International Psychiatry

Bulletin of the Board of International Affairs of the Royal College of Psychiatrists

Issue 7, January 2005

EDITORIAL

Herbal medicines

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Plants have been used for medicinal purposes throughout human history and although it may seem to us that modern life is innately much more stressful than long ago, the struggle for basic survival then must have been at least as worrying as the more 'sophisticated' concerns of today. Thus, it seems likely that healers in primitive societies probably had to treat exactly the same range of disorders as those with which we are familiar. Spells and incantations to drive away evil spirits, which some may interpret as early psychotherapy, might have been combined with the use of herbs with psychoactive properties.

Technology came into play at a surprisingly early stage of herbal medicine, in the way in which plant material was processed. Grinding, roasting and distilling were very early techniques, soon to be accompanied by a variety of horticultural and chemical interventions. Such changes have had a profound effect. They have allowed the active principle of the herb to be concentrated, making the medicine more potent and easier to transport. It also becomes easier to take large doses and unwanted side-effects are often more prominent. Moreover, the beneficial synergistic effects of other compounds present in the original plant material may be eliminated by the purification process. Thus, while modern medicines are firmly rooted in herbalism, they have undergone such profound changes that many people are uneasy about their use and are keen to return to the natural product. However, it is important to emphasise that 'natural' and 'traditional' medicines are not always benign and gentle, and can themselves cause serious side-effects. Unfortunately, the public are poorly safeguarded in this respect because, in most countries, the regulation and registration of herbal medicines are poorly developed and the quality of herbal products sold is generally not guaranteed.

Despite such concerns, interest in herbal medicines is increasing rapidly. One major advantage is their low cost, which is particularly important for poor countries, which often cannot afford the drugs manufactured by the large pharmaceutical companies. There is, therefore, a financial incentive to build on existing knowledge of traditional medicines and to utilise them to the full.

This is further fuelled by changes in industrialised countries. Here, the accelerating pace of medical advance, accompanied by increasing medical sub-specialisation, is an additional driver for the growing interest in herbal medicine, because conventional care frequently fails to deliver the holistic, patient-focused treatment that many people crave. They therefore turn to the past and seek 'traditional' medicine, with its emphasis on the 'whole' patient and not on the disease or the malfunctioning bodily system in isolation. This attitude is further reinforced because modern drugs may have powerful and unpleasant side-effects, so that the 'cure' feels worse than the disease state itself. The desire for a holistic approach is perhaps even more understandable for those suffering from symptoms of mental ill health, which may threaten an individual's very sense of 'self'.

Rising above individual concerns, there is an acute awareness of our ignorance of this huge subject, combined with an anxiety that its sources are under threat environmentally. This threat is not only to the as yet unrecorded plants that may have therapeutic properties – it extends to the indigenous peoples whose knowledge has been handed down over centuries. Thus, there is a real fear that the plants and the associated knowledge may be lost before their existence is known or acknowledged. The World Health Organization (WHO) is responding to this growing interest. It issued a strategy paper on traditional medicine in 2002, the objectives of which are in line with the WHO's overall medicines strategy (World Health Organization, 2002):

- to integrate relevant aspects of traditional medicine within national healthcare systems by framing national policies on traditional medicine and implementing programmes
- to promote the safety, efficacy and quality of traditional medical practices by providing guidance on regulatory and quality assurance standards

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Subscriptions

International Psychiatry is published four times a year.

Subscription: £15.00 per annum.

For subscription enquiries please contact: Publications, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.

Printed in the UK by Henry Ling Limited at the Dorset Press, Dorchester DT1 1HD.

- to increase access to, and the affordability of, traditional medicines
- to promote national use of traditional medicines.

Evaluating herbal medicines is difficult and costly. Accurate plant identification is essential and then active ingredients have to be isolated. The latter is made more difficult because the active ingredients may be influenced by the time of plant collection, the area of plant origin and different environmental conditions. A single medicinal plant may have hundreds of natural constituents and establishing which is responsible for which effect can be prohibitively difficult and expensive.

