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EDITORIAL

International Divisions and International Associateships

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

Although the College has always had an international perspective, the establishment of the Board of International Affairs has given a new impetus to this area of its activities. Although the Board was set up to address the needs of members residing overseas, it has enjoyed the wholehearted support of those living and working in the UK and Ireland; this has been manifested by the way in which the College and its various committees have acknowledged the need to look outwards more than they have done in the past – to scan new horizons and form new partnerships so that the College can play an active role in international psychiatry for the benefit of all those suffering from mental ill health. The College has also taken decisive action by developing International Divisions and International Associateships. These have been approved by the Privy Council of the UK and were formally established at the College's annual meeting in July 2004.

The main objectives of the International Divisions are to facilitate communication between the different countries in a region and to promote discussion of psychiatry. They will focus on:

- enhancing collaboration and cooperation in the training of psychiatrists
- facilitating professional development
- increasing the professional standing of all staff in the field of psychiatry and mental health.

It is the firm hope and belief of the College that the International Divisions will build on the successes of earlier overseas groups and bring the members of the College together across national boundaries in powerful local coalitions that will better support mental health and benefit individuals as well as institutions.

The Divisions will be more than the sum of their parts. Their creation offers a unique opportunity to provide a coherent, professional and responsive regional approach to training and educational activities in psychiatry and mental health. It is hoped that this multinational activity will engage the interests and enthusiasm of all psychiatrists and psychiatric associations in countries in each region and that this, in turn, will both foster research and evaluation and facilitate the dissemination of the results. In time the International Divisions will be a powerful influence on national policies for improving standards of care and destigmatising mental illness. In the long term they will not only provide tangible support and benefit to individual psychiatrists and their institutions, but also steadily raise the standing and status of psychiatry as a discipline. These are ambitious but realisable aims which can be achieved only through partnership and participation, and in a spirit of inclusiveness.

By the end of 2004 the six International Divisions will be up and running, with membership open to all existing Members and Fellows of the College working or residing in each region and to the new Associate Members (see below). Although no person may belong to more than one International Division, participation in conferences and meetings and collaboration with colleagues in other Divisions are very much encouraged.

At the heart of the new Divisions will be their executive committees, whose officers will be elected by the members. Ballot papers for the election of chair, secretary and treasurer will be going out to all members shortly and I would like to take this opportunity to urge you to use your vote so that the executive committee of your Division has a clear mandate to take initiatives on your behalf. The elected officers of each International Division (i.e. chair, secretary and treasurer) may co-opt other members onto the executive committee as appropriate. A list of the members (elected and co-opted) of each executive committee will be submitted to Council after each election or as and when co-opted members are replaced. The executive committee will be responsible for organising and running scientific, educational and social activities in the International Division, as appropriate to academic, training and service needs. Each Division will

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provide an annual report to the Director of the Board of International Affairs, who will present them to Council at the first meeting in the following year.

It is expected that the International Divisions will work cooperatively with national associations and societies, World Psychiatric Association regional zonal representatives and the World Health Organization, as well as university departments, in pursuance of mental health and the practice of psychiatry. I am confident that the members of the International Divisions will rise to this challenge and will work together to ensure that the Divisions set an example for other Colleges and other organisations with similar mandates. The development of genuine partnerships between equals to the benefit of all partners will be important for both the College's international role and the Divisions' regional responsibilities.

The College's other initiative – the establishment of International Associateships – is also very much welcomed. In most countries there are many experienced, competent and highly qualified psychiatrists who are not Members or Fellows of the Royal College of Psychiatrists. The category of International Associate of the College has therefore been developed to acknowledge the contribution of psychiatrists who reside outside the UK or Ireland and who do not hold the MRCPsych, but who do have a specialist qualification in psychiatry. The award of International Associateship by the Court of Electors will be based entirely on nominations provided by members of the College, and the contribution of the candidates to the activities of the College and to its International Divisions will be taken into account. Members and Fellows of the College and the Divisions are encouraged to identify well-qualified and interested individuals and recommend them for election for International Associateship.

With these exciting developments – of the six International Divisions and International Associateships – the College has taken an important step in the promotion of collaboration and cooperation across national boundaries. Ultimately, however, their success will rely on the commitment of individual members and psychiatrists in the regions to seize the opportunities and to build on them.

THEMATIC PAPERS – INTRODUCTION

Reforming psychiatric services: a global financial perspective

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What is the most efficient and effective way of providing psychiatric care? In most countries, resources are always going to be severely limited and psychiatrists are well aware that the specialty will be a long way down the pecking order.

This issue presents three perspectives on contemporaneous approaches to financing mental health services. First, we have an overview by Dr Shekhar Saxena and Pratap Sharan, of the World Health Organization (WHO). They point out that a recent WHO-sponsored survey of provision found, in no less than one-third of the 191 countries that provided information, that there was no mental health budget at all. Further, in a third of those countries with such a budget, it represented less than 1% of overall health care expenditure. They make the interesting and important observation that, because many countries provide services only for those who are able to pay, people with serious mental disorders are selectively disadvantaged. Moreover, they are especially likely to be unable to meet these financial obligations because of unemployment and chronic disability. The authors also emphasise that the prevailing philosophy, which recommends a move from hospital to community care, is not a cheap option. Wise recommendations are made in their conclusions.

We then have two contrasting articles on the refinancing of psychiatric services, one from Australia and the other from Poland. Vaughan Carr and colleagues lament the underfunding and poor organisation of community provision for people with psychosis, which result in lengthy and unnecessary hospital stays in Australia. They discuss the importance of using an evidence base to plan alternative provisions. Such a reorganisation of services for patients with psychosis would increase efficiency and could be widely adopted. Finally, Wanda Langiewicz and Elzbieta Slupczynska-Kossobudzka examine the effect of the health care reforms in Poland that were implemented 5 years ago. Poland spent just under 5% of its health care budget on psychiatric services when the reforms were introduced, which would place the country in the middle tier of financing according to the WHO analysis reported by Saxena and Sharan. The Polish authors bemoan the 'also-ran' status of psychiatry in comparison with specialties that attract more immediate and urgent attention from reformers, but there is good news as well as bad. In the past year, there have been additional resources hypothecated for psychiatric services; consequently, the aspirations of the psychiatric profession to provide a rational balance between in-patient care and community services may yet be realised.

Financing of mental health services: an international perspective

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Financing is a critical factor in the realisation of a viable mental health system. It is the mechanism by which plans and policies are translated into action through the allocation of resources. Financing is essential for operations and the delivery of services, for the development and deployment of a trained workforce, and for the required infrastructure and technology (Chernichovsky & Chinitz, 1995; World Health Organization, 2003). Financing mechanisms can also be used to facilitate change and introduce innovations in systems (World Health Organization, 2003).

Financing of mental health services across countries

The World Health Organization, in its Project Atlas, collected information on the resources available for mental health care from 191 countries during the year 2001 (World Health Organization, 2001). Information related to policy, programmes, financing and mental health resource indicators (beds, personnel, services for special populations and availability of drugs) was sought from the Ministry of Health of each country.

The results were worrying:

- one-third of countries did not have a specified budget for mental health
- out-of-pocket payment was the primary method of financing mental health care in one-sixth of countries (one-third of countries in the African and the South East Asia regions)
- no country in the African, South East Asia and the Western Pacific regions used social insurance as the primary method of financing mental health care.

Eighty-nine countries were able to report the mental health budget as a proportion of the overall health budget. More than one-third of these countries spent less than 1% of their total health budget on mental health (African region – 79%, South East Asia region – 63%). Low- and lower-middle-income countries (World Bank classification) spent a significantly smaller proportion of their health budget on mental health than did high- and higher-middle-income countries. However, the situation in high-income countries was not uniformly satisfactory: many spent less than 5% of their health budget on mental health.

The 89 countries were categorised into three groups – those spending less than 1%, those spending 1–5% and those spending more than 5% of their health budget on mental health – which were compared in terms of policy, programme and resource indicators. The presence or absence of policies and programmes was not associated with the level of mental health financing, but the categorisation was significantly associated with the availability of disability benefits and other mental health service indicators – total number of mental hospital beds, number of mental health beds in the general health sector, number of psychiatrists, number of psychologists, number of nurses in the mental health field, services for special populations (e.g. minorities, refugees), availability of psychotropic medications and the availability of anti-Parkinsonian drugs (Saxena *et al*, 2003).

Disparity between burden and resource allocation

There is a marked disparity between the burden of mental illness and the resources allocated to its treatment and prevention: World Health Organization (2004) data on the global burden of disease (GBD) showed that mental illness accounted for 12.9% of disability-adjusted life years (DALYs), while federal governments allocated only 3.5% of their health budgets to mental health (Saxena *et al*, 2003). The extent of underfunding was highlighted further by the fact that depression alone accounted for 4.4% of DALYs worldwide (Üstün *et al*, 2004).

Among the many factors that can give rise to underfunding are: poor economic conditions in countries; inadequate recognition of mental health problems and their consequences; unwillingness or inability of individuals with mental health problems (or their families) to pay for treatment; and failure by policy makers to understand what can be done to prevent or treat mental disorders, which results in a belief that funding for other services is more beneficial to society (Desjarlais *et al*, 1995; World Health Organization, 2003).

Financing the mental health system

The financing of mental health services occurs in widely disparate political and economic contexts and, often, within the context of more general health care financing. The first actions required to ensure adequate financing are the building of a coalition – of policy makers, service providers, researchers, advocates and so on – and reaching a consensus on what the key needs are (Hu, 2003;

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World Health Organization, 2003). The following issues have to be addressed in financing mental health systems (World Health Organization, 2003):

- mobilisation of finances
- allocation to address priority needs
- controlling the cost of care.

Mobilisation of finances

An important consideration in mobilising finances is the fact that out-of-pocket payment is a greater obstacle for mental health care than it is for general health care, as individuals (and their families) with mental disorders are commonly poorer than the rest of the population and less able or willing to seek care because of stigma or previous negative experiences of services (Chernichovsky & Chinitz, 1995; McAlpine & Mechanic, 2000; World Health Organization, 2003). However, mandatory coverage through social insurance is difficult to achieve in many systems (not necessarily only in poor countries); hence, plans that differ in terms of comprehensiveness, nature of funding, degree of federal control, involvement of insurance agencies and the degree of cost sharing between the individual and the insurer should be considered (Hu, 2003; World Health Organization, 2003).

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Allocation to address priority needs

The allocation of funds must be tied to policy priorities. These priorities should include policy development, planning, innovation and advocacy, in addition to services (World Health Organization, 2003). One approach proposed for building community-based systems involves transferring resources from hospital-based systems; however, careful evaluation of the situation prevailing in the community is needed before hospitals are downsized (McAlpine & Mechanic, 2000; World Health Organization, 2003). Double funding may be needed initially in order to ensure that a community system can accommodate people discharged from hospital. Especially in countries that do not have a well articulated mental health system, it is important to ensure that the financing of mental health services is an integral component of the financing of general health services, and that specific allocations are made for mental health, albeit associated with other health initiatives. Equity in health care is a cornerstone for public financing. Information on the prevalence of mental disorders, existing resources, accessibility of services, and types and cost-effectiveness of services may be relevant to the allocation for specific subgroups (World Health Organization, 2003).

