department

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The move to provide psychiatric services within the general health care system has resulted in emergency departments becoming the means of access to acute psychiatric care in Australia (Gillette & Bucknell, 1996). Triage within the emergency departments ensures that patients are reviewed and treated in a timely manner, in accordance with the urgency of the presenting problem. The National Triage Scale was developed as a clinical tool for this purpose for use in Australia and New Zealand (Australasian College for Emergency Medicine, 1994). However, this scale tends to attach lower priority to psychiatric issues (Smart *et al*, 1998).

The implications for the triage of psychiatric clients are significant. The available research suggests that nurses do not consider themselves to have the skills and experience or the appropriate facilities to meet the needs of psychiatric clients (Gillette & Bucknell, 1996; Putman, 1998; Bailey, 1998; Crowley, 2000). This has reportedly resulted in increased waiting times, with the result that many clients leave the emergency department before being seen (Gillette & Bucknell, 1996; Bailey, 1998; Putman, 1998, Smart *et al*, 1998; Crowley, 2000).

A comprehensive evaluation of psychiatric clients' perceptions of and satisfaction with the services offered by emergency departments has not been conducted in Australia to date. This information is crucial for future service planning. The current research project was initiated in order to determine the level of satisfaction with the services provided and to identify areas where further development or improvement is required.

Method

The results presented are based upon secondary analysis of data collected as part of a study conducted in the emergency department. The primary study focused on clients presenting following an episode of deliberate self-harm; however, contact details were collected for all clients assessed by psychiatric service staff in the emergency department over 6 months. The complete sample has been included in this study.

Emergency psychiatric staff assessed a total of 276 clients during the 6 months of the study. Telephone contact was made with 180 clients within 3 weeks of their presentation at the emergency department, following consultation with the psychiatric team. Ninety-five clients could not be contacted and one declined to participate in the interview.

Telephone interviews were conducted by a registered psychologist (who had not interviewed the client at the time of presentation) using a semi-structured interview schedule designed to elicit information on what was helpful and what was not helpful, and to encourage feedback that could improve the service provided by the emergency department. Data were coded and entered into a Microsoft Excel database. Data were primarily analysed to produce descriptive statistics.

Results

The diagnosis was recorded for all 276 of the psychiatric clients. The most frequent causes of presentation were adjustment disorder (22%), depression (21%), psychotic disorder (20%), personality disorder (16%) and

The move to provide psychiatric services within the general health care system has resulted in emergency departments becoming the means of access to acute psychiatric care in Australia.

substance misuse (8%). Other causes included delirium, post-traumatic stress disorder and anxiety disorders (13%). Of the clients assessed by emergency psychiatric services, 39% (n = 108) had had prior episodes of self-harming behaviour.

The results from the telephone interviews indicated a high level of satisfaction with the service provided by the emergency psychiatric staff. All participating clients reported the staff to be easy to talk to and considered interactions to be helpful, while 93% felt that the staff listened to their problems and 94% felt they received relevant information from the staff. In addition, 97% considered the staff to be professional in the manner they dealt with them.

When clients were asked what could have been done to improve the service offered in the emergency department, most of their comments related to the triage process. Three clients suggested that a separate window for psychiatric clients would be helpful because of the pace of activity and the level of noise in the emergency room. These clients reported that they experienced considerable discomfort in imparting personal and health-related information regarding their presentation to the triage nurse. Six clients indicated a preference for dealing with staff with a psychiatric background.

Waiting time was another area of concern to participants. The clients described lengthy periods of waiting before being seen (up to 9 hours). Responses from some clients called into question the sensitivity of some non-psychiatric emergency staff. This involved, for example, not regarding the client as a 'whole person', laughing about him or her, and making offensive comments they did not expect the patient to be able to comprehend.

Discussion

The responses from this study suggest the majority of clients were satisfied with the emergency psychiatric services provided, particularly in terms of receipt of information, the professionalism of the psychiatric staff and the way in which their problems were listened to. The most unhelpful aspects were reported to be lengthy waiting times, inappropriate treatment or comments made by emergency department staff and environmental factors such as noise and lack of privacy.

It could be argued that, since overall satisfaction was high, the service provided is adequate. However, the negative factors articulated are significant and must be addressed to improve the quality and responsiveness of the service. The current process for the triage of psychiatric clients was identified as a major issue.

The triage process in the emergency department is the basis upon which available resources are allocated according to clinical urgency (Smart *et al*, 1998). The National Triage Scale generally used in Australia (Australasian College for Emergency Medicine, 1994) focuses primarily on physical illness and consequently has not catered well for clients with a primary psychiatric problem. Consequently, there are few guidelines to assist emergency nurses to triage clients with psychiatric illness.

The inappropriateness of the National Triage Scale for the assessment of psychiatric clients was the focus of a study by Smart *et al* (1998). The authors trained emergency nurses in the recognition of presenting psychiatric problems and to designate a category of urgency using specifically designed mental health triage guidelines. The emergency nurses were also trained to facilitate a non-threatening environment, in interview methods and in mental state examinations. The research suggested that appropriate training can improve the quality of care provided to psychiatric clients in an emergency department. Recognition, during triage, of the signs and symptoms of mental illness assisted in assigning an appropriate triage category, subsequent referral to psychiatric services and the delivery of optimal care. It should also decrease waiting times. The degree of training provided as part of this study means it is unlikely that the mental health triage guidelines alone were responsible for improved outcomes. It is likely that the provision of an efficient and responsive triage system will require the training of emergency department staff in mental health issues.

Fundamental to the National Mental Health Policy of Australia (Australian Health Ministers, 1992) was the desire to provide a comprehensive mental health service. The move to provide psychiatric services within the general health system has been crucial to the implementation of this policy, as it should increase the accessibility of psychiatric services and reduce the stigma associated with their use. An effective triage process is an essential component of an effective and responsive service.

The study findings also reinforce the importance of the presence of expert psychiatric practitioners within emergency departments. This supports the contention of McEvoy (1998) that a psychiatric nurse consultant should be considered a core service requirement for emergency departments.

The study findings also reinforce the importance of the presence of expert psychiatric practitioners within emergency departments.

The authors would like to acknowledge the invaluable contribution of Ms Caroline Driscoll, Psychologist. Caroline designed, implemented and coordinated the research project from which the data are drawn. We are grateful to her generosity in allowing us to use her data to conduct this secondary analysis.

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Patient satisfaction and treatment outcomes as quality indicators for mental health services

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In the United States, the patient has emerged as the central focus in evaluations of mental health services (Buckley, 1993). Whereas evaluation research in the 1980s emphasised the structure and process of mental health care, current evaluation research incorporates client-based measurements of treatment outcomes, such as symptom reduction, functional status and quality of life (Chisholm *et al*, 1997; Campbell, 1998). In addition, patient satisfaction with mental health services is increasingly used as an outcome dimension and an indicator of service quality (Center for Mental Health Services, 1996; Teague *et al*, 1997; Howard *et al*, 2003).

The purpose of this study was to investigate patient perspectives on service quality, satisfaction with services and mental health treatment outcomes in two public-sector psychiatric hospitals in a south-eastern state.

Method

A simple survey design with a non-random sampling technique was used at two hospitals (designated 1 and 2 below). The sample consisted of eligible patients admitted during the study period who agreed to participate in the study. Inclusion criteria were:

- 18 years of age or older
- currently hospitalised
- identification by the treatment team as being symptomatically stable and near discharge from the hospital.

Exclusion criteria were:

- inability to give informed consent
- physical condition that precluded participation
- forensic classification.

Data collection

Research associates collected data at both hospitals. The research associates had received mental health services but were stable and living in the community at the time of the study. Inclusion of those who had received services in the role of data collectors enhanced the validity of the study findings (Howard & El-Mallakh, 2001). At hospital 1 the research associates were supervised by graduate students from the sponsoring university's College of Nursing, and at hospital 2 by the risk management staff and patient advocate.

Sample characteristics

A total of 215 patients participated in the study: 107 participants from hospital 1 and 108 from hospital 2. Of these, 204 were acceptable for analysis: 103 from hospital 1 and 101 from hospital 2. The majority of the 204 respondents in the sample were male (60.8%); 84.8% were European–American and the remainder were African–American. The mean age of the participants was 37.4 years (s.d. = 11.1). The most prevalent psychiatric diagnoses among respondents were major depression (42.7%), schizophrenia (25.0%) and substance misuse (11.8%). Less frequent psychiatric diagnoses included delusion/other psychoses (4.9%), Alzheimer's/organic brain disorders (3.9%), impulse control disorders (3.4%) and anxiety disorders (2.5%). The majority of participants (63.7%) were admitted to the hospital on an involuntary basis.

Instruments

Study instruments included the 19-item Kentucky Consumer Satisfaction Instrument (KY–CSI), the 21-item Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, the 8-item Consumer Satisfaction Questionnaire (CSQ–8) and the single-item Quality of Mental Health Care (QMHC) instrument. The KY–CSI is a multi-dimensional scale that measures respondents' satisfaction with the physical environment of care, affiliation with staff, family and other patients, and goal attainment/self-actualisation (Howard *et al*, 2001). One additional item questions whether the respondent would return to the facility if mental health services were needed in the future. The MHSIP Consumer Survey is a multi-dimensional scale that measures perceptions of access to care, appropriateness of mental health services, outcomes of treatment and general satisfaction with services (Ganju, 1999; Center for Mental Health Services, 1996). The CSQ–8 measures global satisfaction with health services (Attkinson & Greenfield, 1996). The single-item QMHC measures respondents' overall perception of the quality of mental health care; response choices range from 0 ('worst possible care') to 10 ('best possible care').

Patient satisfaction with mental health services is increasingly used as an outcome dimension and an indicator of service quality.