Such problems are made worse by the lack of co-operation and sharing of information among countries in relation to the regulation of herbal products on the market. Progress would be made more swiftly if this situation were remedied, so that practical and cost-effective ways of evaluating herbal medicines could be devised. However, although regulation and registration procedures for herbal products existed in nearly 70 countries in 2000, only 25 had reported to the WHO that they had a national policy on traditional medicine (World Health Organization, 2002).

Medical education

The effective use of herbal medicine depends on having enough adequately trained physicians. Courses in complementary and alternative medicine are now much more generally available and they are also being offered to medical students, although they tend to provide an academic introduction only, rather than teaching specific clinical skills. The proportion of medical schools in the UK that offer such courses rose from 10% to 40% between 1995 and 1997, and in the USA a large number of medical schools now have classes and seminars on these topics.

Given the holistic philosophy that underlies much traditional medical practice, a few additional classes and seminars in specific subjects, such as herbal medicine, seem a barely adequate response to this very complex area of study. In contrast, on the Indian subcontinent there is an ancient and continuing tradition of teaching traditional medicine, with 108 undergraduate institutions in India that award degrees after 4.5 years of training in the Ayurvedic and Unani traditions – and the medicines used in the latter are primarily herbal in origin (Chopra & Prabhakar, 1994). In China, too, there is a fund of knowledge of herbal medicines that could be a resource for the whole world.

Financial implications

Finally, it is important to consider the financial implications of developing herbal medicine and this is well illustrated by the use of St John's wort (*Hypericum perforatum*) in Germany, where sales of the extract had a market value of US$66 million in 1996 (Nash, 1997). The world market for herbal medicines based on traditional knowledge is now estimated at US$60 billion (World Health Organization, 2002), so the financial incentives for the big pharmaceutical companies are obvious. However, the needs and rights of often impoverished countries must be protected, so that they are not outwitted in areas such as patent protection. Above all, it is essential that their patients retain access to the benefits of herbal medicines, which are often very much part of their heritage.

All of this is relevant to all herbal medicines, not just those used in mental illness, although the latter are very much a special case. Given the scale of physical illness and deprivation in many of the poor countries of the world, and the inadequate resources to tackle even the most pressing problems of communicable diseases, it is not surprising that the treatment of mental illness is a comparatively low priority there. Indeed, one of the great inequalities of the modern world relates to the consumption of psychoactive drugs in different countries, with overuse in many developed countries and virtually no use in many of the poorer ones (Ghodse, 2002). Although the cost of synthetic psychoactive drugs and the lack of psychiatrists may remain barriers to treatment for the foreseeable future, it is possible that herbal medicines and traditional knowledge could be developed and provide effective treatment at a lower cost, so that they would be more accessible to those who need them most. Safeguarding the necessary resources should be seen as a global priority.

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Ethical international recruitment

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In the October 2004 issue of *International Psychiatry* (no. 6), we published special papers on the recruitment of consultant psychiatrists from low- and middle-income countries. The case for such recruitment was made by Catherine Jenkins, the NHS International Fellowships Project Manager at the Department of Health, and the case against was made by David Ndetei, Salman Karim and Malik Mubbashar. Not surprisingly, because of the role played by the College in facilitating this 'brain drain', there have been many responses – mostly supporting the views of the latter authors. Because of the importance of the topic, and the intense feelings aroused by the policy among psychiatrists in the developing world, we are pursuing the subject in January 2005. We publish here two articles written by eminent psychiatrists who provide a perspective on the issue from outside the UK, and a response from Gareth Holsgrove, Medical Education Adviser at the College.