Controlling the cost of care

Efficiency in finance and the provision of care could free resources for a higher level of care (Chernichovsky & Chinitz, 1995). This could be achieved through integration of services (Browne *et al*, 1999), downsizing of big hospitals (World Health Organization, 2003), appropriate training of staff (Chisholm *et al*, 2000) and development of an infrastructure for mental health financing (World Health Organization, 2003).

It has been suggested that there is a shortage of economic data, particularly from developing countries, to support discussions on mental health policy and resource allocation at national and international level. This situation has changed considerably with the WHO–CHOICE study, which showed that cost-effective interventions for psychiatric disorders exist in all sub-regions (Chisholm *et al*, 2004).

Conclusions

In view of the large and increasing burden of mental disorders, many countries should consider an increase in their mental health budgets to provide for necessary services, training and research. This is needed in most low- and middle-income countries, but also in some high-income countries. Countries that rely on out-of-pocket payment as the primary method of financing mental health care should consider the possibility of providing coverage under social insurance. To use resources more efficiently and judiciously, countries should support integration of services, reallocation of mental health beds and research on the financing of mental health care.

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Resource allocation for psychosis in Australia

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Using a census-based prevalence survey (Jablensky *et al*, 2000), we estimated the cost of psychosis in urban Australia at AU$2.25 billion (£0.86 billion) per year when valued at prices pertaining in the year 2000 (Carr *et al*, 2003). About 40% of these costs were spent on direct mental health care, the remainder being the costs of lost productivity (limited to unemployment in our study). The total costs amounted to AU$46 200 (£17 722) per person per year, 20% higher than the average annual male income. The bulk of the treatment cost was accounted for by in-patient care, which appeared to have become the default option in the absence of adequate levels of supported community accommodation. This was indicated by the fact that after 'non-discretionary' treatment costs (42% of direct costs) were accounted for (i.e. visits to a general practitioner, medication, crisis or emergency care, acute hospitalisation), almost three-quarters of the remainder was spent on long-stay hospitalisation (Neil *et al*, 2003). When patterns of community-based service delivery were examined, we found a marked paucity of delivery of psychosocial treatments, rehabilitation and substance use interventions, reflecting the skewing of expenditure towards long-term hospitalisation and away from community care.

This does not look like good value for money. Indeed, attention has been drawn to the fact that the burden due to schizophrenia that is averted by current treatment practices is low, in spite of the high cost. Modest but significant gains in burden averted could be achieved with better deployment of evidence-based treatments, and with almost double the cost-effectiveness (Andrews *et al*, 2003, 2004). Thus, there is an opportunity cost in maintaining the status quo.

The question, then, is how can the existing 'discretionary' resources (i.e. non-primary care, non-emergency care and long-stay hospitalisation) be re-allocated from their current pattern of distribution for the psychoses to ensure wider delivery of evidence-based community treatments and improved outcomes, with greater cost-effectiveness?

We argue that the starting point ought not to be with relativities in disease burden but with the identification of evidence-based interventions that are efficient (i.e. effective, good value for money and affordable), subject to equity and feasibility considerations (Neil *et al*, 2003).

Efficiency

In the absence of pragmatic economic trials, the determination of treatment efficiency is likely to proceed through several steps, from the assessment of treatment efficacy, to treatment and programme effectiveness, to cost-effectiveness and likely societal benefits. The identification of *effective treatments* first entails a review of efficacy studies of 'experimental' treatments based on randomised controlled trials, the 'gold standard' of efficacy measurement. Examples in schizophrenia are: antipsychotic drugs, family-based interventions (which include psychoeducation and the development of problem-solving skills); cognitive–behavioural treatments for better psychotic symptom control, relapse prevention and medication adherence; assertive community treatment; and supported employment programmes. Second, clinical effectiveness studies are needed – that is, systematic, non-experimental investigations of the effectiveness of such treatments as the foregoing in ordinary clinical settings, with the determination of clinical outcomes and costs. Where they are lacking, services ought to conduct these evaluations themselves. This has the advantage of staff being trained to deliver evidence-based treatments, to conduct appropriate clinical measurements, and to assess outcomes. In turn, this has a cascade effect, with other staff seeking to learn the treatment and measurement techniques. Subsequently, these skills are likely to generalise to other areas of their clinical work as a culture of evidence-based practice and clinical measurement begins to take hold. Third, findings from service systems research need to be examined, for example comparisons between community *v*. residential treatment, primary health care *v*. treatment in specialist settings, and separate *v*. integrated substance misuse services for those with dual diagnoses, with outcomes measured in terms of re-admission rates, referral patterns and so on.

Estimations of the likely *cost-effectiveness* of such interventions constitute the next step in the process; the additional benefits must be worth the additional costs if these interventions are to represent value for money. Economic evaluations entail analyses of the costs and consequences of an intervention compared with those of an appropriate comparator. The evaluation techniques used (e.g. cost–benefit, cost-utility, cost-effectiveness, and cost-minimisation analyses) primarily depend on the available range of outcome measures and the differences in outcomes across the various treatment arms. Ideally, economic evaluations should be context specific and

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employ a societal perspective in addition to any other perspective utilised (e.g. individual, third-party payer, government).

Affordability is simply the question of whether the available resources are sufficient to meet the costs of implementing and maintaining the proposed interventions.

Cost modelling studies do not directly address the above issues, but they can help identify the main drivers of costs and assess the effect of interventions on broader costs (e.g. Carr *et al*, 2004).

There is a demonstrably high level of expenditure on psychosis in Australia and a more rational basis for resource allocation is required, driven primarily by treatment efficiency and equity considerations.

Equity and feasibility

The principle of equity has to do with the extent to which a given society may seek preferential allocation of resources for socially and economically disadvantaged groups, marginalised or less powerful groups, remote or isolated communities, and diseases that may be conspicuous in the community or associated with high levels of disability (e.g. psychoses). Feasibility refers to whether the intervention falls within the existing or readily achievable range of human expertise or technological capacity.

Other issues

Having thus established a priority list of potential evidence-based, cost-effective interventions, assessed their affordability, and addressed questions of equity and feasibility, there are further issues to be addressed. Structural adjustments are necessary to permit the flexible allocation of 'discretionary' expenditure (e.g. in Australia, shifting from long-term hospitalisation to supported community accommodation in the treatment of psychosis). Other implementation issues include training, administration, uptake by clinicians, and intangible or hidden costs. Programmes are necessary to increase clinicians' and administrators' awareness of efficient interventions, to improve the therapeutic skills of clinicians, and to motivate them to provide the identified interventions. Motivation to deliver the interventions can be enhanced through the provision of incentives. These may include a combination of financial rewards and disincentives, prestige enhancement or promotion, performance reviews, and feedback of information concerning effectiveness and efficiency. Implementation should also be monitored at the individual, health system and government levels so that timely adjustments can be made.

Conclusions

There is a demonstrably high level of expenditure on psychosis in Australia and a more rational basis for resource allocation is required, driven primarily by treatment efficiency and equity considerations. We also contend that many of the principles outlined above are not just applicable to the psychoses but could usefully inform decisions about resource distribution in mental health services generally.

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THEMATIC PAPER – REFORMING PSYCHIATRIC SERVICES

Psychiatric services in the fifth year of health care reform in Poland

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Changes in the Polish health care system, introduced by a Parliamentary Act in 1999, resulted from an urgent need for a more effective provision of health services, which were held in poor esteem by the public. Public expenditure on health care at the time of the reform was equivalent to 4.19% of gross national product, or US$363 at purchasing power parity (PPP) per capita. This amount was considerably lower than in the most developed countries (i.e. members of the Organisation for

Economic Cooperation and Development, OECD). The reformers' main modification consisted of replacing state financing of health services with insurance-based financing. Statutory health insurance covers 99.4% of Poland's 38.2 million citizens. The insurance fee is to be increased from 7.0% of personal income at the beginning of the reforms to 9.0% (at present it has reached 8.25%). The aim was also to achieve relatively stable health care expenditure, independent of the annual political budget allocation. A special administrator was appointed for the Sickness or National Health Fund and was authorised to contract for health services. These market-oriented developments were paralleled by the implementation of special programmes, financed from the Ministry of Health budget, which were aimed at restructuring health care facilities.

Since the earliest days of the reforms, attention has been drawn to the problem of so-called 'blurred responsibility' – namely, it was difficult to specify the extent of responsibilities and mutual relations between the state administration units, regional governments, payers, service providers and patients. Another objection concerned confusion about how public resources were to be distributed among the regions and health care areas. Disproportionate allocation, in many cases, limited access to some specialists and health care facilities. These difficulties were usually attributed to an insufficient supply of financial resources, due to an insufficiently low health insurance rate, as well as poor management. Reimbursement rates offered in the contracts for health services frequently did not cover the real costs. In turn, this resulted in many health care facilities experiencing growing debts and financial liquidity problems.

The effect on psychiatric care

Although the above problems pertained also to the provision of psychiatric care, the reforms were expected to aid the development of community-based psychiatric care in Poland. The following are the main achievements of the past 5 years.

- Sixteen psychiatric wards have been established within general hospitals, which has increased the proportion of this category of bed from 13% to 15% (the latter figure represents a total of 5000 beds).
- More than 50 day hospitals for psychiatric patients have been opened (an increase of 45%).
- In large mental hospitals, the process of psychiatric bed reduction has continued (their number has decreased by 3000, or 17%).
- There has been a restructuring of mental hospitals – less expensive units providing nursing–therapeutic care have been created.
- The number of psychiatric out-patient clinics has been increased by 50%, to some 950.

In general, the above changes are in line with the National Mental Health Programme set up by a team from the Institute of Psychiatry and Neurology.

Financial resources

The popular belief that success of the health care reform programme depends largely on the financial resources allotted seems to be correct. Public expenditures on health care have increased since the pre-reform period insufficiently in relation to needs, the more so as a large proportion of the increment has been spent on medication. Psychiatric care is also affected by the scarcity of resources. At present about €220 million is allotted to psychiatric care provision (without the costs of medication reimbursement), which is about 3.4% of all health service expenditure. The estimated shortfall of 15–20% significantly reduces the chances of attaining the planned targets. Any large-scale implementation of the community-based model of psychiatric care would require considerable additional funds.

Medical priorities

The (frequently modified) reform regulations lack mechanisms to link health policy targets to payers' decisions. The Mental Health Programme outlined the major targets and tasks of psychiatric care but has no statutory power, so the interests of psychiatry have usually been secondary to those of other areas of health care (which have a higher social and medical profile). The majority of the changes noted above in the psychiatric infrastructure have been made in response to opportunities arising after the reform implementation, rather than being planned.

Out-patient and day patient care

The allocation of funds to cheaper alternatives than psychiatric hospitalisation (i.e. day hospitals and psychiatric out-patient clinics) is beneficial for the payer, and is in tune with reform priorities. The 50% increase in the number of psychiatric out-patient clinics noted above has led to a 63% increment in the number of treated patients. However, this success was achieved at the cost of a well-developed network of such clinics that existed before the reform, some of which were divided into smaller and understaffed units. Since traditional bonds between hospitals and out-patient clinics have been disrupted in some regions, and after-care continuity has deteriorated. There has been a marked increase in psychiatric day hospitals and alcohol and drug treatment day centres, resulting from the payer's decision to promote these cheaper forms of care, which are easily located on the premises of existing health care facilities. Accessibility of day patient services has therefore improved mostly in large cities, where it is also easier to find appropriate staff.