The research associates had received mental health services but were stable and living in the community at the time of the study. Inclusion of those who had received services in the role of data collectors enhanced the validity of the study findings.

Despite the current emphasis on patient-driven care in the United States, the findings suggested that respondents did not have input into their treatment planning. In addition, lack of education about medications and treatment side-effects are cause for concern when coupled with the lack of involvement of family and friends in the process of treatment planning.

Data analysis

Univariate analysis was used to calculate means and standard deviations for continuous variables, and frequency distributions for categorical variables.

Results

All the satisfaction scales demonstrated relatively high mean values when averaged across respondents. For example, the QMHC item, which measured respondents' perceptions of the overall quality of their care, had an average score of 7.7 out of a possible score of 10. For items on the KY–CSI and MHSIP, 70% or more respondents indicated that they were satisfied with the services they had received during their hospital stay. The areas of greatest satisfaction were the time available to be with other patients (94%) and the cleanliness of the facilities (92%). In addition, staff–client relationships were a major source of satisfaction among respondents. Staff were reported to be available to speak with patients by 83% of respondents and 85% said they were comfortable talking to staff about their problems. Most respondents (86%) reported that staff provided them with the information they needed to 'take charge' of their illnesses, and 84% said they received the services that they needed to get better. The majority of respondents (87%) indicated that they understood what was expected of them during treatment, and that they perceived that staff had confidence in their ability to grow, change and recover (86%). Furthermore, 84% of respondents reported that they felt better about themselves as a result of treatment.

Despite the overall high ratings of satisfaction, up to 20% of respondents reported some dissatisfaction with the services they received. For example, on the KY–CSI, 16.3% indicated that they would not return to the facility if they needed services in the future. Similarly, on the MHSIP, 19.6% of respondents indicated that if they had other options, they would not choose this health plan in the future. On the KY–CSI, 13.8% of respondents reported that they did not receive medication education.

Treatment planning issues were a source of dissatisfaction for some respondents. Nearly 14% reported that staff did not ask them what they thought would help them get better, and 16.8% indicated that they did not feel free to complain. In addition, 16.8% of respondents indicated that their family and friends were not included in treatment planning. The physical environment was also a source of dissatisfaction; for example, 11.8% of respondents perceived a lack of privacy in the in-patient setting. Respondents also reported dissatisfaction with access to care; for example, 17.3% indicated that the location of services was inconvenient.

The need for patient-driven care

In general, the degree of satisfaction with mental health services appeared to be quite high. The findings suggested there had been a therapeutic, trusting and reciprocal relationship between staff and respondents. In addition, respondents reported high levels of satisfaction with staff–client relationships, staff availability and their ability to talk to staff members about their problems. Given the high degree of satisfaction with staff–client relationships and delivery of needed services, it is not surprising to find that the majority of respondents felt better about themselves as a result of treatment.

However, some items related to service dissatisfaction are noteworthy. Despite the current emphasis on patient-driven care in the United States, the findings suggested that respondents did not have input into their treatment planning. In addition, lack of education about medications and treatment side-effects are cause for concern when coupled with the lack of involvement of family and friends in the process of treatment planning (Howard *et al*, 2003). When patients and their carers do not understand treatment, or do not know about the side-effects of medication, recovery is compromised and the consumer is at risk of relapse and readmission to hospital. Finally, the findings about areas of dissatisfaction raise questions about a continued emphasis on the provider's, rather than the client's, perspectives in the process of making decisions about the client's plan of care.

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Patients' opinions of psychiatric care: a Swedish study

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Over the past few decades, health care as a whole and psychiatry specifically have evolved as a result of various societal influences. Quality assurance, evidence-based treatment and patients' satisfaction with care are all examples of such trends. In Sweden, the patients' satisfaction with care has become the concern both of researchers and of mental health care administrators. This may be a result of changed social norms and of the relatively recent apprehension of patients' wish to participate in their own health care.

There is a documented, although weak, relationship between satisfaction with care and treatment outcome (Priebe & Gruyters, 1995; Ries *et al*, 1999). However, although in surveys patients routinely record high levels of satisfaction with mental health services, non-compliance with treatment continues to be a major problem (Ries *et al*, 1999; Webb *et al*, 1999). There also seem to be problems with the concept of patient satisfaction and its assessment. Satisfaction is a vague term that can be operationalised in several ways and from different perspectives. It is unclear how satisfaction should be measured and studies have focused on very different aspects of it, such as the physical environment, waiting time, administrative routines, information, access to staff, attitudes of staff, and the relationship between staff and patients. Furthermore, different rating or survey instruments are often used, which makes the generalisation of findings problematic.

The Swedish study

The variability in the measures of satisfaction, the weak relationships between satisfaction and treatment outcome, and the paradoxical finding of satisfaction coupled with widespread non-compliance with treatment were the motives for a study conducted by Johansson & Eklund (2003). They investigated patients' subjective perspectives on what they considered to be good psychiatric care. It seemed important to understand more specifically the causes of high or low satisfaction. A qualitative research approach was used, based on in-depth interviews. The study was conducted in two typical Swedish psychiatric settings, one for out-patients (who had depressive or neurotic or personality disorders) and one for in-patients (who had various psychoses). These settings were selected to reflect the different types of care for different kinds of patients, provided by a variety of staff.

The need for understanding relationships

Although all patients and staff were selected to form a heterogeneous sample, the results clearly revealed one common main theme in what constitutes good psychiatric care, namely the establishment of a helping relationship, such that the patients felt understood by the staff. The ideal relationship was characterised by warmth, empathy and understanding, by a lack of pressure of time, and by the patient having a feeling of being provided for. The staff had to be able to enter into the patient's feelings and to understand his or her unique communication, problems and situation. Some sub-categories in establishing the helping relationship emerged.

Giving enough time

Giving enough time was important in two ways. First, patients needed enough time to open up and disclose their inner life and to express their situation. Second, it was important that the staff did not intervene too fast. This was true for medical and pharmacological as well as for psychotherapeutic interventions. Notable was that, according to the patients' perception, the staff were convinced that they needed to be efficient, but the patients did not share this belief. Instead, they wanted more time with staff. This is an important discrepancy, as there is a tendency towards fewer and shorter encounters between patients and staff in Swedish psychiatric practice, as there is internationally (Olfson *et al*, 1999).

Values, preconceptions and understandings

This factor concerned the idea that staff should not be governed by their own values, ideas and preconceptions of psychiatric patients, but should listen to the individual and base their actions on the patient's unique situation. Also, the patients believed that it was important for the staff to have approximately the same explanation and understanding of the patients' problems as they had themselves. This meant that the patients could discuss and influence their treatment, which in turn would allow the patients to keep some of their autonomy and independence.

Supportive psychosocial climate

Another important factor for the development of a helping relationship was that a supportive psychosocial climate should be present. Warmth, support, interest and engagement should characterise the relationships between patients and staff. This could be counteracted by, for

Satisfaction is a vague term that can be operationalised in several ways and from different perspectives. It is unclear how satisfaction should be measured and studies have focused on very different aspects of it.

Notable was that, according to the patients' perception, the staff were convinced that they needed to be efficient, but the patients did not share this belief. Instead, they wanted more time with staff.

example, staff avoiding eye contact, not remembering the patient's name, or reading the medical record while the patient was talking about his or her problems. The patients emphasised that they would not like to experience the staff as uninterested or unconcerned.

A high-quality therapeutic relationship is essential between all providers and patients: it is the essence of satisfaction with care and it determines the outcome of psychiatric treatment.

Ambivalence

The in-patient group expressed some ambivalence regarding the helping relationship. Some were disappointed with their contacts and longed for a much deeper relationship than the one they had with staff. At the same time, they expressed a fear of or rejected such relationships, preferring instead more distant contact. This ambivalence is probably due to the diagnosis (i.e. psychosis) and might be interpreted as a wish to be seen and a longing for complete contact, and at the same time a fear of closeness and of being rejected.

Meaningfulness

The in-patient group also experienced meaningfulness as a sub-category of the helping relationship. They expressed a wish to be perceived as meaningful themselves and that what they communicated was regarded as meaningful and understandable. Another aspect of meaningfulness related to what patients experienced while they were in hospital – that is, they wished to understand the meaning of different events and contexts.

Discussion

Whether the patients were satisfied or dissatisfied with the care they received, they all suggested that the quality of the relationships between the patient and individual members of staff (e.g. therapist), and being understood by the staff, were central to the quality of the care.

In the field of psychotherapy there is a long tradition of research concerning the determinants of outcome. It has been shown that psychotherapy in general is effective – and that there is little difference between various techniques or theoretical orientations (Wampold, 2001). As a consequence, the research has focused on what aspects of therapy are responsible for the outcome. A common research approach is to divide the factors that influence outcome into those specific to a particular therapeutic technique and non-specific or common factors (Lambert & Barley, 2002). The common factor that has generated the greatest interest in research is the therapeutic alliance, because its effect has been shown to be similar across various forms of treatments and it has consistently been shown that its quality is related to outcome (Horvath & Bedi, 2002).

The common factor that has generated the greatest interest in research is the therapeutic alliance, because its effect has been shown to be similar across various forms of treatments and it has consistently been shown that its quality is related to outcome.

The results from our study, where the focus was on patients' satisfaction with care and not on the therapeutic alliance, revealed a connection between the constituents of good care and the phenomenon of the helping alliance. The findings pointed to the importance of the therapeutic relationship within general psychiatric care. Results from other Swedish studies of patients' satisfaction with care (Bjoerkman *et al*, 1995; Samuelsson *et al*, 2000), as well as from studies from other parts of the world (Priebe & Gruyters, 1993; Olusina *et al*, 2002), point in the same direction. Moreover, research in general mental health services has shown that the quality of the therapeutic relationship has an effect on the outcome of treatment (Eklund, 1996; Priebe & Gruyters, 1993).