The first article is from Norman Sartorius, who directly questions the validity and ethical status of the commentary on this recruitment policy provided by Catherine Jenkins. The statement which has caused him particular concern (and is quoted by all three authors) concerns the response of the Indian Minister of Health and Family Welfare to a parliamentary question on the issue – to the effect that 'the overall availability of doctors in India is sufficient'. It is worth noting that the Department of Health has also explained that the government of India has indicated it has a 'surplus of nurses'. Unfortunately, it is unclear on what basis these assurances were made. However, Professor Srinivasa Murthy makes much the same point, and he goes on to add a challenge to the Royal College of Psychiatrists (UK), by asking – how can the College believe it is acting ethically by supporting the International Fellowship Programme? We turn to the response by Gareth Holsgrove for an explanation. As I understand his argument, he regards the recruitment plan as 'ethical' for a variety of reasons. First, long-standing lack of strategic planning in the UK has ensured we do not have sufficient trained doctors to service our population's needs. Second, doctors in those parts of the developing world from which we recruit are underpaid, and cannot necessarily find jobs even when appropriately qualified for them. Clearly, if the placements in the UK did offer appropriate training opportunities and were time limited, much of the heat would be taken out of the debate.

Ethical international recruitment – a response

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This note is written for two reasons: the first is to thank Drs Ndetei, Karim and Mubbashar for their fine article (Ndetei *et al*, 2004) and for reminding the readers of *International Psychiatry* of the problems arising from the 'brain drain'; and the second is to comment on the astonishing argument presented in the paper written in reply by Catherine Jenkins, of the UK Department of Health (Jenkins, 2004).

Drs Ndetei and Mubbashar are veterans of the small army of mental health workers that has for many years fought to establish mental health programmes in developing countries. They have chosen to stay in their respective countries (Kenya and Pakistan) and spent much of their working lives advocating better mental healthcare, educating students of health and other professions, providing services to the population and carrying out research. They have trained many of the overseas consultants and other senior staff now working in the UK and in other industrialised countries. I do not have the most recent figures for Kenya or Pakistan but would not be surprised to learn that most of those whom they have trained are working today in one of the developed countries. They would have good cause to feel bitter about a continuing brain drain, which is among the most important reasons for the slow development of mental health programmes in their countries. Yet their article is not emotional or aggressive: it states the facts and invites

action to correct a serious problem that has in recent years received continuously diminishing attention.

The editors of *International Psychiatry* are to be congratulated for inviting Catherine Jenkins to respond to the article and so helping in the search for a solution. The response that they obtained is very valuable because it illustrates the depth of the problem and some of the main reasons for it. That response tells us that 'We [the Department of Health] have worked closely with the Indian Ministry of Health in the development of the [recruitment] campaign in India' and that the Ministry 'has been very supportive of the opportunities' that are being offered to doctors who have been trained in India.[1] The article then goes on to say that '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', that UK officials have met with the Indian High Commission 'regularly', and that the Indian government was asked to alert the Department to any changes of position. This statement is important because, in the next paragraph, Catherine Jenkins stresses ('It is vital to stress') that the NHS would not recruit from India if the Indian government did not 'want' it to do so.[2]

The 25-fold difference in the number of fully trained psychiatrists should by itself be enough to stop any effort on the part of a richer country to take any of them away from a less industrialised country.

Thus reassured, the UK government has developed a campaign (working 'closely with the Indian Ministry of Health') to facilitate the brain drain from India. It is amazing that the answer to a question in parliament was more important to the UK government than all that has been written and is well known about the weaknesses of and problems facing mental healthcare in India.

A recruitment campaign might be justified if it were necessary to inform potential candidates from a country that had a well functioning mental health system and a surplus of trained staff (who were finding it difficult to find employment) about options in another country. A first step therefore – if the campaign were to avoid objections on ethical and practical grounds – would be to examine whether the health system was functioning well and satisfied the needs of the population. The second step would be to examine whether there were people who had been fully trained but could not find a job, for whatever reason (e.g. because of a lack of coordination between the educational system and the health system, which resulted in a surplus of trained staff).

It is probably true that there are psychiatrists in India who have difficulties in finding a job that gives them satisfaction and a decent income. Disappointed by this they may consider the option of leaving to work in another country. This, however, should not be seen as a reason to help them get away.