In-patient care

In-patient psychiatric care was a particular challenge to the reformers, since in some regions there were too many hospital beds while in others there was a scarcity of them. The replacement of large mental hospitals by psychiatric wards within general hospitals was financially and socially difficult. Because they had only modest budgets, the regional governments, which formally owned the mental hospitals, were unable to support the planned modernisation. None the less, general hospitals did create new

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psychiatric wards. Their establishment was aided, on the one hand, by financial support from the so-called restructuring programmes and, on the other hand, by the payer's readiness to contract for such psychiatric services.

A detailed cost-effectiveness analysis revealed that in large mental hospitals beds were not fully used, too many patients were hospitalised for social reasons, and there was a liberal attitude towards treatment duration. Over the 5 years of reform, the number of excess beds has been reduced and the remaining ones have been better used. The average treatment duration has been shortened by 12 days, to 35 days.

After-care

While after-care in sheltered housing and hostels is desirable, there are insufficient funds for its general implementation. Moreover, funds for this purpose are regarded as improving quality of life, which does not constitute a priority within the tight constraint on budget limits.

Hypothecated funding

It should be noted that the National Health Fund formally allotted special resources to psychiatric care for the first time in the 2004 financial plan. This is an encouraging move and will improve the regional distribution of funds. There were also reforms in contracting principles, including prescriptive conditions for psychiatric service provision, developed by our Institute and approved by the psychiatric community in general.

Further reading

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COUNTRY PROFILE

The state of mental health in the Philippines

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The Philippines, known as the Pearl of the Orient, is an archipelago of 7107 islands, bounded on the west by the South China Sea, on the east by the Pacific Ocean, on the south by the Sulu and Celebes Sea, and on the north by the Bashi Channel. The northernmost islands are about 240 km south of Taiwan and the southernmost islands approximately 24 km from Borneo. The country has a total land area of some 300 000 km^2. It is divided into three geographical areas: Luzon, Visayas and Mindanao. It has 17 regions, 79 provinces, 115 cities, 1495 municipalities and 41 956 barangays (the smallest geographic and political unit). It has over 100 ethnic groups and a myriad of foreign influences (including Malay, Chinese, Spanish and American).

The last official census (2000) put the population at 76 498 735. However, the National Statistics Office Population Projections Unit estimated it to be 81 081 457 in 2003. The annual population growth rate (1995–2000) is 2.36% (a reduction from the 1980s). The population is young: 38% are under 15 years old and only 3.5% over 65 years. Most (83%) of the population is Catholic. The literacy rate is fairly high at 95.1% for males and 94.6% for females, which possibly accounts for the facility with which Filipinos find work abroad. Labour is, in fact, a prime export of the country.

More than half of the Philippine population resides in Luzon. Within that area, the National Capital Region (NCR) has 12.9% of the national population (9 906 048 inhabitants in 61 728 km^2 of land). It is composed of 13 cities, 4 municipalities and 1693 barangays. Three cities in the NCR have emerged as the most populous: Quezon City, Manila and Caloocan, which have populations of 2.17 million, 1.58 million and 1.18 million, respectively. Among the provinces, Pangasinan is the most populous, with 2.43 million, followed by Cebu, with 2.37 million and Bulacan, with 2.23 million people.

Opportunities brought about by economic development vary from region to region and this has affected internal migration. In 1980, about 37% of the total population resided in urban areas. By 1990, the urban proportion of the population had increased to 49%, with the NCR getting the bulk of this population increase. By the year 1995, more than half of the population (54%) lived in urban areas and this proportion increased further, to 59%, by the end of 2000.

A 1997 survey conducted by the National Statistical Coordination Board showed a poverty incidence of 31.8%. If this rate is applied to the 2000 population census report, then, for that year, over 24 million Filipinos can be considered poor and therefore likely to be at high risk in terms of health status.

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General health care

Health status indicators sourced from the National Statistics Office are shown in Table 1.

The available health resources are not only inadequate but also inequitably distributed. There are 548 government and 1146 private hospitals; the government

Table 1. Health status indicators for the Philippines, 2001 and 2002

Health status indicator	Year 2001	Year 2002
Life expectancy at birth (years)		
Male	66.63	66.93
Female	71.88	72.18
Crude birth rate (per 1000 population)	26.24	25.7
Crude death rate (per 1000 population)	5.83	5.80
Total fertility rate (no. of children per woman)	Not available	3.23

Source: 1995 census-based national, regional and provincial projections, National Statistics Office.

health workforce comprises 2848 doctors, 4945 nurses, 16 173 midwives and 14 267 staff working in barangay health stations. Based on the population in 1997, the ratio of government health workers to population is as follows: 1 doctor per 9727 people, 1 dentist per 36 481, 1 nurse per 7361, and 1 midwife per 4503. This situation has been aggravated by increasing numbers of health workers gaining employment overseas. A wave of physicians, both general practitioners and specialists, have been shifting to nursing in order to cash in on the great demand for nurses in the USA, the UK and other countries. Already, many hospitals are finding difficulty in keeping experienced nurses and maintaining optimum standards of care as nurses use the hospitals merely to acquire the required minimum clinical experience before seeking employment abroad.

Mental health care: provision and demand

The provision of mental health services is outlined in Table 2.

There has been no nationwide study on the prevalence of psychiatric disorders in the Philippines. However, the World Health Organization (2001) estimates that 1% of the population suffers from severe psychiatric disorders or neurological conditions. In a country where disasters, both natural and manmade, are common, psychosocial problems abound, yet mental health remains a low priority for health agencies.

Some other studies on mental health are listed below.

- Baseline study conducted in a Pampanga municipality by the Department of Health (DOH) Division of Mental Hygiene (1964–67). The prevalence of mental disorders was estimated to be 36 per 1000 adults and children.
- WHO Collaborative Studies for Extending Mental Health Care in General Health Care Services. This was a seven-nation collaborative study conducted in 1980. It found that 17% of adults and 16% of children who consulted at three health centres in Manila had mental disorders. Significant also was the finding that depressive reactions in adults and adaptation reactions in children were frequent.
- University of the Philippines–Philippine General Hospital (UP–PGH) Study in Sapang Palay, Bulacan (1988–89). This found that the prevalence of schizophrenia was 12 per 1000 adults.
- Population Survey for Mental Disorders by the UP–PGH Psychiatrists Foundation, Inc. (1993–94), done in collaboration with the Regional Health Office. This study covered both urban and rural settings in three provinces (Iloilo, Negros Occidental, and Antique). It estimated that the prevalence of mental disorders was 35%. The three most frequent diagnoses among adults were: psychosis (4.3%), anxiety (14.3%) and panic disorder (5.6%). The five most prevalent psychiatric conditions among adolescents and children were: enuresis (9.3%), speech and language disorders (3.9%), learning disabilities (3.7%), adaptation reactions (2.4%) and neurotic disorders (1.1%).

Current realities of Philippine mental health care

Financing

Only 2–3% of the national budget is allocated to health care – a figure way below the World Health Organization's recommendation for developing countries. Of the total health budget, the country spends only 0.02% on mental health. The primary sources of mental health financing, in descending order, are: taxation, out-of-pocket expenditure by the patient or family, and social insurance. Sadly, mental disorders are not covered by most health maintenance organisations, nor by the Philippine health insurance system.

Policy

The Philippines has as yet no mental health act. The National Health Policy was expressed in the National Objectives for Health (1999–2004), which had two key objectives:

- a reduction in morbidity, mortality and disability and complications from mental disorders

A wave of physicians, both general practitioners and specialists, have been shifting to nursing in order to cash in on the great demand for nurses in the US, the UK and other countries. Already, many hospitals are finding difficulty in keeping experienced nurses and maintaining optimum standards of care as nurses use the hospitals merely to acquire the required minimum clinical experience before seeking employment abroad.

Table 2. Numbers of psychiatric beds and professionals

Total psychiatric beds per 10 000 population	0.9
Psychiatric beds in mental hospitals per 10 000 population	0.56
Psychiatric beds in general hospitals per 10 000 population	0.3
Psychiatric beds in other settings per 10 000 population	0.03
Number of psychiatrists per 100 000 population	0.4
Number of neurosurgeons per 100 000 population	0
Number of psychiatric nurses per 100 000 population	0.4
Number of neurologists per 100 000 population	0.2
Number of psychologists per 100 000 population	0.9
Number of social workers per 100 000 population	16

Source: World Health Organization (2001).

‘Mental health problems do not affect 3 or 4 out of 5 persons, but one out of one’ (Dr William Menninger).

- the promotion of mental health through less stressful lifestyles.

The vision enunciated in the National Mental Health Policy is ‘better quality of life through total health care for all Filipinos’. It provides direction for ‘a coherent, rational and unified response to the nation’s mental health problems, concerns and efforts through the formulation and implementation of the mental health program strategy’. The goal of the Policy is to achieve ‘mental health care through the development of efficient and effective structures, systems, and mechanisms that will ensure equitable, accessible, affordable, appropriate, efficient and effective delivery to all its stakeholders by qualified, competent, compassionate, and ethical mental health care professionals and service providers’.

Although the National Health Policy was written by the Department of Health, its policies, programmes and guidelines have reached only to the regional level. At the local level (provincial, city and municipal), the Department of Interior and Local Government implements only basic health services, based on available budget, the priorities of local leaders, political will and local realities.

Drug misuse is a major area of concern. It has recently been given a boost with the enactment in 2002 of the Dangerous Drugs Act (Republic Act 9165). With this Act, the Department of Health has been tasked to set standards and monitor the operations of drug testing laboratories, to set standards for the operation of drug treatment and rehabilitation centres, and to accredit physicians who evaluate and treat substance misuse.

Likewise, the Tobacco Regulation Act of 2003 (Republic Act 9211) explicitly assigned to the Department of Health the demand-reduction efforts concerning tobacco dependence and smoking cessation.

Within the Department of Health, the National Programme for Mental Health is being restructured as the National Programme for Mental Health and Substance Misuse, to reflect the changes imposed upon it by the newly revised drug law.

Service delivery

The Department of Health’s current number of in-patient beds for mental disorders amounts to 5465. Of these beds, 77% (4200) are in the National Centre for Mental Health (NCMH) in the NCR. The rest (23%, or 1265 beds) are distributed across the remaining regions. Only 10 regions have psychiatric in-patient facilities. Mental health units have 25–100 beds; these provide out- and in-patient care, consultation–liaison, and forensic services.

In response to the ill effects of long-term confinement and the advantages of community-based mental health strategies, acute psychiatric units (APUs) were developed. Ten government general hospitals were designated as pilot areas for the development of APUs, which initially provided out-patient services. The objective was to integrate mental health within general health care in these centres and to bring mental health services closest to where the need is. This was also part of the process of eventually phasing out the NCMH and distributing patients to psychiatric units in regional medical centres or provincial hospitals. Primary health workers were likewise trained in the identification and management of common psychiatric morbidities in order to prepare the community for the eventual closure of psychiatric institutions.