As it is well known from psychotherapy and general psychiatric research that the helping alliance is an important determinant of outcome, a conclusion must be that, in order to improve mental health services and therapeutic outcome, staff should incorporate psychotherapeutic principles in their work. A high-quality therapeutic relationship is essential between all providers and patients: it is the essence of satisfaction with care and it determines the outcome of psychiatric treatment.

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Psychiatry in Jordan

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Jordan, one of the most recently established countries in the Middle East, was part of the Ottoman Empire. It was declared a political entity known as Transjordan under the mandate of the British government in 1923, until it gained independence and was declared a Kingdom in 1946. In 1950, Transjordan and the West Bank were united and assumed the current name of the Hashemite Kingdom of Jordan. The next major change for the Kingdom came in 1967, when the occupation of the West Bank and Gaza Strip by Israeli forces caused a massive influx of migrants to the East Bank.

Jordan has a total area of 89 342 km^2 and a population of 5 329 000 (2002 statistics). The gross domestic product (GPD) per capita is US$1765. The illiteracy rate (among those aged over 15 years) is 10.3% (5.4% for males and 15.2% for females). Life expectancy at birth is 71.5 years and the infant mortality rate is 22.1 per 1000 births. The unemployment rate is 15.3%.

The Ministry of Health budget is 5.7% of total spending. There is one hospital bed for every 568 citizens and one psychiatric bed for every 9000. There is one physician for 600 citizens and one psychiatrist for every 75 000.

Evolution of psychiatric services

At the time of the British mandate in Palestine in 1915, all psychiatric services were obtained from Palestine. The only psychiatric hospital (in Bethlehem) was in Palestine. In the late 1950s a visiting psychiatrist from Bethlehem hospital used to attend an out-patient psychiatric clinic once a week. Three separate streams of evolution occurred subsequently, in the armed forces, in the Ministry of Health and in academic psychiatry.

Psychiatric services in the armed forces

In the early 1960s there was only one psychiatrist, who had been trained at the Maudsley Hospital in London. In 1966 a department of psychiatry was established within the main military psychiatric hospital, in Marka, Amman, the capital city. A graduate training programme was implemented, which was recognised by the British Medico-Psychological Association.

In 1973 the King Hussein Medical Centre was founded and its psychiatric department was established in 1975. However, in 1997 it was transferred to its original place in the Marka hospital; this was considered a setback and a failure on the part of medical administrators to understand the need for a multi-disciplinary approach to psychiatry.

Currently there are 12 qualified psychiatrists who run psychiatric services in the armed forces; most of them were trained in Britain.

Psychiatric services provided by the Ministry of Health

The need for a psychiatric hospital became apparent after the 1967 war with Israel, when the West Bank fell under occupation. In April 1987 the National Centre for Mental Health was established, with 300 beds. In addition, 150-bed hospitals were established for patients with chronic illness and for rehabilitation. Recently, a centre for the treatment of drug addiction was established, with 46 beds.

There are 30 out-patient clinics throughout the country, which are attended by 33 000 patients annually. There are currently only 8 psychiatrists providing this service, largely because neighbouring Saudi Arabia, which can afford to pay higher salaries, draws many health professionals away from Jordan.

Academic psychiatry

There are two medical schools in Jordan, at the University of Jordan, in Amman, and at the University of Science and Technology, in the town of Irbid in northern Jordan. Medical students undergo 1 month of training in the government psychiatric hospital in their 5th year. There is no psychiatric department at the University of Jordan, although there are two psychiatrists working at its out-patient clinic. Recently, the University of Science and Technology established a psychiatric unit (with 30 beds) in the newly built university hospital. Undergraduate and graduate programmes are being established.

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Psychiatric journals

The *Arab Journal of Psychiatry* is published biannually under the auspices of the Arab Federation of Psychiatrists. It is published in Jordan although it represents all Arab psychiatrists.

The private sector

There are 30 private psychiatrists who work exclusively in their own clinics. Psychiatrists in the public sector, described above, are not allowed to work privately. There is one psychiatric hospital, with 70 beds, which serves psychiatrists in the private sector.

Psychotherapy is being practised by some psychiatrists who were trained in specialised centres in the UK and USA, generally in the field of cognitive–behavioural therapy; psychodynamic therapies are not practised in Jordan.

Psychiatric treatments

Trends in psychiatric treatments in Jordan have run parallel to those in Britain, largely because many of the country's psychiatrists have trained in Britain since the early 1960s. Accordingly, tricyclic antidepressants, monoamino oxidase inhibitors and conventional neuroleptics were used. More recently, since the late 1980s, the new generation of antidepressants (e.g. the selective serotonin reuptake inhibitors) and novel antipsychotics have been extensively prescribed. Mood stabilisers, including lithium and various anticonvulsants, are available. Electroconvulsive therapy, abreactive techniques and hypnosis are also used. Psychotherapy is being practised by some psychiatrists who were trained in specialised centres in the UK and USA, generally in the field of cognitive–behavioural therapy; psychodynamic therapies are not practised in Jordan.

Group therapy, occupational therapy and rehabilitation are usually practised for in-patients.

Educational issues

The universities have their own undergraduate syllabus. Postgraduate teaching is accredited under the auspices of the Jordan Medical Council, which is the medical body that deals with all academic issues. The Council has a psychiatric division that steers the theoretical and clinical aspects of psychiatry. After a 4-year training programme, which covers basic sciences and clinical experience, the candidate sits the psychiatric board examination.

Professional body

The Jordan Psychiatric Association is a division of the Jordan Medical Syndicate. There are 60 registered psychiatrists.

Fields allied to psychiatry

Clinical psychologists, social workers and occupational therapists, in addition to psychiatric nurses, are part of the psychiatric teams in the psychiatric hospitals and departments. Generally speaking, there is always a lack of adequate staffing in all these fields, as in psychiatry. There is a Psychological Association run by psychologists, which is licensed by the Ministry of Health. Some members of the Association run clinics in the field of counselling psychology. Unfortunately, there is no collaboration with psychiatrists, at any level.

The Mental Health Act 2003

The Act provides for the compulsory admission of psychiatric patients, who include those with a drug addiction (to narcotics or psychotropic agents). It states the conditions for the admission and discharge of such patients. The following are notable sections.

Section 15

A general hospital can allocate a department for psychiatric patients provided that it has on its staff one or more psychiatrists, as well as the required numbers of resident doctors and specialised staff.

Section 16

Section 16A states that psychiatric patients may be admitted to either a psychiatric hospital or a psychiatric department of a general hospital either voluntarily or compulsorily in the following cases:

- if the patient or the addict needs treatment that is provided only at these facilities
- if the patient is causing harm to him/herself or others, whether this harm is physical or psychological
- if the patient or the addict is causing damage to property
- if a court of law so decides, in accordance with the medical evidence presented.

Section 16B sets out the following conditions for hospital admission (excepting the last, forensic case above):

- an application must be addressed to the hospital manager
- a medical report must be issued by a psychiatrist in support of the application addressed to the hospital manager
- the hospital manager (or whoever is authorised to act on the manager's behalf) gives approval.

Section 17

In the case of compulsory admissions, the Minister of Health can refer the patient to a psychiatric committee to examine the reasons for admission. Accordingly, the Minister can decide to discharge the patient or to prevent the patient's admission, except where the patient has been admitted as a result of a court hearing.

Section 18

The attending psychiatrist must discharge the patient after recovery, with the approval of the hospital manager. The patient's family should be notified about the date and time of the discharge. Where the patient was admitted as a result of a court decision, the court should be notified.

Research and publications

There are limited funds for research. No epidemiological research has been carried out so far in Jordan. Most research work is published locally in one of the two medical journals or in the one psychiatric journal, mainly for the purpose of career progression. The papers mostly address clinical and cultural issues.

Mental health strategy (1988)

The main goals are:

- the teaching of psychiatry to general practitioners and paramedical staff
- the extension of psychiatric services to all provinces of the country
- the appointment of counselling psychologists and social workers to all schools

- the incorporation of mental health services within primary health care.

A fair portion of this strategy has been implemented. For example:

- by 1995, 100 general practitioners had received training (with notable success), as had 60 paramedical staff
- psychiatrists now cover 36 health centres in Amman, and this programme has been extended to four other *muhafazat* (governorates)
- psychological counselling centres, staffed by social workers and psychology graduates, have been established in all the main schools in Jordan.

Cultural issues

Social stigma is quite strong in relation to psychiatric patients and treatments. Consequently, resort is often made to faith healers before or even after visiting a psychiatrist. There is great ignorance about psychiatry in all sectors of society: rich, poor, illiterate and educated. Stigma also affects the status of psychiatry among the other medical specialties. This has restricted progress in the delivery of psychiatric services.

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Website

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COUNTRY PROFILE

The mental health care system in Malta

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The Maltese Islands are located in the Mediterranean Sea and have a total area of 316 km². They consist of three inhabited islands – Malta (the largest of the group), Gozo and Comino – and two uninhabited islands – Filfla and Cominotto. Malta is a democratic republic. Since its independence in 1964, Malta has played a more significant part in international relations. It became a member of the Commonwealth, the United Nations, the World Health Organization and several other organisations. In May 2004, Malta also became a member of the European Union.

The organisation and delivery of mental health services, and access to them, are influenced by Malta's socio-cultural specifics. Most (98%) of the Maltese population is Catholic and the Church plays an influential role in Maltese society. It contributes to the Maltese perception of mental illness and its aetiology and consequences, as well as to the nature of presentation and the utilisation of services. It also affects the community support network and rehabilitation. The geographical proximity of the populace and the predominance of the extended family also play a significant role in the perception, nature and progression of mental illness.