The population of India has reached 1.1 billion and, according to the World Health Organization (2001) *Atlas* (based on government reports), there are 0.4 psychiatrists per 100 000 population in India and 11 psychiatrists per 100 000 population in the UK. What is wrong with the UK population? Do they really need 25 times more psychiatrists per capita than the Indian population? The fact that the UK Department of Health has realised that those who are mentally ill in the UK need more care and that services must be improved by an increase in the numbers of psychiatrists (among other things) is most laudable: but the same facts apply *a fortiori* to a country such as India. We know that the prevalence of many mental disorders is the same in developing and developed countries and that there are mental disorders and impairments that are more frequent in poor countries because of insufficient perinatal care, malnutrition and other ills. People with mental illness living in the developing world need just as much care of good quality as their brethren in the developed countries. The 25-fold difference in the number of fully trained psychiatrists should by itself be enough to stop any effort on the part of a richer country to take any of them away from a less industrialised country.

The Indian Minister has spoken in parliament and said that (in his opinion) the situation concerning doctors in India is satisfactory. The UK Department of Health knows – from its own sources, from the World Health Organization and from the scientific literature – that India lacks sufficient trained personnel and other resources to provide satisfactory mental healthcare to its population. No matter what the Minister said, a campaign to facilitate the brain drain and further deplete the mental health programme in India should therefore not have been launched.

It is probably true that there are psychiatrists in India who have difficulties in finding a job that gives them satisfaction and a decent income. Disappointed by this they may consider the option of leaving to work in another country. This, however, should not be seen as a reason to help them get away: rather, this is a good reason for arguing that mental health programmes should be given higher priority and for a variety of actions that the UK Department of Health could take – through the World Health Organization, or directly, or through other agencies and institutions – to improve the mental health programmes of developing countries and the lot of people who work in them.

Finally, Catherine Jenkins also tells us that the UK Department of Health is doing its best to treat the newcomers well. They are given chances to advance to the level of consultants, obtain registration, have a 'good relocation package' and receive 'induction, mentoring and pastoral support'.[3] This is laudable but surprising: has the situation until now been so bad in the UK that it is necessary to emphasise that fully qualified psychiatrists who come to work in a country upon the invitation of the government will be treated similarly to those who are already in the country?[4] But the fact that people who have been taken away from their own country are treated decently will in no way help the Indians in India who suffer from mental illness and find it impossible to obtain care.

In many ways the situation concerning mental health personnel in the developing world is worse today than it was four or five decades ago. Mental health programmes are progressing in a manner that does not allow us to hope that they will be in a position to respond to the mental health needs of the population in the developing world in the foreseeable future. Campaigns to recruit mental health professionals from the developing world to work in industrialised countries – no matter how attractive the positions they can be offered – will make progress even more difficult and slower.

Notes

1 Catherine Jenkins refers to action in India: it would be of interest to know whether the UK Department of Health had discussions with ministries in other developing countries from which psychiatrists are being recruited and what agreements have been reached with them.
2 Is it really true that the Indian government wants the UK government to recruit people whom it has trained at great expense? Or is it simply that it does not object to such a course of action? Or is it that it did not give the matter serious attention?
3 I would be interested to know how the UK Department of Health provides 'pastoral' support to Indian psychiatrists.
4 The other initiatives that Catherine Jenkins describes obviously have many merits but are only marginally relevant to the issues raised by Dr Ndetei *et al.*

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THEMATIC PAPER – INTERNATIONAL RECRUITMENT

Human resources for mental health – challenges and opportunities in developing countries

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Human resources for mental health are a challenge in all countries. In countries rich and poor, there is a big gap between the need for mental health services and the availability of those services. In an unusual way, the barriers to mental healthcare appear to be universal, which is not true of non-psychiatric healthcare. Nonetheless, the *World Health Report 2001* and the World Health Organization's *Atlas* project have recorded extremely low levels of service in most developing countries (World Health Organization, 2001*a*,*b*). The recruitment of consultant psychiatrists from low- and middle-income countries, discussed in the October 2004 issue of *International Psychiatry* (Ndetei *et al*, 2004; Jenkins, 2004), raises a number of challenges for both developing and developed countries.

The *World Health Report 2003* (World Health Organization, 2003) recognised the importance of human resources:

> 'The most critical issue facing health care systems is the shortage of the people who make them work. Although this crisis is greatest in developing countries, particularly in sub-Saharan Africa, it affects all nations.… Furthermore, all countries are now part of the global marketplace for health professionals, and the effects of the demand–supply imbalance will only increase as trade in health services increases. Accordingly, new models for health workforce strengthening must be developed and evaluated.'