Workforce

There are currently 412 psychiatrists in the Philippines. Of these, over half (237 or 58%) practise in the NCR. Similarly, the majority (65%) of the 181 (44%) board-certified specialists practise in the NCR.

All 27 medical schools in the Philippines teach psychiatry in the undergraduate curriculum. There are 12 training centres accredited by the Philippine Psychiatric Association to offer residency training programmes in psychiatry. Of these accredited training centres, eight are in the NCR, 1 in the Cordillera Autonomous Region (Baguio), 1 in Region VI (Iloilo), 1 in Region VII (Cebu) and 1 in Region XI (Davao).

Challenges to overcome

New mental disorders are emerging, including the behaviour disorders of youth and the mental health consequences of HIV. The absolute and relative numbers of mental and neurological disorders are expected to increase in the years to come. Demographic changes, changed patterns of substance misuse, and the successes of medications (leading to survival of people who would have died from chronic diseases) will contribute to the trend of increasing prevalence of mental health problems.

The rising costs of mental disorders are forcing managed care to the forefront of medical practice in the Philippines. Associated costs arise from: lost employment and productivity, the impact on the productivity and social function of families and carers, and premature death (including suicide). As practised in the USA, a business ethos dictates the practice of medicine.

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Thus, there are major challenges to contend with. These include the following:

- the increased incidence and prevalence of mental disorders
- the low priority given to mental health programmes and services
- separation of mental health from general health programmes
- neglect of the psychological needs of people living with chronic diseases
- stigma and discrimination against people with mental illness and substance misuse or dependence, and their families
- limited capacity for research into mental health and evaluation of mental health services
- coping with the effects of social factors negatively affecting mental health (e.g. poverty and the effect of minority status – children, women, ethnic groups – disasters, armed conflict and terrorism)
- weakening of the informal social support given to people in need and of social cohesion in general
- poor community awareness of the nature and determinants of mental health and mental illness

- limited coordination between the Department of Health, the Philippine Psychiatric Association, academia, and other agencies providing prevention, treatment, rehabilitation, disability support and social services, including housing, employment and welfare
- serious shortages of professional workers trained in mental health
- lack of medicines and other resources
- insufficient attention to demand-reduction and harm-reduction strategies for alcohol and substance misuse and dependence.

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COUNTRY PROFILE

Mental health services in Bermuda

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Bermuda comprises a group of small islands in the Atlantic Ocean, situated approximately 1000 km east of the USA. It is a self-governing crown dependency of the UK. It is the third richest country in the world, with average wages per head of US$41 495 in 2000. Its economy is based on a flourishing offshore insurance industry and tourism.

Psychiatric services

Bermuda's health care comprises both private and public initiatives. Employees are required to obtain health insurance for themselves and their dependants. For those who are not insured, the government provides through the public system.

The island has two hospitals, King Edward VII Memorial Hospital, a general medical hospital, and a separate psychiatric unit, St Brendan's Hospital. The latter provides mental health care for the majority of the islanders and receives a budget of over US$28 million per year.

Human resources

St Brendan's Hospital employs three adult and one child and adolescent psychiatrist. Each adult psychiatrist takes on the responsibility for providing one specialist area of service. The majority of staff in the hospital are Bermudian, although, given the global shortage of suitably qualified mental health staff, Bermuda recruits actively for doctors, nurses and allied staff in jurisdictions such as the UK, Canada, Australia and the USA. The cultural diversity of the staff produces an interesting mix of perspectives and ideas about health care policy.

Overview of services

Since the early 1980s, mental health policy within Bermuda has focused on making services more accessible, more community oriented and less stigmatised.

The closure of two long-stay wards in the 1980s provided the momentum for the development of community mental health teams. Teams are multi-disciplinary; individual members case manage up to 50 patients. Bermuda's small size facilitates assertive outreach.

There is a housing shortage for people with severe mental illness. The high cost of real estate due to the expansion of the business sector makes accommodation costs prohibitive for those on a low income and finding cheaper accommodation, such as at the island's Salvation Hostel, can be difficult. Many individuals with severe mental health problems live with their families, despite the high level of burden this frequently places on carers.

There are 25 acute hospital beds, including 5 on a psychiatric intensive care unit. Shortage of beds is unusual and this reduces the pressure to discharge patients before recovery is complete. A small rehabilitation unit offers a comprehensive package of psychosocial interventions for patients with complex needs; it has a philosophy of engagement for up to 2 years.

Two learning disability wards remain within the hospital but a government initiative aims to provide one new group home each year and a community learning disability service.

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Consumers of mental health services

The population of Bermuda is some 65 000, approximately 60% Black and 40% White. The population is relatively wealthy and well educated.

Despite the turnover of expatriates employed in the business sector, the population is relatively static and this allows for an accurate and up-to-date case register of clients who use the service.

Education and research

St Brendan's Hospital is currently accredited for training by the Royal College of Psychiatrists. This is important to

the hospital, as it helps to maintain standards of care and benchmarks training against UK standards and practice.

A recent community survey commissioned by the hospital board highlighted the need to improve the awareness of mental health issues in Bermuda; a campaign to reduce stigma and provide education is under way.

The relative stability and small size of the population of Bermuda facilitate genetic and epidemiological studies into mental illness. In particular, there appears to be a strong line of schizophrenia and bipolar affective disorder among the St Davids islanders. Collaborative research projects are currently being explored. One study is currently looking at the effect of cannabis on the presentation of psychosis.

Mental Health Act

The Mental Health Act is largely based on the English Act. There is an assessment order and a longer treatment order that lasts for up to 1 year. Two consultant psychiatrists make a recommendation to either a nearest relative or a mental welfare officer. Appeals are allowed and there is a tribunal which hears cases, presided over by a lawyer.

COUNTRY PROFILE

Canadian psychiatry: a status report

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The delivery of health care in Canada is shaped by a number of variables – geography, legislation, federal structure, location and culture.

A vast geography

At 10 million km^2, Canada is the second largest country in the world but it is sparsely populated – it has only 32 million inhabitants. Canada would cover the whole of Europe and part of Asia but two-thirds of the population live within 300 km of the US border.

A federally monitored Health Act

Since 1967, the country has embarked on the ambitious provision of 'medically necessary' health care to all its citizens based on five tenets – universality, comprehensiveness, accessibility, portability of coverage and non-profit public administration. These equally apply to mental and addiction disorders. Currently, the main problem is long waiting lists interfering with accessibility.

The dynamics of provincial jurisdiction

Each of the governments of the ten provinces and three territories has the responsibility and control of health care within its own boundaries. The national congruence of service delivery remains remarkable.

Location

Canada's contiguity with the USA shapes the public debate concerning health care. On the one hand, national pride is readily expressed at the high standards of North American care delivery, while training and publishing in the USA are highly valued; on the other hand, there is widespread public concern about the excesses of US-based managed care and the significant portion of that population without insurance. This results in a determined effort to learn from both US and European influences to create a uniquely Canadian blend (Rae-Grant, 2001).

A cultural mosaic

Canada is a welcoming land of opportunity to a steady stream of immigrants and with a birth rate of 1.5 children per couple the country will continue to depend on migration for its sustenance. With two official languages, English and French, and many unofficial cultures, multiculturalism rather than a 'melting pot' policy is one of the prized social characteristics. The health care workforce reflects society's mosaic. The first inhabitants of this country, the First Nations, have not fared well so far and this is reflected in higher morbidity and mortality risks.

Canadians in general highly value their health care system, known as medicare (which is publicly financed but privately run) and public polls suggest that medicare is considered an essential ingredient of Canadian identity. There are concerns, however, about the capacity to sustain it (Romanow, 2002).

Mental health policies and statistics

The Canadian Community Health Survey (CCHS) in 2002 reported that some 20% of Canadians personally experience some form of mental illness during their lifetime (Health Canada, 2002). Eighty-six per cent of hospital admissions for mental illness are to general

The Canadian Community Health Survey (CCHS) in 2002 reported that some 20% of Canadians personally experience some form of mental illness during their lifetime.

hospital. Seven major mental illnesses (excluding addiction) account for 3.8% of all general hospital admissions. Between 1950 and 1975, 35 000 beds for patients with mental illness were eliminated from psychiatric hospitals but only 5000 were added to general wards. In 2001–2002, while psychiatric hospitals accounted for only 13% of all admissions for mental illness, the average length of stay in psychiatric hospitals was 162 days, compared with 25 days for general hospitals. These average lengths of stay were down 35% from 1994–1995. The widespread policy of deinstitutionalisation did not, however, induce an appropriate increase in community-based services. Provincial Mental Health Acts have increasingly upheld patients' rights, and involuntary hospitalisation is currently limited to the presence of 'immediate danger to self or others'.

Canada's suicide rate is relatively high. Suicide accounts for 24% of all deaths among 15- to 24-year-olds and 16% among 25- to 44-year-olds. Suicide rates among the First Nations population are three to six times the national average. In 1998, the direct and indirect costs related to mental health problems were estimated to be arguably the highest of all conditions, representing some 14% of the national corporate net operating profits.

Human resource planning for psychiatry

Physician resource planning is a puzzling task. Canadian psychiatry has been involved in human resource planning for some 40 years and in the process doubled the number of psychiatrists per population between 1972 and 1997 (el-Guebaly, 1999). Severe shortages remain in all geographical areas and all sub-specialties. Since the 1990s, a target psychiatrist : population ratio of 1 : 8400 has been achieved and surpassed in many urban areas. Some 4000 psychiatrists, 10% of whom are child psychiatrists, address the needs of the population of 32 million, with an average working week of 46 hours. Only the USA and The Netherlands have comparable ratios. The patients seen display a DSM–IV Axis I diagnosis (American Psychiatric Association, 1994) in 86% of cases and half will have more than one diagnosis.

There are on average 600 residents in training programmes and of the graduates of medical school 6–7% choose psychiatry. While statistics about the supply of physicians abound, less is known about the drivers of demand for their services – demographics, prevalence of illness, standard of living or accessibility or cost. Family physicians are the most commonly consulted professionals for mental health problems, followed by psychiatrists and psychologists. Of late, a shared-care model of delivery with family physicians and, on a more limited basis, with paediatricians has been implemented (Kates *et al*, 1997). Interdisciplinary teams staff most publicly funded mental health services, but national figures about other professions specialising in mental health are not readily available.

International medical graduates have accounted for about a quarter of the supply of physicians in Canada, this portion doubling in the provinces of Newfoundland and Saskatchewan. The current shortage of physicians and the fact that their average age is 49 years have spurred a renewed effort to streamline the entry of prospective immigrants through the Medical Council of Canada, provincial licensing colleges and medical schools.