Population

The population of the Maltese Islands in 2002 was recorded at 394 000. Since 1974, the population has grown linearly and in 2001 the natural population growth was estimated at 2.5 per 1000 population (World Health Organization, 2003). The total number of births in 2002 was 3805, giving a crude birth rate of 9.7 per 1000 population. In the same year, the total number of deaths was 3031, giving a crude death rate of 7.7 per 1000 population. The main causes of death among the Maltese population are non-communicable diseases, mainly circulatory disease and cancers. The life expectancy at birth in 2002 was 75.8 years for males and 80.5 years for females (National Statistics Office, 2003; Ministry of Health, 2004*a*).

The organisation of health care

The Maltese government provides a free national health service, for which the Minister of Health has overall responsibility. Residents receive comprehensive care, funded from general taxation (Ministry of Health, 2004*b*). The proportion of Malta's gross domestic product allocated to the health budget is 6.3%. Residents are not obliged to have health insurance in order to be entitled to health

Most (98%) of the Maltese population is Catholic and the Church plays an influential role in Maltese society. It contributes to the Maltese perception of mental illness and its aetiology and consequences, as well as to the nature of presentation and the utilisation of services.

Residents are not obliged to have health insurance in order to be entitled to health services, and those determined by means-testing to have a 'low income' and those suffering from chronic conditions (e.g. schizophrenia) are entitled to free drug treatment.

services, and those determined by means-testing to have a 'low income' and those suffering from chronic conditions (e.g. schizophrenia) are entitled to free drug treatment. Means-tested social assistance benefits are offered to some of those who have a mental health disorder, including those with severe learning disabilities, schizophrenia, certain neurological conditions (e.g. epilepsy) and substance misuse (World Health Organization, 2002).

Private health services run alongside the national health service. Private general practitioners as well as specialist practitioners offer community health services. There are three private hospitals on Malta.

Mental health resources

The provision of mental health care falls under the same organisational system as general health. Of the overall health care budget, 9% is allocated to mental health (World Health Organization, 2002). Most of the services are offered as part of the national health service, although private services also offer community specialist care. Two non-governmental organisations, the Friends of Attard Hospital Society and the Richmond Foundation, run alongside the public and private provision.

The Ministry of Health gives its mission statement as follows: 'to promote and provide for the health care needs of the Maltese people and to deliver appropriate services' (Ministry of Health, 2004*c*). The mental health policy aims to promote a healthy environment within Maltese society, and to empower individuals to cope better with mental health issues. The policy's objectives are to deliver a wide range of services, and to facilitate advocacy, promotion, prevention, treatment and rehabilitation (World Health Organization, 2002).

The public mental health service falls under eight consultant-led firms. In-patient facilities are offered at two sites: St Luke's Hospital, which has a short-stay psychiatric unit (with 11 beds); and Mount Carmel Hospital, which has beds for acute, rehabilitation and long-stay patients, as well as beds specifically for older people, children and adolescents and people with learning disabilities, and a forensic ward. Mount Carmel Hospital provides for 520 beds in total, accounting for 143.3 beds per 100 000 population (World Health Organization, 2003). When compared with other European countries, Malta has one of the highest numbers of psychiatric beds per 1000 population (World Health Organization, 2003). However, when considering the provision for acute admissions, each consultant firm is entitled to only four beds (two for men and two for women), which makes acute in-patient care difficult to access.

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Mount Carmel Hospital also offers para-clinical services, electroconvulsive therapy and a consultation–liaison service to other government hospitals. Community care facilities are offered at other sites and include:

- psychiatric out-patient facilities at St Luke's Hospital and Gozo Psychiatric Hospital, as well as within community-based health centres
- a child guidance clinic
- a clinical psychology service
- electroconvulsive therapy at the St Luke's site
- occupational therapy day services.

Other community care facilities include day centres, sheltered homes, long-stay hostels, respite centres and independent living, offered by both the governmental and non-governmental organisations, including the church. Community care, principally in the form of out-patient follow-up, is also offered by the private sector, by a psychiatrist or a general physician. Mount Carmel Hospital coordinates the overall mental health provision. Non-governmental organisations' main roles are advocacy, promotion and rehabilitation for individuals with mental illness and their families.

The eight consultant-led firms operate within all the mental health facilities; some teams offer some specialist care, depending upon the relevant consultant's training and special interests. For example, the team led by the consultant author offers specialist provision for eating disorders and sexual disorders, as well as general psychiatric provision. Fifty psychiatric nurses, eight generic occupational therapists, six generic social workers and four psychologists work alongside the eight consultants, with the aim of implementing a multi-disciplinary approach. In-patient and community care facilities also aim to function through holistic approaches, according to individual needs, which may involve engaging the whole family in treatment. However, partly because of the limited human resources, in-patient care still operates in a largely custodial manner. Similarly, a multi-disciplinary approach within community care facilities is limited, with provision mainly consisting of follow-up by a physician.

Provision for substance misuse falls under the Ministry of Family and Social Solidarity. Most of the substance misuse services are provided by a government-funded autonomous agency, the National Agency against Drug and Alcohol Abuse (Sedqa). The objective of the Agency is:

> '[to] plan and recommend developments and updates of the National Policy in the field of drug and alcohol abuse and to provide services in health promotion, prevention, treatment and rehabilitation to persons with drug and/or alcohol problems and to their families so as to help them live a stable life and to integrate better [into] society' (Sedqa, 1994).

The services principally employ a multi-disciplinary approach, and provide a range of treatment modalities, including out-patient and in-patient detoxification, community-based one-to-one as well as group psychosocial interventions, family therapy facilities and longer-term residential rehabilitation facilities. Other community-based provision includes prevention programmes and a parental skills programme (Bell, 1997; Bugeja, 2000). Acute provision for substance misuse, however, falls under the Department of Psychiatry within the main psychiatric hospital. A non-governmental organisation, Caritas, works alongside the National Agency; its main roles are prevention and community-based rehabilitation. The Department of Psychiatry also provides for psychiatric care within the criminal justice system.

Training

Basic undergraduate training in the field of psychiatry forms part of the MD curriculum. This is in the form of formal lectures as well as clinical placement within the various mental health facilities (University of Malta, 2003). Opportunities for postgraduate training in psychiatry include clinical placements at the levels of house officer (four posts) and senior house officer (seven posts), under the supervision of the consultant psychiatrists. Formal training in psychiatry leading on to full qualification as a psychiatrist is not provided in Malta and hence doctors must acquire formal training abroad.

The National Agency against Drug and Alcohol Abuse provides basic training in substance misuse for those involved in service provision. It also offers a 'Voluntary Action Training Programme' for leading figures in the community, to facilitate a preventive approach with youths (Bugeja, 2000).

Membership of the Association of Maltese Specialists in Psychiatry provides the specialist registration of psychiatrists. Following recent developments, all psychiatrists will have recognition and registration of their specialty only if they are approved by the Association. There is no specialist registration for the other disciplines.

Research activities

Mental health research activities are conducted by each consultant on some practical aspect of psychiatric care. The aim of such research is the improvement of psychiatric care and its delivery. Research projects are usually conducted over a 12-month period and are funded in part by the Merit Award Scheme. Other research activities are conducted by undergraduate and postgraduate students at the University of Malta.

Conclusion

Mental health services in Malta are tailored to the sociocultural needs of the population. Provision of care tends to be personalised and holistic, with specialist care being an integral part of general psychiatric care. The national health service and services provided by both non-governmental organisations and the private sector function together, which allows individuals to choose their preferred option of care, and it is easy to switch between each mode of provision. The number of beds available for acute admissions is insufficient for the population, despite the relatively high number of psychiatric beds per 100 000 population. This is likely to be a consequence of the custodial care approach employed and of ineffective community care. Although services have actively been trying to move away from institutionalisation to a more community-based setting, the limited number of fully qualified mental health professionals makes this move difficult. Investment in and upgrading of training and research among all disciplines would provide the basis for a more modern, community-based, multi-disciplinary approach to the delivery of mental health care.

Although services have actively been trying to move away from institutionalisation to a more community-based setting, the limited number of fully qualified mental health professionals makes this move difficult.

Formal training in psychiatry leading on to full qualification as a psychiatrist is not provided in Malta and hence doctors must acquire formal training abroad.

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COUNTRY PROFILE

The mental health policies of Trinidad and Tobago

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The Republic of Trinidad and Tobago is the most southerly of the Caribbean island states. Trinidad is just 14 km from the coast of Venezuela. Trinidad covers an area of 4828 km^2 while Tobago, the sister isle, has an area of 300 km^2. The total population is approximately 1.3 million; 40.3% of the population is of East Indian descent, 39.6% of African descent, 18.4% mixed

and 1.7% belong to other ethnic groups (Central Statistical Office, 2001). St Ann's Hospital in Port of Spain, the capital, was established in 1900 and is the country's only psychiatric hospital. There are two general hospitals, one in the north, at Port of Spain, and the other in the south, at San Fernando.

The per capita gross domestic product (GDP) is US$8948 and total health expenditure represents 5.2% of GDP. Life expectancy at birth is 67.3 years for males and 72.6 years for females; a healthy life expectancy at birth is projected at 58.9 years for males and 62.0 years for females. Adult mortality is 235 per 1000 population for males and 150 per 1000 population for females; the male child mortality rate per 1000 population is 24 and the female rate is 18 per 1000 population (World Health Organization, 2004). The literacy rate for males is 95.3% and that for females is 91.5% (World Health Organization, 2002).

The plan divided the country into five sectors, each serving a population of approximately 200 000. Multi-disciplinary teams were assigned to each sector and the regional hospitals were used for admissions. It was reported that a wave of excitement and enthusiasm engulfed all those involved, as it was felt to be the dawn of a new era in psychiatry in Trinidad and Tobago.