Human resources have been described as the heart of the health system in any country, the most important aspect of healthcare systems and a critical component of health policies (Hongoro & McPake, 2004).

The present article examines the effect of the migration of specialist personnel on a national mental health programme. It addresses three aspects of the issue, using India as an example:

- the reality of mental health services within the country
- the role and responsibility of the Royal College of Psychiatrists in the recruitment of psychiatrists
- the unique opportunities open to developing countries to plan their human resources for mental health.

First, however, it is of interest to note the emotive nature of the issue.

Professional reactions to international recruitment

In order to gain a better understanding of professional reactions to the overseas recruitment of mental health professionals, I wrote to a handful of colleagues, seeking their reactions to it. These, as expected, covered a wide spectrum. For example, one senior psychiatrist opined:

> 'It is to an extent an unethical and exploitative practice. It amounts to the intellectual property of poor countries going cheap to rich countries as the individuals cannot be blamed for accepting the NHS UK jobs; a country like India, which is so acutely short of psychiatrists, cannot afford to lose its highly trained manpower, leaving its own people in desperation.'

At the other extreme was the opinion of another professional: 'in this age of economic globalisation, goods move to those markets which offer better process; so will services'. Other responses included: 'people should

The statement suggests that India has more than enough psychiatrists and that the loss of some will not have any significant effect. However, while adequacy of numbers may apply to doctors in general, it does not apply in the case of psychiatrists.

look for local solutions to local problems'; 'in a free world movements are inevitable'; 'what is required is to develop an international Convention on this issue to generate consensus, awareness and guidelines to regulate such movements and how the donor countries can be compensated'.

The reality of mental health human resources in India

I submit that the College should have stepped in more actively and shared its understanding of the mental health situation in India, and called for clear guidelines for the recruitment of psychiatrists from India.

In her contribution Jenkins (2004) noted that:

> 'We [the Department of Health] have worked closely with the Indian Ministry of Health in the development of the campaign 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* [emphasis added] in India is sufficient.... It is vital to stress that we would not recruit from India if the Indian government did not want us to.'

The statement suggests that India has more than enough psychiatrists and that the loss of some will not have any significant effect. However, while adequacy of numbers may apply to doctors in general, it does not apply in the case of psychiatrists. By the most generous estimate, India has less than half the number of psychiatrists of the UK per capita (its population is 20 times that of the UK). Further, the distribution of mental health professionals and psychiatric beds across India is very uneven: states like Kerala, Goa and Delhi have high numbers but, equally, some have low numbers, like Himachal Pradesh (with 4 psychiatrists for some 5 million population) and Chattishgarh (with 12 psychiatrists for 20 million people). The situation of Himachal Pradesh is significant as it is one of the states recognised as socially most progressive (it came second in this respect in a recent ranking of states reported in *India Today*, 16 August 2004). However, it is very poor in mental health services; indeed, the state was not able to recruit a full-time psychiatrist for its district mental health programme until 2003. Without doubt, most of India has few specialist human resources for mental healthcare.

The responsibility of the Royal College of Psychiatrists

During the 2004 annual conference of the Indian Psychiatric Society, in Hyderabad, one of the biggest exhibition stalls was run by the UK National Health Service, for the recruitment of psychiatrists. Is this method of recruitment ethical? What should be the role of the Royal College of Psychiatrists in this regard?

During the 2004 annual conference of the Indian Psychiatric Society, in Hyderabad, one of the biggest exhibition stalls was run by the UK National Health Service, for the recruitment of psychiatrists.

The Royal College is a professional body with members from a large number of countries, including India. Its official publication, the *British Journal of Psychiatry*, is an essential journal in all psychiatric centres in India. The deliberations of the Royal College are viewed with respect by psychiatrists in India. There have been attempts to form a South Asia branch of the College, and this indicates the respect in which the College is held in many countries in the region.