Educating physicians in psychiatry: a lifelong process

Undergraduate courses

The 16 medical schools generally have a 4-year medical curriculum, although a few offer a 3-year course. The Canadian Psychiatric Association, founded in 1951, supports the organisation of Coordinators of Undergraduate Psychiatric Education (CUPE) to provide a forum for identifying the core knowledge, attitudes and skills required for graduation. Graduating students are evaluated by the Medical Council of Canada Licensing Examination, where about 20% of the questions are on psychiatry. A multiple-choice format as well as observed structured patient interviews are used to test the students. Broad topics taught in the pre-clinical years include interviewing skills, the doctor–patient relationship, detection of psychopathology and diagnosis, as well as specific subjects such as violence and mental health legislation.

Currently most schools have autonomous courses in psychiatry somewhat complementary to the neurosciences. The clinical clerkship rotation in the final years varies between 6 and 8 weeks. Medical students, particularly female students, have of late regarded psychiatry as a much more attractive specialty than in the past (Leverette *et al*, 1996).

Evolving postgraduate education

The accreditation of postgraduate training is the purview of the Royal College of Physicians and Surgeons of Canada (RCPSC), which has the task of certifying specialists from all disciplines. With the incorporation of the internship year under the direction of the chosen specialty, training in psychiatry is, in fact, a 5-year process, not uncommonly complemented by a 6th year of academic fellowship.

Training requirements and objectives reflect a balance between biological and psychotherapeutic approaches, as well as the promotion of evidence-based clinical practice guidelines (Cameron *et al*, 1999; Paris, 2000). The 'social contract' required of medical specialties is also a concern of the Royal College. The 'Can MEDS 2000' project identified a cluster of seven competencies to be achieved in training: medical decision maker, communicator, collaborator, manager, health advocate, scholar and professional (Societal Needs Working Group, 1996). It remains uncertain as to how well these requirements are being met.

Other training challenges have included the provincial budget reductions to the hospital sector, which have resulted in a shift to 'community-based care' training and increased involvement in multi-disciplinary teams. This shift has also resulted in the increased involvement of family

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Canada's suicide rate is relatively high. Suicide accounts for 24% of all deaths among 15- to 24-year-olds and 16% among 25- to 44-year-olds.

physicians in the care of people with a mental illness and 'shared care' programmes, where psychiatrists and trainees provide consultations in family physicians' offices.

A perennial organisational issue has been the accommodation of sub-specialty training. Canadian psychiatry, compared with US psychiatry, has been very conservative in recognising sub-specialties and currently identifies only three – child, geriatric and forensic psychiatry. The Royal College recommends a 2-year sub-specialty programme, one within the 5-year complement and one additional to it, but the debate continues. Members of other sub-specialty practices such as addiction or administration have sought credentialing from US organisations to remedy the lack, so far, of such an avenue in Canada.

Pressure to incorporate new knowledge and skills in the training programme has somewhat eased with the concept of lifelong education.

Continuing professional development and maintenance of certification

Education does not end with graduation from a training programme. Indeed, graduation certifies the acquisition of necessary skills to embark upon a journey of lifelong learning. It is of interest that several of the less popular topics among training residents are in high demand in continuing education activities.

'Top down' lectures are of limited value and have been partly replaced by needs-based activities, including reading, meeting with colleagues, quality assurance and brief traineeships. The Royal College Maintenance of Competence programme rates continuing medical education programmes, including their funding source, particularly from industry; there is also a random audit of learning diaries. An annual report of these activities for a total of 400 credits over a 5-year period is required to maintain specialty certification (Royal College of Physicians and Surgeons of Canada, 1999).

The practice of psychiatry is increasing in complexity, with such cumulative demands on practitioners as lifelong learning, as well as the expectations of increasingly informed consumers.

The challenges of psychiatric research

Following the Second World War, Canada made a far-reaching decision not to create national research institutes like those in the USA but to create instead a Medical Research Council and develop research capacity within the 16 medical schools. This initiative has had mixed results and over the past 5 years the Canadian Institutes of Health Research have channelled research funds from governments while fostering the creation of multi-disciplinary, inter-provincial research teams to implement a consensual research agenda.

Compared with the burden on society placed by mental illness and addiction disorders, research into these has been persistently underfunded, at about 4% of the total government expenditure on health research.

Compared with the burden on society placed by mental illness and addiction disorders, research into these has been persistently underfunded, at about 4% of the total government expenditure on health research. Indeed, this funding shortage would have been worse were it not for the ability of Canadian researchers to access US funds. This has also led to the pharmaceutical industry assuming a prime role in funding pharmacological clinical trials, which range from the truly innovative to post-marketing surveys.

In the 1950s, the McGill University group, headed by Dr Lehman, was credited for introducing several neuroleptics and tricyclics to North America. Currently the Canadian College of Neuropsychopharmacology monitors a thriving network of trials in schizophrenia, mood and anxiety disorders and more recently pharmacological trials on the early manifestations of mental illness.

In the field of epidemiology, Dr Leighton's Stirling County Study of Psychiatric Disorders has now developed into a multi-sited group of collaborators, which has resulted in achievements such as Dr Bland's Edmonton city-wide surveys, Dr Offord's Ontario Child Health Study, and Dr Arboleda-Florez's forensic work.

Several diagnosis-specific clinical investigations have had a significant effect on practice. These studies have looked at: linkage and association in schizophrenia (Drs Bassett and Maziade), sex differences (Dr Seaman), eating disorders (Dr Garfinkel), personality disorders (Drs Paris and Livesley), affective disorders (Dr Kennedy), anxiety disorders (Dr Stein), addiction (Drs Negrete and el-Guebaly) and psychotherapy (Drs Azim, McKenzie and Leszcs).

Conclusion

Psychiatry in Canada is a vibrant specialty within an evolving universal health care system. A recently formed coalition of 12 non-governmental organisations, including the Canadian Psychiatric Association, has urged government to identify specific mental health goals, a policy framework embracing both mental illness and mental health promotion, adequate resources to sustain the plan and an annual public reporting mechanism (Canadian Alliance on Mental Illness and Mental Health, 2000).

At the same time, the practice of psychiatry is increasing in complexity, with such cumulative demands on practitioners as lifelong learning, as well as the expectations of increasingly informed consumers. Hospitals downsizing and the pressure to discharge patients early without a significant increase in community resources have increased workload stress. Programmes addressing physicians' stress and impairment are increasingly popular. Expanding telehealth programmes appear to provide some relief to poorly resourced communities. While fee-for-service was the main form of remuneration for physicians, alternative forms of sessional payments are becoming popular. The motto 'the only constant is change' describes well Canada's current health care and psychiatric practice.

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SPECIAL PAPER

Recruitment of consultant psychiatrists from low- and middle-income countries

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The UK's 2-year International Fellowship Programme for consultant doctors has inadvertently highlighted the long-standing issues of the costs and benefits of such recruitment for the countries of origin, and of whether it is ethical for rich countries to recruit health personnel not only from other rich countries but also from low- and middle-income countries. The 'brain drain' from poor to rich countries has been recognised for decades; it occurs in the health sector as well as other sectors, such as education, science and engineering. It has had serious ramifications for the health service infrastructure in low-income countries, where poverty, morbidity, disability and mortality are increasing rather than decreasing, and it is a matter of serious concern for both the World Health Organization and the International Monetary Fund (Carrington & Detragiache, 1998; Lee, 2003).

This article seeks to explore some of the ethical issues surrounding the recruitment of psychiatrists from low- and middle-income countries, and to stimulate debate. The UK is not alone in its recruitment from low- and middle-income countries as well as from rich countries, and a number of other articles have drawn attention to the attendant problems (e.g. Ehman & Sullivan, 2001; Pang *et al*, 2002; Patel, 2003; Scott *et al*, 2004).

The ethical issues of international recruitment of psychiatrists as well as other health personnel concern:

- the rights of those who are recruited
- the rights of the population to which they are recruited
- the rights of the population from which they have come.

On the first, the UK Department of Health has gone to considerable lengths to establish a supportive framework for recruitment, and provides an enhanced package, relocation expenses on arrival and return, and refund of pension contributions upon return. Recruits are entitled to participate in a programme of continuing professional development in the same way that all consultants are encouraged to do.

On the second, the UK has long experience of recruiting from low- and middle-income countries, and the clinical and cultural competence of psychiatrists from regions such as Africa and Asia is not in question.

This article is focused on the third aspect – the ethical issues for the population from which the psychiatrist was recruited. What are the rights of people living in poor countries to have accessible health care, which is not doubly disadvantaged by the Western-driven brain drain, as well as by the economic structural adjustment programmes which are imposed by Western aid donors?

This article is focused on … the ethical issues for the population from which the psychiatrist was recruited.

Variation in the distribution of psychiatrists worldwide

The World Health Organization (2001) has recently compiled data from governments on the distribution of human resources in mental health, and the International Consortium for Mental Health Policy and Services has produced detailed country profiles of context, needs, service inputs, processes and outcomes (Gulbinat *et al*, 2004; Jenkins *et al*, 2004; website www.mental-neurological-health.net). While the UK has 1 psychiatrist per 25 000 population, the US has 1 per 10 000,

Denmark and Iceland have 1 per 2000–3000, and Eastern Europe has 1 per 10 000 (although Eastern European psychiatrists have generally received much shorter specialist training than in the UK), there is on average 1 psychiatrist per million in sub-Saharan Africa and in some countries as few as 1 per 5 million.

Kenya is currently depleted of over a quarter of its psychiatrists and nearly all its occupational therapists. Sri Lanka has trained over 70 psychiatrists, of whom 62 have left the country, mostly for the UK.

Costs for low- and middle-income countries

If the UK recruits a consultant psychiatrist from a low- or middle-income country, the opportunity cost for that country is significant. First, there is the cost of training that psychiatrist (6 years in general medicine, 1 year in internship and at least 4 years in psychiatry, comprising at least 11 years' training). These are costs for the health services and the universities which provided the training and clinical supervision, and ultimately costs for the general population, from whom the taxes were raised.

Second, there is the cost of the loss of the accumulated years of consultant experience in service development and policy dialogue, teaching, clinical supervision and direct clinical work, which will not be available to the country of origin while the consultant is absent in the UK. These consequences will be felt for decades, in teaching programmes, which are severely weakened, a lack of mental health input into the health sector reform process, and a lack of consultancy, supervision and support for other mental health professionals and for primary care. For example, Kenya is currently depleted of over a quarter of its psychiatrists and nearly all its occupational therapists. Sri Lanka has trained over 70 psychiatrists, of whom 62 have left the country, mostly for the UK.

Third, there is the cost of trying to find a replacement, the opportunity cost of diverting someone else, for example a senior psychiatric nurse or clinical officer from the job which they are currently doing, with a cascade of consequential opportunity costs down the line, and the cost of living without a replacement. If the UK lives without one consultant, 25 000–50 000 people are deprived. If a middle-income country lives without a psychiatrist, 500 000 people are deprived, and if a low-income country lives without a psychiatrist, 1 000 000 or more people are deprived.

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It has been argued that skilled health personnel are an exportable asset for poor countries, and generate income (in the form of remittances) for the source country, so offsetting the costs of training and other losses. However, remittances by health workers are not directly reinvested in human capital for the health system (Stilwell *et al*, 2003) and cannot match the losses resulting from the exit of experienced health personnel from a grossly understaffed health service (Scott *et al*, 2004).