Early mental health policies (1848–1975)

Under British rule, the early treatment policies of the mentally ill in Trinidad paralleled the treatment of the insane in Britain. In 1848, an ordinance was passed to detain the criminally insane at the Royal Gaol. The Belmont Lunatic Asylum was established in 1858. The facility later transferred to the St Ann's Asylum, now renamed the St Ann's Hospital. For the following five decades, policies of treatment were custodial, with the use of malaria therapy for syphilis, insulin coma therapy, bromide mixtures, veronal and sulphonal, transorbital leucotomy, electroconvulsive therapy and immersion therapy in cold water.

The advent of chlorpromazine and the open-door policy of the 1950s heralded a period of aggressive treatment outside the hospital, with an emphasis on decentralisation and deinstitutionalisation as models of care. In that decade, two plans were also submitted: the Julien report of 1957 and the Lewis plan of 1959. In the latter, commissioned by the Ministry of Health, a recommendation was adopted for the creation of psychiatric units at the two general hospitals. In 1962, the Chan report recommended the subdivision of St Ann's Hospital into four autonomous units. However, this proposition received little attention.

The Sectorisation Plan (1975)

The Sectorisation Plan, adopted from the French model, was introduced in Trinidad and Tobago in 1975. The goals of this programme related to both community and institutional care. Its objectives were:

- to provide psychiatric care as near as possible to the patient's own home
- to upgrade the facilities of St Ann's Hospital, to reduce its size and to rehabilitate and return to the community the majority of its patients
- to introduce additional sub-specialist services (e.g. child guidance and geriatric services)
- to develop a system of consultation with the community, to ascertain their needs and their views
- to consult with community leaders of all sorts in the development of health attitudes and education programmes, aimed at prevention
- to integrate mental health care with general and public health care as far as possible
- to devise an effective system to evaluate this programme
- to provide in-patient psychiatric services for patients (a proportion of beds in each sector would be general hospital beds)
- to set up out-patient services – wherever possible at district health offices
- to establish day and night hospitals
- to develop geriatric services
- to establish rehabilitation services – halfway houses, sheltered workshops, industrial therapy units
- to organise preventive services (e.g. early identification and work with special risk groups).

The plan divided the country into five sectors, each serving a population of approximately 200 000. Multi-disciplinary teams were assigned to each sector and the regional hospitals were used for admissions. It was reported that a wave of excitement and enthusiasm engulfed all those involved, as it was felt to be the dawn of a new era in psychiatry in Trinidad and Tobago (James, 1984).

In June 1975, St Ann's Hospital was divided into four autonomous units and, together with the psychiatric unit at Port of Spain General Hospital, admitted patients from the five well-defined geographical areas (sectors). Patients from the city of Port of Spain and from Tobago were admitted to the General Hospital unit. The psychiatric unit at the San Fernando General Hospital formed an extension of one of the St Ann's Hospital units. Out-patient clinics were set up in each sector. This was supported by Mental Health Act No. 30 of 1975, which empowered mental health officers to treat patients. There are at present 75 out-patient clinics held monthly.

Towards the end of 1976, the initial enthusiasm of the Sectorisation Plan waned, as it became evident that the major objective of the programme, which was the decongestion of St Ann's Hospital and the treatment of patients in the community, was not being achieved. Adequate clinic facilities were lacking and no provision was made for hostels, halfway houses or sheltered workshops (James, 1984). Since 1975, there have been no major changes in community mental health in the Republic.

The regional health authorities

The Regional Health Authorities (RHA) Act No. 5 of 1994 led to the establishment of five health regions. This new policy proposed the realignment of the sectors to the RHA boundaries and a shift towards primary care. The RHA Act legislated for the decentralisation of all health services and the five regions were empowered to develop their own psychiatric services. This generated some concern, since the only mental hospital in the

country was situated in the North West Region and there was some ambiguity surrounding the allocation of human resources and infrastructure.

In 2000, the RHA Act was amended. The five regions were reduced to four, the Central Region being incorporated into the North West Regional Health Authority (NWRHA). The system is still in transition, as there are now two parallel administrative bodies, the Ministry of Health and the RHAs. In 2000, the psychiatric unit at the Port of Spain General Hospital was closed by the NWRHA and in 2003 the Ministry of Health aligned part of the Central Region to the South West Region.

A new mental health plan (2000)

Against the background of persisting problems with the mental health programme, the Trinidad and Tobago National Mental Health Policy and Plan was formulated by the Ministry of Health and the Pan American Health Organization (PAHO) in 1995 and approved by Cabinet in 2000. The two main goals of this programme were to encourage the development of the highest level of mental health and to promote an adequate level of individualised care for those who have a mental disorder (Ministry of Health, 2000). The objectives of this new plan closely followed those of the Sectorisation Plan of 1975 and are as follows:

- to educate the population regarding mental health and to promote healthy lifestyles
- to reverse negative perceptions about mental disorders
- to reduce the incidence of certain kinds of illnesses and disabilities
- to reduce mortality associated with certain kinds of mental disorder
- to provide adequate primary, secondary and tertiary care for persons with mental health problems, although with an emphasis on primary care
- to integrate mental health with general health services as far as possible
- to develop linkages with other governmental, non-governmental and consumer organisations
- to undertake evaluation, research and training for improvement of the mental health services.

The delivery of the mental health services will now be the responsibility of the RHAs, while the Ministry of Health will be involved in the formulation and evaluation of policies. The RHAs have also established a National Mental Health Commission (NMHC) and a Regional Mental Health Committee (RMHC) in every sector for the implementation of the National Mental Health Policy and Plan. These coordinating committees are expected to formulate and implement specific plans of action in mental health. The most important function of the NMHC includes the evaluation of the effectiveness and quality of services.

The following changes in the present system are proposed:

- St Ann's Hospital is to see a phased reduction in bed numbers, from 1026 to 600
- the Eric Williams Medical Complex will provide in-patient child psychiatry care
- four extended care centres will provide 30 beds – 10 for psychogeriatrics and 20 for rehabilitation
- San Fernando General Hospital will provide 30 beds for acute psychiatric care
- residential units of 125 beds will provide care for patients with low levels of dependency
- non-residential day care units and sheltered workshops will be established
- a 25-bed psychiatric unit will be reopened at the Port of Spain General Hospital.

Human resources are said to be the single most important component of the National Mental Health Policy and Plan. Multi-professional teams will provide services at primary, secondary and tertiary levels. The Plan proposes to have, in each region, at least one health facility that provides child guidance services, psychology services and occupational therapy. In addition, drug dependency services are provided at Caura and St Ann's Hospital.

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Training

In 1987 a 4-year programme of the DM Psychiatry was introduced at the University of the West Indies. To date, approximately 20 psychiatrists have graduated. Continuing medical education (CME) is ongoing and there is a proposal to make it mandatory.

Personnel

In 2001, there were 187 nursing aides and 1383 nursing assistants (Central Statistical Office, 2001). There are at present 7.92 psychiatric beds per 10 000 population in the only mental hospital and 0.24 psychiatric beds per 10 000 population in general hospitals. There are 22 trained psychiatrists, 6 psychiatrists in training and 23 psychiatric social workers.

Conclusion

Psychiatry in Trinidad and Tobago remains a unique blend of current scientific knowledge purporting a neurobiological basis of diseases and traditional practices based on superstition, religion and folk medicine (Maharajh & Parasram, 1999). Over the years, changes have been minimal. Mental health planning for culturally diverse and secular communities are difficult to construct and even more difficult to implement. Policies must be tailored to suit the needs of the population, with solutions for people with mental disorders in developing countries (Jacob, 2001). The planning and delivery of services must have a clear focus and vision, supported by both efficient legal machinery and a willingness on the part of government to invest in a rolling programme of service improvement. Patients' rights and regard for the individual's autonomy are imperative. This is indeed a tall order for a developing country.

> Psychiatry in Trinidad and Tobago remains a unique blend of current scientific knowledge purporting a neurobiological basis of diseases and traditional practices based on superstition, religion and folk medicine.

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SPECIAL PAPER

Postgraduate psychiatry training for global mental health: a Canadian experience

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As globalisation has diminished the distance between the developed and developing worlds, it has highlighted the impact of global health issues on domestic health concerns and has underscored the reality of global health disparities. In the Canadian context, there is a need for Canadian physicians to have an understanding of medicine from a global perspective and to appreciate and understand the impact of global health issues on both international and domestic health care. Consequently, there is a need to create and incorporate a global or international health curriculum into general as well as specialty physician training programmes. This will provide future physicians with the skills, knowledge and understanding necessary to provide globally informed practice in domestic as well as international health.

The global mental health burden

Training in and understanding of health issues from a global perspective is particularly relevant in the area of mental health. As the global burden of communicable diseases has decreased, mental illness has become one of the most common types of disabling disease worldwide (World Health Organization, 2001). Mental disorders are now estimated to account for 12.3% of the global burden of disease and this is predicted to reach 15% by 2020 (Desjarlais *et al*, 1995; World Health Organization, 2001).

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Advances in the understanding of biological, social and epidemiological determinants of mental disorders, the development of effective treatments and service delivery models, and the implementation of mental health legislation and policy protecting the rights of people with a mental illness in the developed world have not to date been translated into applications which can be used by the majority of the world's population. In low- and middle-income countries (LMIC) there continues to be a dearth of effective mental health services, insufficient dedicated resources and an absence of effective mental health legislation for, as well as stigmatisation, discrimination and human rights abuses of, people with mental illness (Desjarlais *et al*, 1995).

Over the past decade, international agencies, including the World Health Organization and the World Bank, have increasingly recognised the need to make global mental health an international priority. The focus of the 2001 World Health Day celebration and the 2001 *World Health Report* on global mental health is an example of the commitment to highlight the global significance of mental disorders and to promote mental health reform worldwide (World Health Organization, 2001).