I submit that the College should have stepped in more actively and shared its understanding of the mental health situation in India, and called for clear guidelines for the recruitment of psychiatrists from India. The College as a professional body has good knowledge of both the position of psychiatrists and the development of psychiatry in India and could have envisaged the effect of recruitment on the country. I cannot but find fault with the College on this account.

The opportunities for developing countries to rethink their human mental health resources

The shortage of specialist personnel can be seen as an opportunity to think of organising mental healthcare in a very different way, using a variety of community resources (Srinivasa Murthy, 2000). There should be a shift from service provision by relatively few specialist professionals to a wide range of mental healthcare providers.

There are a number of mental healthcare activities that can be undertaken by patients themselves, family members, volunteers, general health personnel and others in the service sectors, like education workers, police and prison staff. Such people can be trained specifically for a limited range of tasks. It is this approach that can address the human resource needs within mental healthcare (Srinivasa Murthy & Wig, 1983). More specifically, four avenues are open to address the need:

- *To enhance training in psychiatry within undergraduate medical education*. Currently, the length of training (a few hours of lectures and a few clinical sessions) does not reflect the amount of mental health work a general medical doctor has to provide, and the skills for meeting service needs are not provided as part of the training. In some developing countries, such as Pakistan, Sri Lanka and Oman, major changes have been made to undergraduate training in psychiatry. There is a need for other countries similarly to reform their training curricula. Most courses are largely academic and do not provide trainees with opportunities to acquire the knowledge and skills relevant to the practical work of mental healthcare. Practical training is required, in clinical settings. Suitable modifications to the curriculum would open up the possibility of increasing human resources for mental healthcare. This could be achieved by linking the training to the development of national mental health programmes and the emerging roles of voluntary organisations.
- *To develop short training programmes for non-specialists*, such as medical officers, general psychologists and general social workers and nurses. The training could emphasise the clinical and practical aspects, to suit the specific situation of the country or region or a programme, for example school mental health or rehabilitation.
- *To use a wide variety of non-professionals*. Mental health programmes have pioneered the use of

volunteers in suicide prevention, patients functioning as therapists in drug dependence programmes like Alcoholics Anonymous, and family members becoming therapists to other family members. The key characteristic of this sort of 'service' is the limited role individuals take on in one specific situation, in which they call on their own personal experiences. The strength of these personnel is in their focused expertise and their acceptance by help seekers.

- *To involve staff in other sectors*. As part of the 'de-professionalisation' of mental health services, personnel working in different sectors (e.g. education or police) have frequently been used. Here, the health worker, preschool teacher, schoolteacher, police officer and so on add on a component of mental health to their traditional work activities.

As part of the 'deprofessionalisation' of mental health services … the health worker, preschool teacher, schoolteacher, police officer and so on add on a component of mental health to their traditional work activities.

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THEMATIC PAPER – INTERNATIONAL RECRUITMENT

The International Fellowship Programme: some personal thoughts

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Disclaimer: These are the writer's personal views and do not necessarily reflect the official College position on the International Fellowship Programme.

The International Fellowship Programme (IFP) was launched in 2003 under the name of the International Fellowship Scheme, its title being changed in 2004 because it was causing confusion to US doctors, who interpreted the word 'scheme' as having Machiavellian implications.

The purpose of the IFP is to recruit senior doctors from overseas on short-term contracts to fill consultant vacancies in the National Health Service (NHS). From its very inception, though, it has been severely criticised, for a variety of reasons. Since the number of psychiatrists recruited under the Programme exceeds that of every other specialty put together, the Royal College of Psychiatrists has unsurprisingly become strongly associated with much of the criticism. Indeed, a great deal of it has come from within the College's own membership, and by far its most common basis has been the ethics of recruiting highly qualified doctors from low- and middle-income countries.

Most of the issues have already been discussed in some detail in various publications. For example, Patel (2003) asks whether the NHS could justify schemes to recruit staff from poor countries, and points out that:

- the developing world has fewer doctors per head of population than developed countries
- recruiting from these countries damages their fragile health systems
- the cost of their training has been borne by the poor country, yet the rich country reaps the benefit.