Case examples of ethical issues posed by recruitment from a middle-income country

South Africa's former President Nelson Mandela has specifically asked the International Fellowship Programme not to recruit from South Africa. If President Mbeki had agreed to active recruitment from South Africa, would this have made it ethical?

The Indian government, on the other hand, has agreed to active recruitment by the UK and so the International Fellowship Programme has established an active and successful recruitment scheme in India. The Indian Minister of Health and Family Welfare responded to a parliamentary question in July 2003 by saying that the overall availability of doctors in India is sufficient.

In this context, it is worth noting that India has only 4 psychiatrists per million population (Khandelwal *et al*, 2004) and that the National Mental Health Programme 2002–2007 for India comments that 'The available resources with regard to trained manpower, infrastructure and fiscal inputs need to be augmented to deal with the immense burden of mental illness'. Even these scarce resources are unevenly distributed and vast sections of the population do not have ready access to mental health care. Only 27 of the 593 districts in the country are covered by the District Mental Health Programme. Furthermore, India is a federal country, and the experience of individual states does not necessarily support the Federal minister's confidence. For example, the government of Gujerat's mental health care policy (draft, February 2004, para. 17.1) states that:

> There is a shortage of trained MH professionals in MH sector. Gujerat has 163 qualified psychiatrists (0.4 per 100,000 of population) and less than 50 psychologists. Despite the fact that Gujerat has 23 general nursing colleges, there are few trained psychiatric nurses. Availability of other para-MH professionals such as trained social workers in this area is also low. Involvement of these professionals is considered to be the basic condition for developing and implementing community based and cost effective interventions in the MH sector. Non-availability of trained human resources hinders the process of developing interventions. This constraint is experienced at all levels and in all settings of care. Lack of professionals also hinders the use of multidisciplinary approaches to improve quality of care.

The advantages of recruitment from low- and middle-income countries

A small number of recruits have come to escape persecution in their own countries; clearly, we would wish to offer asylum as usual in such cases, and the Department of Health has instigated a training programme for refugee health professionals.

The International Fellowship Programme argues that it is of benefit for international recruits from low- and middle-income countries to spend 2 years in the UK learning new skills, and to sample life in the UK. On the first issue, that of learning new skills, there is substantial experience in low- and middle-income countries of the costs and benefits of sending people overseas for training, and there are better ways of learning new treatment and service development skills which can be more appropriately tailored to the service contexts of their countries. This would involve brief training placements in the UK

and training the trainers inside the country of origin, thus avoiding the risk of permanent emigration and ensuring that training is appropriate to the local service context. On the second issue, of sampling life in the UK, there is unfortunately long experience that if health personnel move to a rich country such as the UK for more than a few months, particularly if they bring their families, then they are likely to stay. The decision to stay will undoubtedly be in the UK's interest, but hardly in the interest of the country from which those doctors come.

What are the possible ways forward?

The National Health Service does increasingly fund small numbers of short visits of UK personnel to travel for training and service development purposes to low-income countries; universities have long had such international relationships and the College is exploring the establishment of a database and monitoring system to facilitate tailored placements of senior UK consultants at the request of low- and middle-income countries. The Department of Health is working on an exchange programme of visits, each of 2–3 months, whereby young consultants can visit the UK and be exposed to the areas of work which they would like to develop back home, and where experienced specialist registrars can visit India for short attachments (although there is as yet no agreement that this will count towards higher training, and it will depend on trusts continuing to support their UK salaries as well as any additional living expenses in the host country). However, these welcome initiatives do not begin to compensate low- and middle-income countries for the extensive permanent brain drain which they have suffered and continue to suffer.

It is important to distinguish between the individual liberty to work where one chooses and the systematic exploitation of relatively poor health systems by relatively rich countries. The College has spoken out on a number of occasions about the damage done to low- and middle-income countries through the overseas recruitment of their medical professionals, has an honourable record in not recruiting from South Africa, and has repeatedly expressed disquiet about the International Fellowship Programme. However, the College does have a role in scrutinising initial applications, and has allowed them to go forward from poor countries. Should the College negotiate with the Department of Health to restrict the eligibility of people from low- and middle-income countries? Would this be ethical? What of equal opportunities? Is the current College position on the recruitment of consultants compatible with its approaches to trainees? More strategic action could be taken to find local solutions to developing sufficient numbers of psychiatrists (Jenkins & Scott, 1998; Department of Health & Royal College of Psychiatrists, 2004).

The Department of Health could speedily restrict its active recruitment to rich countries, before substantial further damage is done to poorer countries. Even middle-income countries have much to lose. There are considerable urban–rural variations in the distribution of psychiatrists, so that even in middle-income countries large parts of the population have access to less than 1 psychiatrist per million population. For example, in Egypt there are a number of regions of 3 million population with only one psychiatrist.

There could be an international agreement (e.g. Commonwealth Secretariat, 2003) between all member states of the World Health Organization so that the country of origin is compensated on an annual basis for the cost of the training and experience of the international recruit, preferably multiplied by the relative disparity in the doctor : population ratio. Thus the UK would have to pay proportionately more to a country where the average doctor : population ratio was 1 per million than to a country where it was 1 per 10 000. Then the argument that such recruitment was of benefit to the country of origin would be rather stronger than it is now, and richer countries would be more circumspect in recruiting from low- and middle-income countries. Indeed, it would then rapidly become more cost-effective to design alternative solutions, and to increase local training capacity, than to recruit experienced professionals from poorer populations, take advantage of the training investment previously made by the poorer country, and thereby exacerbate the net flow of resources from poor to rich populations.

There could be an international agreement … between all member states of the World Health Organization so that the country of origin is compensated on an annual basis for the cost of the training and experience of the international recruit, preferably multiplied by the relative disparity in the doctor : population ratio.

Low- and middle-income countries perforce have to design service structures that are tailored to their human resources. There is much that the UK can learn from some of these service designs (Jenkins *et al*, 2002), with their emphasis on primary care and on nurse leadership, so that it does not continue to recruit from poorer countries in order to achieve a gold standard service which can be maintained only at the expense of the poor populations of the world.

Conclusion

In conclusion, the damage to low- and middle-income countries caused by the emigration of psychiatrists as well as of other health personnel is all too apparent, and continues to be of substantial concern. The World Health Assembly recently passed a resolution on migration to the developed world (WHA57.19 on the WHO website www.who.int). We welcome debate on potential ways forward to protect the health investments made by low- and middle-income countries, including in their psychiatrists.

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The Editor invited the Department of Health to respond to the issues raised by David Ndetei *et al*, and Catherine Jenkins, NHS International Fellowships Project Manager at the Department, does so in the article 'Ethical international recruitment'.

SPECIAL PAPER

Ethical international recruitment

Catherine Jenkins

NHS International Fellowships Project Manager, Department of Health, email Catherine.Jenkins@doh.gsi.gov.uk

Right from the start of our international recruitment campaign the Department of Health was determined to ensure that international recruitment takes place using a planned and managed approach. Now, the UK leads the way in developing and implementing the types of international recruitment policies called for by the World Health Assembly.

The UK is:

- the first country to produce international recruitment guidance based on ethical principles and the first to develop a robust code of practice
- the only country to produce a list of developing countries from which active international recruitment should not take place, because we are concerned to protect the health care systems of developing countries
- the only country to publish an approved list of commercial recruitment agencies and to monitor their activities abroad
- the only country to commit publicly to recruit via government–government agreements.

National Health Service (NHS) trusts work to a Department-approved Code of Practice, which can be found on the Department's website (www.dh.gov.uk). The principle we follow is that there should be no international recruitment which harms either health care staff or the health care system of the country from which they come. The NHS does not actively recruit from developing countries unless they invite us to do so.

Compendium of the NHS's Contribution to the Developing Nations – see www.dh.gov.uk/assetRoot/04/06/88/33/04068833.pdf

Where a developing nation has invited us to recruit health care staff, then we do so in full consultation with its government. This applies both to the Philippines in the case of nurses and to India in the case of medical specialists and some nursing staff.

We have worked closely with the Indian Ministry of Health in the development of the campaign in India and it has been very supportive of the opportunities we are offering doctors who have trained in India. The Indian Minister of Health and Family Welfare responded to a parliamentary question in July 2003 by saying that the overall availability of doctors in India is sufficient. We meet with the Indian High Commission regularly and have asked the Indian government to alert us to any changes in the position.

It is vital to stress that we would not recruit from India if the Indian government did not want us to. We take our responsibilities to developing countries very seriously, and we work closely with India and other developing countries to support them in developing programmes to retain and develop their staff. In some cases, we offer fixed-term placements in the NHS as part of their health care professionals' career planning.

Medical personnel from India move all over the world. They do so to improve their prospects and opportunities, quality of experience, standard of practice, and chances for development and training. If the doctors relocate without support there is greater risk of exploitation by agencies and of being isolated and unsupported when they arrive. The Department's international recruitment programmes offer:

- routes to appointment as consultants
- support for obtaining registration
- a good relocation package, including support for the doctor's family
- induction, mentoring and pastoral support while they are in the UK.

The NHS International Fellowship Programme was launched in spring 2002 and is designed to recruit qualified specialists to work in the NHS for 2-year Fellowships. It is particularly targeted at North America, member states of the European Economic Area, Australia and New Zealand. We also recruit Fellows from India with the agreement of the Indian government. So far over 200 Fellows have accepted offers of appointment in the NHS and over 100 are now in post.

The majority of Indian specialists recruited through the Department's international recruitment process are International Fellows and are using the opportunity to sample living and working in England for a relatively short period. The programme pays for interview expenses, registration expenses and an enhanced relocation package. There is also, very importantly, support to return to India at the conclusion of the Fellowship.

The feedback we have received shows that the Fellows value the opportunity to work in a different health system, acquire new skills, get wider work experience, pursue research interests and develop their teaching skills. Our *International Recruitment Case Studies* publication shows that international recruits are placed in appropriate clinical environments that offer significant benefits both for the doctor appointed and for managers and colleagues.

We have worked very closely with all the Royal Colleges, including the Royal College of Psychiatrists, to make this programme a success. We discuss regularly with the Colleges issues that they are concerned about, including ethical issues. We are working with the College to try to open up more opportunities for well qualified psychiatrists from the USA to get on to the specialist register and work in the UK.

It is also vital that we try to support the health systems of developing countries. In fact, there are many examples of NHS trusts putting a great deal back into developing countries. Much of this work is voluntary and receives little publicity. Many NHS volunteers devote considerable time and resources developing and providing diverse services in countries such as India, Ghana, Uganda, Iran and China. In India, for example, volunteers are providing services in mental health, leprosy prevention, neonatal resuscitation, women's health, sexually transmitted infections and HIV. More examples are given in the *Compendium of the NHS's Contribution to the Developing Nations*.

We have also recently implemented a Support for Humanitarian Aid Fund. This is funded by the Department of Health and is administered through the British Medical Association. Grants from the Fund have been allocated to multi-disciplinary teams, or individuals, who reflect the range of skills and experience within the NHS. Reports received from recipients of the Fund have already indicated the value of their work in developing areas of the world.