A Canadian initiative

Canadian health training institutions have not kept pace with the increasing activities pertaining to global mental health. For example, in terms of physician training, there is currently no developed curriculum specifically focused on international mental health in Canadian postgraduate psychiatry training programmes. The growth of cultural diversity within the Canadian population has precipitated the development of a cultural psychiatry curriculum, which psychiatry residency training programmes across the

country have begun to use. However, this does not afford postgraduate trainees the knowledge or experience necessary to appreciate mental health in a global context. For this, a different model is needed.

In response to this gap in postgraduate training, the Dalhousie University Department of Psychiatry has created a programme entitled 'Living and Working in an LMIC' for senior psychiatry residents in Canadian universities. It is designed to facilitate physician understanding of mental health issues from a global perspective, by providing opportunities for residents to practise in an LMIC.

The programme began as a 3- to 6-month clinical elective experience in the Caribbean state of Saint Kitts and Nevis for Canadian senior psychiatric residents. Residents provided: clinical services in both in-patient and out-patient settings; mental health educational seminars for health professionals; and both mentoring and on-site teaching for mental health care staff. The goals of the programme for the residents who take part include the following:

- to gain an appreciation of the cultural beliefs, values and behaviours related to mental illness and emotional suffering
- to experience issues related to mental health within the context of a developing country
- to have exposure to psychiatry in an international context, which will create opportunities for the resident to become acquainted with mental health systems in LMICs
- to gain an appreciation of the global mental health issues faced in a different socio-cultural environment, such as the profound impact of stigmatisation and lack of mental health awareness on the provision of clinical care
- to gain an appreciation of the relationship between poverty and mental health
- to see the effect of the limited availability of resources on care for people with a mental illness.

The partnership between the Dalhousie Department of Psychiatry and the government of Saint Kitts and Nevis arose within the context of a long-standing relationship between the Dalhousie Faculty of Medicine and this eastern Caribbean nation. Since the inception of this relationship in 1999, the Dalhousie Department of Psychiatry has assisted the government in addressing mental health service needs for the islands. In this capacity, the department has performed a national mental health systems review, has developed and delivered a training programme in acute care psychiatric nursing and has established the 'Living and Working in an LMIC' programme for senior residents.

Saint Kitts and Nevis

Saint Kitts and Nevis are twin volcanic islands located in the northern part of the Leeward Islands in the eastern Caribbean. They encompass a total area of 269 km^2. The climate is tropical and the topography is generally mountainous. The population of about 42 000 is predominately of African or Euro-African descent, although a small minority is of British, Portuguese or Lebanese origin (Pan American Health Organization, 2002).

Saint Kitts was one of the last of the eastern Caribbean economies to be predicated on sugar production. Today, tourism, construction and agricultural sectors all contribute to the economy, which remains vulnerable to external international market factors. The twin island federation, which gained full political independence from Britain on19 September 1983, is governed by a democratic British parliamentary system (Pan American Health Organization, 2002).

Mental health services in Saint Kitts are delivered in both hospital and community settings (Pan American Health Organization, 2002). Acute care is provided by a 12-bed psychiatric unit, within the general hospital, which is staffed by a small number of acute care nurses, many of whom, until recently, have had little formal training in psychiatric nursing. Community services are provided by five health clinics, the majority of which are located in rural areas. Clinical psychiatric services are provided by one full-time psychiatrist and two trained community psychiatric nurses.

The 'Living and Working in an LMIC' programme

Four senior Dalhousie psychiatry residents (two men, two women) have taken part in the international elective experience in Saint Kitts and Nevis since the inception of the programme. All four had demonstrated initiative in their residency programmes and all four shared prior interest in cultural issues pertaining to mental health, travel and working abroad.

All four residents rated the experience very highly overall, although most struggled with the limited infrastructure and human resources, with the limited availability of medications, medical technologies and mental health services, as well as with socio-cultural issues pertaining to the expression, management and acceptance of mental disorders. The elective provided the residents with opportunities to learn about LMIC mental health care first-hand, as they were exposed to a rich diversity of clinical and personal experiences. This facilitated their understanding of the socio-cultural and political issues related to care provision and illness presentation in that setting.

Through this exposure, residents grew to appreciate the effect of social, cultural, spiritual and historical factors in the creation of the local idioms for mental disorders that continue to perpetuate fear about and stigmatisation of those with a mental illness. For example, the widely held belief that mental disorders are related to malevolent spiritual forces and the general acceptance of mental illness as a permanent and untreatable condition interfered with care for the mentally ill and impeded understanding and advocacy on the part of the patient, family and health professionals. Residents saw how stigma led to the displacement of the person with mental illness from both family and community, as well as sectors such as government and health care. They experienced in their

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It is hoped that introduction of curriculum and clinical opportunities in international psychiatry/global mental health will create a future for Canada in global mental health by enabling Canadian psychiatry residents to view mental health issues from a global perspective.

caring for patients the consequences of the inequities in terms of human rights policy and legislation, available health services, access to effective treatments, and availability of skilled mental health professionals.

Mental health services on the island were constrained by the limited availability and allocation of resources to mental health, which greatly affected provision of mental health care. Residents were challenged to create innovative strategies and solutions to problems, in a manner which optimised the use of the few available resources.

Many of the residents invested time in the education of mental health care providers:

- they provided information on the diagnosis and management of the common mental disorders
- they offered instruction on basic behavioural techniques to control disruptive or dysfunctional behaviours of severely mentally ill patients in the institutional or community setting
- they helped dispel myths about mental illness, by exposing mental health care providers to the benefits of successful interventions and positive patient outcomes.

Others became involved in community outreach interventions, including dissemination of basic psychoeducation to youth groups, participation in health information radio programmes, and facilitation of advocacy and promotion of mental health by community organisations.

Response to the ‘Living and Working in a LMIC’ programme by the government, health care professionals, mental health consumers, families and community in Saint Kitts and Nevis has been overwhelmingly positive. Each resident has sequentially contributed to increasing the local capacity to provide appropriate mental health care. Through teaching and mentoring of mental health care providers, such as nurses, they have assisted in the enhancement of professional mental health skills. Consequently, mental health care providers are better equipped to improve patient care and are able to witness the benefits of their psychiatric interventions. This has led to increased commitment and investment in patient care and patient advocacy among mental health professionals.

Through their interactions with other medical disciplines in their capacity as consultants to medical wards and the emergency department, the residents were able to make significant headway in the promotion of mental health by increasing the mental health knowledge of health care professionals. As a result of these interactions, health care professionals have obtained a better understanding of mental illness, and this has led to decreased stigmatisation and improved physical health care of the mentally ill. Additionally, through the basic psychoeducation of patients and families, the residents have assisted in the dissemination of mental health awareness to communities. Consequently, locally held idioms of mental disorders which have propagated the stigmatisation and discrimination of people with a mental illness are being challenged at all levels of the mental health care system.

The future

The ‘Living and Working in an LMIC’ programme appears to have met its intended goals of increasing awareness of and interest in global mental health issues on the part of participants. Within the resident body of the Dalhousie Department of Psychiatry, the programme has stimulated both interest and awareness among all trainees and fostered a desire to learn about and participate in global mental health initiatives. Future work on the programme will include:

- comprehensive evaluation
- expansion to include other LMICs (i.e. Trinidad and Tobago)
- inclusion of resident participation from other Canadian universities
- creation of an international psychiatry curriculum
- dissemination of programme information to encourage the development of similar training programmes at other universities.

It is hoped that introduction of curriculum and clinical opportunities in international psychiatry/global mental health will enable Canadian psychiatry residents to view mental health issues from a global perspective. This will facilitate globally informed practice and provide future Canadian psychiatrists with the skills necessary to make meaningful contributions to global mental health. In addition, it will assist in enhancing Canadian capacity for international collaboration and partnership designed to promote global mental health.

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The Section and Board of Psychiatry of the Union of European Medical Specialists (UEMS): achievements and perspectives

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The enlargement of the European Union (EU) creates new inspiration and challenges for the Section and Board of Psychiatry of the Union of European Medical Specialists (UEMS). The Section and Board, which have an active history dating back to the early 1990s, aim to promote and harmonise psychiatry throughout Europe, mainly by working to produce standards for training, including conditions for training and continuous professional development (CPD). However, European society is complex and in transition. The move towards a more unified European professional identity first requires the identification and acknowledgement of differences.

The UEMS

The UEMS was created in 1958, following the Treaty of Rome. It is composed of a Management Council, which has delegates appointed from 'the most representative non-governmental national professional organisation representing medical specialists' in each member state of either the EU or the European Free Trade Association (EFTA). A number of associate member countries also send delegates. The overall purpose of the UEMS is to improve the quality of medical specialist practice in the EU. Thus, education is at the forefront of its activities. The UEMS mainly works on the formulation of policies, such as the Charter of Training, quality assurance, continuing medical education (CME), visits to training centres, and the autonomy of medical specialists. It works through consensus, as its function is advisory and not executive. In order to transform policies into practice guidelines, the UEMS has established mono-specialist Sections and Boards.

The Section and Board of Psychiatry

The Section has 15 countries as active full members (from both the EU and EFTA) and 12 countries as associate members, as well as observers from a number of closely linked organisations, such as the European Forum for Psychiatric Trainees (EFPT), the Permanent Working Group of junior doctors (PWG), the Association of European Psychiatrists (AEP), the World Psychiatric Association (WPA) and the World Health Organization (WHO). Each member country has two delegates appointed by its national medical association, representing the academic as well as clinical disciplines. The delegates represent their national psychiatric associations. However, whereas in some countries, such as the UK, only one national psychiatric association exists (the Royal College of Psychiatrists) which, therefore, has great influence on professional development and policy, in other countries, such as France, there are a number of associations involved in representing the specialist medical workforce and in training. This creates a diversity in the Section. In line with the policy of the UEMS, decisions are, wherever possible, based on consensus and can be reached only after consultation with the national associations. Although consensus is desirable, however, the UEMS acknowledges the need to reach decision by majority vote when consensus cannot be achieved.