In addition, the Department has a programme to support refugee health professionals in the UK. Over the past 3 years, £1.5 million has been made available to support training for refugee health professionals. This funding covers a range of services, including training for English-language testing, communication and clinical training, curriculum vitae and interview skills, mentoring and job clubs. An additional £500 000 will be made available in 2004/05 for refugee health professional projects. This investment is increasing the confidence and success of refugee doctors taking the Professional and Linguistic Assessment Board (PLAB) test and the International English Language Testing System (IELTS).

To suggest that the NHS recruits medical staff solely from developing countries is incorrect. We have successfully recruited doctors from Europe, from the USA and from Australia. There is a long tradition of doctors from other countries coming to the UK at some time in their medical careers. This is something we in the NHS are proud of. The doctors have an excellent learning opportunity, which in turn enhances treatment and care in their country of origin when they return home. The NHS benefits from a highly skilled and well trained workforce.

To receive a copy of *International Recruitment Case Studies*, write to Department of Health Publications, PO Box 777, London SE1 6XH or call 08701 555 455.

ASSOCIATIONS AND COLLABORATIONS

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

Can we – and should we – have a 'Euro-psychiatry' for children and adolescents? The work of the UEMS Section and Board for Child and Adolescent Psychiatry/Psychotherapy

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Since 1994, child and adolescent psychiatry has been a distinct specialty, separate from psychiatry, within the Union of European Medical Specialists (UEMS). It has a slightly curious title, of which more later. It has proved a successful arena for promoting training, and this in turn has led to a developing European view of what exactly child and adolescent psychiatry is, and how it can be practised. This article tries to reflect this.

In the previous issue of *International Psychiatry*, Lindhardt *et al* (2004) explained the composition of the UEMS. One can take various views as to what the UEMS is for. At first sight it is an advisory body to the Council of Ministers and the European Parliament. Because it draws

its members from nominations made by national medical associations, one view is that it is effectively a trade union, promoting the interests of its members. Yet it also draws its delegates from national scientific or academic societies, which indicates that it is rather more than this. It can point, in its policies, to an evidence base for practice and includes both the trainers and the trained. This is a potent source of information and advice on training, and the development of policies on training has been the main success of the UEMS.

It can be argued that another function of the UEMS is as a network of doctors with shared interests yet different traditions, which provides opportunities for fertile discussion of problems and solutions. This occurs both within and outside formal meetings. Within meetings, the UEMS tradition of attempting to obtain consensus first rather than an early resort to voting means that there is considerable open discussion.

Within the UEMS, child and adolescent psychiatrists used to be part of psychiatry. Yet it became apparent that, as is the case in all children's medical specialties, it was adult-oriented physicians who tended to occupy the positions of power.

Why a separate section and board?

Within the UEMS, child and adolescent psychiatrists used to be part of psychiatry. Yet it became apparent that, as is the case in all children's medical specialties, it was adult-oriented physicians who tended to occupy the positions of power. It was sometimes difficult for the child-oriented specialists to be understood or heard. They were in a minority, often used a different knowledge base, had different work patterns and in some countries had separate training from their colleagues in practice with adults.

A small number of child and adolescent psychiatrists, particularly Reinhard Schydlo, made the point that the structure of the UEMS allowed a separate section and board for child and adolescent psychiatry because most European countries recognised child and adolescent psychiatry as a distinct specialty. Accordingly, child and adolescent psychiatry established itself independently within the UEMS in 1994.

One of the first resolutions to be adopted was that the Section (professional interests) and the Board (academic and training) would have the same membership yet different Presidents. This has worked well and has been a protective measure against unhelpful splits.

Why the odd name (Child and Adolescent Psychiatry/Psychotherapy)?

The formal title of the child and adolescent monospecialty within the UEMS is Child and Adolescent Psychiatry/Psychotherapy (CAPP). The last part does not refer to non-medical psychotherapy, nor to psychotherapy with adults. It was chosen because of the difficulty child and adolescent psychiatrists in some countries (particularly Germany) were experiencing in obtaining appropriate reimbursement for psychotherapy with children. It was necessary to make a statement that psychological methods are particularly important in the psychiatric treatment of the young and that they need a degree of medical supervision to prevent inappropriate use by some non-medical practitioners. Whether to retain the '/Psychotherapy' tag is a topic of current debate within CAPP. It has caused a little confusion but it is not the only area in which it is necessary to make the point that child and adolescent psychiatry incorporates a variety of concepts and treatment approaches. For instance, neuropsychiatry is a prominent part of the specialty, especially in Austria and Italy, something which requires emphasis for training purposes.

Well before the existence of the UEMS there was discussion in most countries as to whether child and adolescent psychiatry should be primarily associated with paediatrics or adult psychiatry. This issue came to the fore when medical specialties had to be sorted into groups within the UEMS, so that there could be representation at the Management Council. Taking the views of child and adolescent psychiatrists within the section revealed different opinions. It seemed that those who spent most of their time with pre-adolescent children tended to favour links with paediatrics, and those who treated mainly adolescents saw benefit in close ties with psychiatry.

As it happens, CAPP sends a representative to meetings of each of the two sections and exchanges minutes with both. For the last 2 years CAPP has been one of the leads for representation at the Management Council for a group of specialties including psychiatry.

Training

In common with other Boards within the UEMS, child and adolescent psychiatry has been particularly interested in the harmonisation of specialist training. The first task of the Board was to draw up recommendations and to establish standards, drawing on best practice and giving priority to evidence of effectiveness, independent of any national traditions. This important task has several consequences. First, if specialist training can indeed be harmonised, then there can be free mobility of both specialists and trainees within the European Union (EU) without prejudicing the mental health of children and adolescents. Second, establishing a European consensus as to what training should comprise leads to a definition of a certain sort of specialist. For example, the *Training Log Book* for CAPP, published by the Board and updated in 2000, is explicit that the trained specialist will have 'a bio-psycho-social developmental model in mind' (p. 5). Such a specialist will do more than investigate, diagnose and treat child and adolescent psychiatric conditions, but will include, for instance, preventive activities and advice on issues related to child rearing. Trainees will 'acquire knowledge of and insight into the leadership role of the physician'.

In virtually all European countries, experience in psychiatry with adults of working age is a necessary component of training in child and adolescent psychiatry.

In virtually all European countries, experience in psychiatry with adults of working age is a necessary component of training in child and adolescent psychiatry. Similarly, experience of paediatrics is welcomed or required in many countries. Leaving the traditions of any particular country aside and working out an adequate yet realistic training that would incorporate such experiences led the Board to recommend specific experiences and a 12-month minimum period for training in adult psychiatry. Similar placement in paediatrics or neurology is recommended

but optional. Nevertheless, trainees are required to have knowledge of and practical experience in a number of paediatric clinical problems and situations.

The *Log Book* has been the most important document produced by the Board and has already proved important in helping new EU member countries to develop their own specialist training in CAPP. It can be obtained directly from Aribert Rothenberger.

The standards set in the *Log Book* are high and may well exceed those set by the relevant national authority on training. Nevertheless, they are aspirational. Although it may be the case that a country's training standards fall a little short of the *Log Book*'s standards, there may be individual centres or schemes in that country that do meet them. Such a scheme can apply for Board approval and if a visit confirms that standards are met, the scheme can state that it has UEMS CAPP approval. This requires a visit by Board members, including a trainee, and an unresolved problem is how such visits should be funded. A few have been carried out and the estimated cost is €1000–1500.

Continuing professional development

The UEMS generally is currently concerned with continuing professional development (CPD) and CAPP is no exception. It includes CPD at its meetings but the uneven state of development of CPD across Europe has hampered progress towards harmonisation and the setting of standards. The European organisation established by the UEMS to provide accreditation for CPD events is EACCME and from time to time it asks the Board for advice. The principle adopted by the Board is whether the issues addressed in any CPD event have a scientific evidence basis, and approval hinges upon that. A particular problem for CAPP is that CPD includes contributions from non-medical organisations, for example those concerned with family therapy, and a supranational clearing house for CPD approval needs to be able to accommodate this.

One aspect of CPD that has attracted considerable interest is distance learning. Unexpectedly, this may lead to a closer association with the USA, as there are US commercial programmes for CPD (e.g. in paediatrics) which would like to expand into Europe.

The nature of child and adolescent psychiatry

The point that setting standards and content for specialist training will also influence the type of specialist has already been made. Discussion at UEMS CAPP meetings frequently centres on what child and adolescent psychiatry actually is. Over the past few years, services have been required to provide a remarkable range of activities. At one extreme is finding a place in which illegal immigrant children can stay, while at the other is the need for a precise delineation from paediatric neurology. In order to try to provide an agreed definition of what child and adolescent psychiatrists should do or be required to do, a short statement has been sent out to all EU countries and affiliates. This centres on the specifically medical contribution to child and adolescent mental health and makes the point that the psychiatry as applied to young people is different in many important ways from that applied to adults. Which is, of course, where we came in.

Reference

Lindhardt, A., Gomez-Beneyto, M. & Saliba, J. (2004) The Section and Board of Psychiatry of the Union of European Medical Specialists (UEMS): achievements and perspectives. *International Psychiatry*, no. 5, 19–21.

NEWS, NOTES, FORTHCOMING INTERNATIONAL EVENTS

News and notes

Hamid Ghodse (p. 1) spells out the major developments of the College in its international functioning. The tremendous potential of the International Divisions is illustrated by the issues brought by overseas members to the programme of this year's College conference in Harrogate. Brian Martindale here gives a brief summary.

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Contributions of International Divisions to the College annual meeting, July 2004

Middle East

The Middle East contributions focused on some important cultural aspects of the doctor–patient and family relationships that pose complex issues concerning the therapeutic alliance and ethics when treating the individual. Professor El-Islam informed us of a range of specific cultural issues related to both gender and generation concerning expectations of the psychiatrist on the part of both patients and families. An area that I found particularly interesting was Professor El-Islam's description of the culture-specific dilemmas encountered when working with younger persons with disturbances related to the establishment of their own identity and autonomy, and at the same time the psychiatrist needing the active cooperation of the family for continuation of treatment and the family provision of 'social' services.

Dr El-Dosoky from Egypt gave examples of the complexity of the near ubiquity of the family presence in the relationship with the psychiatrist – its importance and usefulness as well as problematic aspects, including confidentiality. I thought that Middle Eastern psychiatrists may have a great deal to teach UK psychiatrists, who often

A press release from the United Nations Information Service in Vienna has announced that Hamid Ghodse has been elected as Chair of the International Narcotics Control Board (INCB). He is Professor of Psychiatry and International Drug Policy at the University of London, the editor of *International Psychiatry* and Chair of the College's Board of International Affairs. Professor Ghodse is originally from Iran and has been a member of the INCB since 1992; he has served three previous terms as President of the Board.

have little training in working with families and therefore rarely have the confidence and skill to practise evidence-based psychiatry with families.

Other issues that were discussed included the importance of understanding cultural attitudes to emotions, the role of the traditional healer and working out the place of religious treatments. Dr Mahmoud on behalf of Dr Atalla outlined the overall current situation regarding psychiatry and mental health in Egypt and the plans to tackle the uneven distribution of expertise through a health service reform programme, of which a central thrust was the expectation that graduates would spend significant periods in primary care before specialising (as is already happening in Iran).