Achievements and challenges

From the very beginning it was obvious that there were differences in structure, standards of training and even understanding of psychiatry as a discipline, not only between countries but also within the individual countries. Whereas in some countries, mainly in northern and western Europe, training was centralised according to national standards, in others standards were set at university level, in the absence of national standards. The role of the psychiatric associations in the formulation of training standards varied widely.

Thus, one of the first tasks of the Section was to create standards for training in line with contemporary knowledge, current developments and ethical issues. The training standards are published as chapter 6 in the UEMS charter on training (see below), and are revised every second year (the latest revision was approved in Berlin in October 2003).

The past 10 years have seen a great advance in training in all European countries and the standards established by the UEMS have proved their value. National training standards have now been established in most European countries, and these take the recommendations of the UEMS charter as the basis for the development of curricula. The addition of eastern European countries has further

Websites: www.uems.be and www.uems.psych.htm

The overall purpose of the UEMS is to improve the quality of medical specialist practice in the EU.

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enhanced this development, since they have a need for proper tools for training and they wish to comply with a standardised programme.

The working methods of the Section have from the beginning consisted of identifying key issues, describing the state of art in the different countries through surveys and, based on this, achieving agreement on recommendations. Even though some compromises have had to be negotiated, the recommendations have mostly been understood as a means to improve standards, regardless of practical, economic and political difficulties. A key challenge has been to secure their implementation. An audit is now being carried out to get a clear picture of how far the recommendations are being followed.

Charter on training

The charter follows the structure established by the relevant UEMS policy paper. Its five articles relate to:

- a central monitoring authority for psychiatry, including quality assurance and personnel planning
- general aspects of training, including selection and access, duration, common basis, supervision, practical training and the use of a log book
- requirements for training institutions, including recognition, size of institutions and quality assurance
- requirements for teachers
- requirements for trainees.

In nine appendices, training is specified in the following terms (in relation to the surveys mentioned above):

- *Theoretical training* – in terms of number of hours and subjects to be covered. Here the diversity of the specialty is reflected, as training covers research, science, psychopathology, the theories and methods of treatment, legal, ethical and human rights perspectives, leadership, administration and economics.
- *Training in psychotherapy* (see below).
- *Training in community psychiatry*. At least 6 months of training is required as a member of a multi-disciplinary team. This is in order to gain experience both of work with patients outside hospital care and of social interventions.
- *Training in biological psychiatry*. This involves everything related to the pathophysiological substrate of the specialty.
- *Old age psychiatry*. This is an important multidisciplinary field involving joint work with physicians in medicine. In some countries this a sub-specialty while in others it is an integral part of adult psychiatry.
- *Training in leadership and management*. This deals, among other things, with goal formulation, how to motivate and work with patients and relatives, how to delegate and how to supervise staff. It also deals with planning, organisation, administration and the economics of a psychiatric service.
- *The log book*. This is a personal training file which includes a description of training activities and specific educational objectives.
- *Supervision*. Supervision is essential. There is a distinction between day-to-day clinical supervision and educational supervision. For the latter, regular protected time should be set aside, clear and pre-planned objectives are required and a record of the content of supervision should be kept.
- *Quality assurance*. This implies that every training programme should have a defined goal, appropriate requirements for the training process and appropriate means for evaluation. This includes training as a lifelong learning process concerned with professional as well as personal development.

The last appendix to the charter is a glossary that provides for a uniform understanding of the terminology used.

Visits to training centres

A small subcommittee was established in order to visit training centres upon request. Two visits in Hungary and Slovenia were successfully concluded, but since this was rather costly, another model of attending as observers at approved visits by national visitation schemes was adopted. Thus, mutual visits between the UK and the Netherlands have taken place. A report on these visits states that extensive preliminary preparation is needed for each. In both countries, senior trainees are represented on the assessing panels and the trainees meet independently with the visiting team. Similar training issues were noted in both countries, such as tensions between training demands and training needs. Adequacy of supervision and access to psychotherapy training were also commonly discussed.

Training in psychotherapy

From the Section's beginning, psychotherapy was chosen as a core issue to the understanding of psychiatry as a specialty distinct from, but closely collaborating with, other health professions. Also, psychotherapy was felt to be the treatment tool which most clearly distinguished psychiatry as being a part of, but also different from, the other neurosciences. In some countries, such as Germany, psychotherapy was not part of the specialty, whereas in other countries, such as Switzerland, the title of the specialty was psychiatry and psychotherapy. Recommendations for training in psychotherapy as an integral part of training in psychiatry were established early.

From the Section's beginning, psychotherapy was chosen as a core issue to the understanding of psychiatry as a specialty distinct from, but closely collaborating with, other health professions. Also, psychotherapy was felt to be the treatment tool which most clearly distinguished psychiatry as being a part of, but also different from, the other neurosciences.

In the latest revision of the charter it is stated that psychotherapy is a tool for the treatment of patients with specific psychiatric disorders, as well as a tool for relieving emotional suffering and thus promoting personal development. Three main theories – psychodynamic, cognitive–behavioural and systemic – are still fundamental to the development of treatment interventions, even though a number of common factors have been identified and integrated therapies have evolved. Essentially, the understanding is that psychotherapy should be based on an established theory and empirically supported. Psychotherapy provides the tool for establishing and maintaining contact with the patient and maintaining the necessary therapeutic alliance. The question of the need for

personal experience of therapy has been hotly debated; the agreement reached was that it is highly recommended but not mandatory.

The CME/CPD Task Force

Fruitful collaboration between the UEMS, WPA, AEP and WHO started in 2002. The problem of how to create a European supranational accreditation system has for some time been a key issue for a number of organisations. The UEMS established the European Accreditation Council for CME (EACCME) in 2001 as a clearing house for accreditation and it has to some extent, but not through any transparent regulation, used the Sections in an advisory capacity. At the same time, other players started operating in the field of accreditation and without any clear affiliation were seeking links with national organisations. This was the background to the establishment of the Task Force on CME. The Task Force is seeking approval from national psychiatric organisations to start an independent accreditation system, free of any commercial and financial interests. The impression from several meetings with the presidents of national associations is that this idea is strongly supported.

Recruitment and retention

There is great concern over the issues of recruitment and retention. Psychiatry has for many years been a specialty low in hierarchy and in recent years a number of countries have seen a movement away from the less lucrative public sector to the private sector. This creates problems in terms of quality of service and of free and easy access to treatment. The Section has established a working group to investigate the attitudes of medical students towards psychiatry and to give recommendations on to how to increase the attractiveness of the specialty.

Future perspectives

Even though there are differences between the European countries in terms of demography, cultural diversity, service development, family structure and the degree of cultural changes due to migration, for example, the need to educate psychiatrists to encompass these differences and to apply uniform high ethical standards and high levels of qualified skills is increasing. The work of the UEMS Section and Board serves this purpose.

Information on UEMS Section and Board of Psychiatry can be obtained on www.uemspsychiatry.org/ where all reports are posted.

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NEWS, NOTES, FORTHCOMING INTERNATIONAL EVENTS

News and notes

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The Okasha Award for Developing Countries

This award is presented by the World Psychiatric Association (WPA) via an unrestricted grant from APEX Pharma. It recognises the contribution of two young psychiatrists or neuroscientists (below the age of 40) whose research efforts have best served psychiatry and mental health in a developing country (as defined in categories B, C and D of the World Bank). Each award includes: a diploma, a medal and a donation of US$15 000. The two will be given by the President of the WPA, during the opening ceremony of the XIII World Congress of Psychiatry, Cairo, 10–15 September 2005. The breadth of criteria and a nomination form can be found on the WPA website www.wpanet.org/generalinfo/oaward.html. The closing date is 1 November 2004.

The Prize of Geneva for Human Rights in Psychiatry

The prize is intended to acknowledge an individual or an organisation, for exceptional achievement at regional, national or international level in promoting equity and the humane qualities of care for people with mental illness, reducing the negative discrimination of the mentally ill, defending the rights of people with mental illness, and promoting the application of ethical principles in psychiatric services.

The prize consists of a diploma and a monetary award of 20 000 Swiss francs. The winner will receive the Prize of Geneva during an official ceremony that will take place under the auspices of the Patron's Committee, together with a press conference intended to publicise the work. A scientific or cultural event related to the goals of the Foundation will complete the presentation ceremony.

The next award (the third) will be presented in the closing session of the XIII World Congress of Psychiatry in Cairo (September 2005). Further details are available at www.wpanet.org/sectorial/bulletin/eb1303.html.

Arab mental health website

The Arabpsynet website is for Arab psychiatrists and psychologists working with adults and children. It is edited by colleagues in several countries. The site is in Arabic, English and French. It covers a wide range of subjects and is frequently updated. See www.arabpsynet.com.

European Network for Mental Health Service Evaluation

ENMESH is the European Network for Mental Health Service Evaluation and was established in 1991 under the auspices of the World Health Organization's Regional Office for Europe. It arose out of two areas of concern: the impact of developments in mental health care and rehabilitation initiated without sufficient planning, funding or scientific evidence as to their effectiveness; the profound changes affecting many countries in central and eastern Europe, which require new insights and approaches to mental health care. Its sixth meeting, which will focus on inclusion and mental health in the 'new Europe', will take place on 3–5 September 2004 at the Institute of Psychiatry, King's College, London. There are a number of distinguished speakers and further information can be obtained from www.enmesh2004.org.

Dementia in developing countries

The Faculty of Old Age Psychiatry held a workshop at the annual meeting in Liverpool in March, aiming to stimulate interest in working internationally in developing countries and to discuss the possible role of the Faculty. Nori Graham chaired the workshop. Henry Brodaty talked about experience in Australia and South East Asia, and Martin Prince talked about the 10/66 Dementia Research Group: a network of researchers and clinicians, mostly in developing countries, linked with Alzheimer's Disease International (ADI). ADI's 10/66 Dementia Research Group was felt to offer a useful starting point for identifying potential contacts in countries where people may be interested in setting up a training link. Not all its members are psychiatrists, but all have a clinical and research interest in ageing and dementia. ADI and 10/66 websites are www.alz.co.uk and www.alz.co.uk/1066/.

The workshop concluded by noting that the UK is a world leader in old age psychiatry and in its services for older adults with mental illness. Members considered that the Faculty should consider forming an International Special Interest Group in this area to increase awareness, stimulate interest and encourage individuals and organisations to take practical action.

Proposed European Group of the College

There are now a number of International Groups of the College and these play increasingly useful functions for College members. It is intended to initiate a European Group of the College for all members and fellows living in Europe but outside the UK. It is expected that this Group could become particularly important in the coming years as the movement of professionals increases within the enlarged European Union. Interested persons should contact Dr George Christodoulou (email gnchrist@compulink.gr).

A WPA International Congress

Treatments in Psychiatry: An Update will be held in Florence on 10–13 November 2004. There will be a comprehensive update on all evidence-based treatments available for the various mental disorders, provided by prominent international experts to more than 5000 delegates from all regions of the world. Accreditation is expected from the WPA and relevant European bodies. There is an attractive social programme, and there will be 16 update lectures, 36 interactive symposia, more than 50 WPA Section and Zonal symposia and more than 50 workshops and 14 advanced courses, forums and new research sessions.

For more details email info@wpa2004florence.org or see www.wpa2004florence.org.

Post-conflict countries and emergency situations in eastern Mediterranean areas

The Eastern Mediterranean Office of the WHO has brought out a report of the inter-country consultation on mental health issues and the rehabilitation of psychiatric services in post-conflict countries and those in current emergency situations (Iraq). The consultation (held in Cairo) was attended by advisers from Afghanistan, Bahrain, Egypt, India, Iran, Iraq, Lebanon, Morocco, Pakistan, Saudi Arabia, Switzerland, Tunisia, the UK and the USA.

The objectives were to coordinate strategy, methodology and approaches for:

- rapid identification of the most immediate needs
- more comprehensive assessment and situation analysis
- preparation of a plan of action.

The report acknowledges the richness of the region's cultural history and wide contributions to the development of our societies. It describes a number of the contemporary changes and stressors that have contributed to destabilisation in some countries.

Post-conflict countries and complex emergency situations pose many mental health issues. There is a substantial increase in psychotic and non-psychotic disorders, new psychosocial problems for persons of all ages and specific mental health needs of those with physical injuries and post-traumatic stress disorder. These increases will be exacerbated by lack of and loss of resources, essential medicines and staff to offer psychosocial and other interventions. The rapid flow of refugees, migration and rapid economic and family breakdown at times of social change will all add to the mental health burden.

Forthcoming international events

6–9 July 2004
Royal College of Psychiatrists' Annual Meeting: Caring for the Carers
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.

26–27 July 2004
Bridging the Gap: The Inaugural Conference of International Mental Health at IoP
To raise awareness of many kinds of gaps in the international mental health field.
Institute of Psychiatry, London, UK.
Contact: Marie Eagle, Section of Epidemiology, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, UK.
Tel: +44 207 848 0136.
Email: m.eagle@iop.kcl.ac.uk.

4–8 August 2004
Solidarity/Moral Displacement: Stockholm Group Conference on Social Issues and International Association of Group Psychotherapy
Email: Soci2004@hotmail.com.
Website: www.psykoterapisallskapet.se.

22–26 August 2004
16th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP)
Berlin, Germany.
Contact: Dr Helmut Remschmidt.
Email: remschm@post.med.uni-marburg.de.
Website: www.iacapap-berlin.de.

25–28 August 2004
10th European Symposium on Suicide and Suicidal Behaviour
Organised by the International Association of Suicide Prevention (IASP).
Copenhagen, Denmark.
Tel: +45 7023 5056.
Fax +45 7023 5057.
Website: www.suicideprevention.dk.

3–5 September 2004
Inclusion and Mental Health in the New Europe
User/consumer involvement, mental health policy in the new Europe.
London, UK.
Website: www.enmesh2004.org.

8–10 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.

20–21 September 2004
WPA Section on Mass Media and Mental Health
McLean Hospital, Boston, USA.
Contact: Dr Miguel A. Materazzi.
Email: materazzi@arnet.com.ar.

20–23 September 2004
XIII National Psychiatric Congress of the South African Society of Psychiatrists (SASOP)
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.

23–26 September 2004
The Marcé Society International Biennial Scientific
WPA co-sponsored conference.
Oxford University, Oxford, UK.
Contact: Bethan Ramsey.
Email: b.h.ramsey@reading.ac.uk.
Website: www.marcesociety.com.

23–26 September 2004
JPGM GOLD CON: 50 years
International conference on medical writing, editing, journal publishing, electronic publishing, open access, publication ethics.
Mumbai, India.
Contact: Dr Atul Goel.
Tel: 91 22 2412 9884.
Fax: 91 22 2503 2398.
Email: goldcon@jpgmonline.com.
Website: www.jpgmonline.com/goldcon.asp.

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

3–5 October 2004
Middle East Overseas Group of the Royal College of Psychiatrists
Cairo, Egypt.
Contact: Dr Nasser Loza.
Email: info@behman.com.

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

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

8–10 October 2004
The Individual and the Group: Bridging the Gap
EFPP Conference on Psychoanalytic Group Psychotherapy.
Lisbon, Portugal.
Email: admedic@mail.telepac.pt.
Website: www.efpp.org.

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.wcmh.info.

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

26–30 October 2004
VIII National Psychiatric Congress of the Spanish Society of Psychiatry and the Spanish Society of Biological Psychiatry
Bilbao, Spain.
Contact: Dr Enrique Baca.
Email: fespm@wanadoo.es.

28–31 October 2004
XI Scientific Meeting of the Pacific Rim College of Psychiatrists, Hong Kong.
Contact: The Meeting Secretariat, c/o Meeting Planners International (HK) Ltd, 22/F, Pico Tower, 66 Gloucester Road, Wanchai, Hong Kong, SAR.
Tel: +852 2509 3430.
Fax: +852 2667 6927.
Email: PRCP@mphk.com.

1–3 November 2004
VI European Conference of the European Opiate Addiction Treatment Association
Paris, France.
Contact: Cap 15, Centre International d'Affaires et de Congrès, 1 à 13 Quai de Grenelle, 75015 Paris, France.
Email: maremman@med.unipi.it or m.reisinger@worldonline.be.
Website: www.europad.org.
Venue website: www.cap15.com.

10–13 November 2004
Treatments in Psychiatry: An Update
International Congress of the WPA.
Florence, Italy.
Contact: Prof. Mario Maj, Institute of Psychiatry, University of Naples, Largo Madonna Delle Grazie, I-80138, Italy.
Fax: +39 081 566 6523.
Email: majmario@tin.it.

17–20 November 2004
Latin American Psychiatric Association (APAL)
Punta del Este, Uruguay.
Contact: Dr Angel Valmaggia
Email: apal2004@montevideo.com.uy.
Website: www.apal2004.org.

2–5 December 2004
WPA Regional Meeting on Eastern Europe and the Balkans
Craiova, Romania.
Contact: Dr Tudor Udristoiu.
Email: psy@umfcv.ro.

13–17 December 2004
Mal-etre, bien etre: Quelles ressources pour agir?
WPA Suicidiology Section.
Poitiers, France.
Contact: Dr Jean Jacques Chavagnat.
Email: prs.suicide@ch-poitiers.fr.

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 3917 1865.
Email: jke@euro.who.int.
Website: www.euro.who.int/document/MNH/MHleaflete.pdf.

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

16–19 March 2005
14th World Congress of the World Association for Dynamic Psychiatry: Trauma, Attachment, Personality
Cracow, Poland.
Contact: Dr Maria Ammon, World Association for Dynamic Psychiatry (WADP).
Email: dapberlin@aol.com.
Website: www.dapberlin.de.

18–20 March 2005
Financing Mental and Addictive Disorders
Organised by WPA Section on Mental Health Economics.
Venice, Italy.
Contact: Dr Massimo Moscarelli,
Email: Moscarelli@icmpe.org.
Website: www.icmpe.org.

April 2005
WPA Regional Meeting and XXI Congreso Argentino de Psiquiatria
Organised by the Association of Argentinean Psychiatrists (APSA).
Mar del Plata, Argentina.
Contact: Dra. Graciela Lucatelli.
Email: apsa@apsa.org.ar.
Website: www.apsa.org.ar.

21–26 May 2005
American Psychiatric Association Annual Congress
Atlanta, GA, USA.
Contact: apa@psych.org.
Website: www.psych.org.

20–23 June 2005
Royal College of Psychiatrists' Annual Meeting
Edinburgh International Conference Centre, Edinburgh, UK.
Contact: College Conference Office.
Tel: +44 (0)20 7235 2351 × 142.
Fax: +44 (0)20 7259 6507.
Email: mbraithwaite@rcpsych.ac.uk.

16–20 November 2005
WPA Regional Meeting and XIX Congreso Nacional de la Asociacion Psiquiatric Mexicana
Los Cabos, Mexico.
Contact: Dr Luis E. Rivero Almanzor.
Email: aspsiqm@prodigy.net.mx.

13–16 June 2006
15th ISPS Congress (International Society for the Psychological Treatments of Schizophrenia and other psychoses)
Madrid, Spain.
Contact: Dr Manuel Gonzales de Chavez.
Email: mgchavez@teleline.es.
Website: www.ispsmadrid2006.com.