Africa

The African Group was introduced by Dr Frank Njenga, who emphasised how much the formal creation of International Divisions would lead to a real feeling of belonging and a more genuine sense of partnership with College members working overseas.

Professor Wilson Acuda shared with us his experience of work in Uganda, Kenya and Zimbabwe over three decades. Uganda had one of the best mental health services in Africa until the politically induced decimation of the country and its structures set services back for 25 years. Before then, it had a rich mixture of local services and a flourishing university involved in internationally linked research in the mental health field. Professor Acuda had to flee Uganda and then spent 12 years in Kenya, where, following the Alma-Ata Declaration promoting primary care (inspired by the World Health Organization), there was a considerable expansion of trained personnel in the mental health field. The British Council funded training opportunities overseas and Kenya became involved in major research projects, especially in the field of alcohol misuse, and it held some major international psychiatric conferences. Once again, changing socio-economic conditions led to a significant reversal. All readers will be familiar with the serious current situation in Zimbabwe, but may not know how well things were developing during the 1990s, when there was extensive promotion of village health workers. With the collaboration of the World Health Organization there were investigations into the role of traditional healers and, for example, links with Bergen (Norway) led to health promotion and research in connection with substance misuse.

Dr Fred Kigozi spoke of the need for a whole-systems approach as he sketched out plans for Uganda to recover its former status of having one of the best-developed mental health services. That this is possible is borne out by evidence that coordinated work in Uganda has resulted in one of the lowest AIDS rates in Africa.

In similar vein, Professor Zabow outlined the effects of apartheid on mental health systems and on mental health, and the important role of the College in vigorously opposing the effect of apartheid on the practice and organisation of psychiatric services. He outlined the continuing possibilities of abuse and neglect and dehumanisation if differential levels of care are provided according to socio-economic factors. He outlined by way of example the impressive plans through which the Western Cape is reorganising its mental health services so that most are now provided within primary care and how training and support are needed to do this. An impressive feature is that all medical students carry out a 6-month placement in the mental health field. Perhaps as a result, places for psychiatry training are oversubscribed. Perhaps this will assist in the proposed expansion of posts, which will support services in primary care.

Asia

The South Asian Group opened the afternoon sessions through its chairman, Dr Rodrigo, on the theme of poverty and social change. Dr Deva of Malaysia described the situation at the time of independence from Britain in 1957 and the impressive changes of the past 50 years, during which 15 medical schools have been established. It will not be long before there are 200 psychiatrists in the country, of 24 million inhabitants. As with many of the presentations, he made it clear that a major effort is being put into decentralising mental health services and making them available within primary care. This requires careful education and a reduction in stigma.

Dr Chaudry from Pakistan gave an illustrated talk on a major project in Lahore, which has raised funds for a wide range of services. We heard of agrarian, music and group therapy and the important role of traditional healers for certain disorders. Health symposia were important in raising the profile of mental health, as was close liaison with journalists.

Dr Vikram Patel emphasised the need to combat the idea that depression was associated with affluence or Western lifestyles and to make clear that poverty is strongly associated with common mental illnesses such as anxiety and depression. He reported research that helps to clarify who of the impoverished are most vulnerable to depression. Globalisation was shown to be having a major effect on certain traditional forms of employment. International trade has lowered prices for small farmers and workers in the cloth industry, leading to high suicide rates. An important finding was that men who were in further difficulties after borrowing from loan sharks had an increased tendency to domestic violence, leading to depression in their spouses. Official 'micro-loans' to the spouses were altering their status in the eyes of the husband, leading to prevention and sometimes resolution of domestic conflicts.

North America

The North American Group (now the pan-American Division) was introduced by Nigel Bark, who underlined the fact that in the richest country in the world – the USA – there were both poverty and also certain populations who were 'underserved'. The Surgeon General's report of 1999 had highlighted the deficiencies in services for the elderly, children and some rural and minority groups and a further report by the President's Freedom Commission stated that mental health systems were a 'shambles'. Nigel Bark highlighted the increasing prison population

and the high incidence of serious mental illness there. He felt that a great deal could be learned from the experience of other countries in the world that were developing mental health services where there are few psychiatrists and other mental health professionals.

Dr Claire Henderson, a UK psychiatrist, spoke of her experience of taking up a Fellowship in Public Psychiatry in New York City. The purpose of the programme was to attract and train psychiatrists to work in the public sector in deprived urban areas. We were given an insight into a well thought through programme, which combined clinical experience in a variety of settings with opportunities to evaluate the optimum management of complex organisational issues, including the delivery of assertive community teams (ACTs) to serve specific populations.

Finally, Dr Peter Birkett focused on nursing homes and elderly people with mental illness in New York and differentiated them from board and care homes and similar institutions in the UK. He communicated a wealth of experience in his outline of the determinants of who used such facilities. Nursing homes are much more expensive and tended to offer a medical model of care. They tended to be used not only for many persons with dementia but also for those with refractory depression and those with mobility problems. Often there has been a recent hospital admission for the patient or the carer and there may well have been a crisis for the carer, especially if the carer is not a spouse. Persons with more paranoid disorders tend to stay away from homes.

Conclusion

The International Division presentations lasted the whole of the last day of the conference and inevitably the above account has been able to report only a few of the fascinating issues addressed. Important questions were raised about the services available for persons with learning disabilities in developing countries and there was an evident wish to understand better the place of the many kinds of traditional healers.

Those present were impressed by just how much there is to be learned from hearing of difficulties and successes in different parts of the world that transcend the need to take into account particular conditions, cultures and traditions. In addition, the meeting played an important part in fostering a sense of community among psychiatrists from around the world, who often work in relative professional isolation, even when in large cities.

Brian Martindale

International Association for the Scientific Study of Intellectual Disabilities (IASSID)

The 12th Congress was held in Montpellier, France, in June 2004 and was an exciting, week-long celebration of research in learning disability (mental retardation). IASSID was founded by members of the Royal Medico-Psychological Association in 1964. The Congress meets every 4 years and this time attracted 1500 participants from all parts of the world. About one-sixth of the participants came from the UK and many of the leading researchers presenting their work were psychiatrists. Other disciplines represented included psychology, special education, anthropology, nursing and social science, and a number of user/consumer researchers shared their experiences and findings. Professor Hollins' department sponsored a Zambian teacher to talk about a 'case finding' exercise in a shanty town in Lusaka, which resulted in an integrated community school for AIDS orphans, of whom 25% have a disability.

The next Congress will be in Cape Town in August 2008, and as an IASSID Council member Professor Hollins would be keen to hear from anyone working in Africa who would be interested in joining a network before the Congress and in preparation for it (email shollins@sghms.ac.uk).

Professor Hollins, IASSID Council member

Overseas Presidents at College meeting

The Royal College was pleased to welcome the following Presidents of other psychiatric organisations to the annual meeting in Harrogate in July:

- American Psychiatric Association – Prof. M. Riba
- Brazilian Psychiatric Association – Prof. M. A. A. Brasil
- Canadian Psychiatric Association – Dr A. Thakur
- Egyptian Psychiatric Association – Dr S. A. Zim
- Ghana Psychiatric Association – Dr S. Allotey
- Hellenic Psychiatric Association – Prof. G. N. Christodoulou
- Iraqi Psychiatric Association – Dr N. S. Ali
- Kenya Psychiatric Association – Dr F. G. Njenga
- Norwegian Psychiatric Association – Prof. B. Stubhaug
- Royal College of Psychiatrists of Australia and New Zealand – Prof. P. Boyce
- Uganda Psychiatric Association – Dr F. Kigozi.

Higher education link in child psychiatry between UK and India

The main aim of the Child and Adolescent Overseas Working Party of the Royal College of Psychiatrists has been to support the development of services in low-income countries by enhancing their training capacity. Thus, with the help of the British Council, a 3-year project started in 2003 between the Greenwood Institute of Child Health, Leicester, and the Institute of Medical Sciences, Varanasi. Each year three or four professionals from India visit the UK for nearly a month to study child and adolescent mental health services and teaching programmes. Similarly, a team of trainers from the UK visits India to run seminars for a variety of professionals.

The British Council emphasises the alleviation of poverty and gender issues. The link serves this purpose as the university hospital in Varanasi caters largely to poor and lower-middle-class populations. It should help the poor and underprivileged section of society by improving the mental health of the children and alleviating the suffering of the affected families and improving their quality

WPA Congress website: www.wpa-cairo2005.com

The date for all submissions is now 31 October 2004.

The opera *Aida* will be performed at the Pyramids on 14 September 2005.

of life. It also aims to ensure that the project will particularly benefit females. For further details of the project, please contact Kedarnd@doctors.org.uk.

Iraq

Professor Martin Deahl, a Fellow of the Royal College of Psychiatrists, has recently been appointed Commander of the British Medical Group in Iraq. He and his team left Britain for Iraq in July taking a convoy of medical supplies, equipment and so on. At least seven Royal Colleges agreed to donate books and journals to colleagues and medical schools in Iraq. The Royal College of Psychiatrists has donated the entire run of *Psychiatric Bulletin* as well as five copies of the book *Where There Is No Psychiatrist*.

WPA Congress, 10–15 September 2005

The theme of the WPA Congress is '5000 years of Science and Care: Building the Future of Psychiatry'. The Congress will discuss the state of the art in the advances in neurosciences as regards all the complexities of today's psychiatry. The four plenary lectures will be presented by the President, the President elect, the Egyptian Nobel laureate in physics Professor Ahmed Zewail and the winner of the Jean Delay Prize, 2005. We shall have keynote lectures, symposia with contributions from all the WPA's 55 scientific sections, panels, workshops, seminars and more, and from both developed and developing countries. For the first time in a world congress, master clinical case conferences will be discussed with worldwide pioneers in clinical psychiatry, where the opportunity for the active participation of the audience will be available. Emphasis on partnership in the care of mental patients and innovative mental health programmes in developed and developing countries will be the focus of attention. We need in this congress to translate scientific advances to better quality care of patients.

Professor Ahmed Okasha,
President, World Psychiatric Association

Forthcoming events

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

16–18 March 2005
Costa Rica Psychiatric Association National Psychiatric Congress and Central American Psychiatric Congress
WPA Sponsored Conference.
Contact: Dr Rigoberto Castro Rojas.
Email: rcastro@racsa.co.cr
Website: www.asocopsicr.com

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

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

19 April 2005
International Congress of Personality Disorders, Association of Argentinean Psychiatrists (APSA)
WPA Section on Personality Disorders and APAL Personality Section.
Mar del Plata, Argentina.
Contact: Dr Nestor Koldobsky.
Email: koldobsky@speedy.com.ar
Website: www.iaepd.com.ar

20–23 April 2005
Regional Meeting of the Collegium Internationale Neuro-Psychopharmacologicum
CINP WPA Co-sponsored conference.
Cape Town, South Africa.
Contact: Dr Robin Emsley
Email: rae@sun.ac.za
Website: www.cinp.org

10–15 September 2005
XIII World Congress of Psychiatry
World Psychiatric Assocation
Cairo, Egypt.
Contact: Prof. Ahmed Okasha
Email: secretariat@wpa-cairo2005.com
Website: www.wpa-cairo2005.com