Mellor (2003), in a commentary on Patel's article, maintains that recruitment is ethical and that most of the staff being recruited are from Europe, with others from the United States and Australia. While she undoubtedly has access to comprehensive recruitment data, this statement certainly does not apply to psychiatrists recruited under the IFP, the great majority of whom come from India. As far as I can recall, only one psychiatrist has been recruited on this programme from Australia, and none from North America.

Ndetei *et al* (2004) present a strong and persuasive case in their paper, to which Jenkins (2004) responded. Shortly afterwards, Khan (2004) wrote on 'The NHS International Fellowship Scheme in psychiatry: robbing the poor to pay the rich?', to which Goldberg (2004) replied. The essence of the debate is that Patel, Ndetei *et al* and Khan maintain that the IFP is unethical because it is recruiting doctors from countries that can least afford to lose them, whereas Mellor, Jenkins and Goldberg counter by saying that the UK leads the way in developing and implementing recruitment policies of the kind called for by

the World Health Organization. However, the debate appears to have a long way to run, although there does seem to be a risk that it will generate more heat than light.

The International Fellowship Programme

The IFP has two declared aims. It is primarily to recruit overseas doctors to work in consultant posts in the NHS, in a number of identified shortage areas. Its secondary aim is to offer overseas doctors the opportunity to work in the unique healthcare system that the NHS represents, which will include the opportunity to learn new skills and to experience life in the UK. This, though, must be seen as a minor aim of the programme. Patel (2003) says it is a marketing pitch. The NHS is trying to fill jobs in which there is a shortage of staff, rather than to realise a desire to broaden the professional experience of overseas doctors. As Ndetei *et al* (2004) point out, there are better ways of learning new skills, which can be tailored to the service context of their own countries. They also point out that experience has shown that health personnel who move to a rich country for more than a few months are likely to stay there, particularly if they bring their families with them. Patel (2003) reports that experience with other schemes, such as the Overseas Doctors' Training Scheme, suggests that few doctors return to their home countries, and also points out that the IFP ignores the difficulties that doctors will face when they do return home. The IFP has not been running long enough yet to see whether or not this pattern will be repeated, though if it is then one would expect doctors recruited from poorer countries to be more likely to remain in the UK than those from wealthier ones.

I found a paradoxical situation that makes the positions of both the UK Department of Health and its critics correct to a certain extent … the situation consistently reported to me by doctors is one where there is a serious shortage of doctors yet a lack of jobs, especially senior ones.

Another point raised by Patel (2003) is that earlier schemes recruited junior doctors, but the IFP is taking highly experienced specialists. This will have an immediate effect on the human healthcare resources of developing countries and, Patel maintains, the IFP could perpetuate global health inequalities for generations.

One group specifically identified as likely to be attracted by the prospect of living in the UK for a while but then return home at the end of their contracts, and from a country well supplied with doctors, are those from North America. Unlike candidates from low- and middle-income countries, there would not be an ethical concern about doctors from the USA and Canada being recruited, or remaining in the UK after their IFP contractual period. Unfortunately, at the time of writing, no North American psychiatrists have been recruited under this programme. The main reason is that most have undertaken only 4 years of postgraduate psychiatric training and therefore do not meet the requirements for specialist registration under Article 9 of the European Specialist Medical Qualifications Order 1995. This left as the main recruiting grounds Australia, New Zealand, South Africa and India. However, following pleas from Nelson Mandela himself not to recruit in South Africa, the focus is now on the remaining three countries, and by far the greatest number of applicants at present is from India.

Having myself visited India to look into the operation of the IFP and, in particular, ways in which we might 'put something back', I found a paradoxical situation that makes the positions of both the UK Department of Health and its critics correct to a certain extent. I understand, from the many psychiatrists to whom I spoke, that most mental health centres are understaffed and doctors are coping with enormous case-loads. This was clearly so in the centres that I visited. There are also many parts of the country – typically rural areas – that simply provide no mental healthcare at all. However, government spending on healthcare is a very small proportion of gross domestic product, and on mental health it is a very small proportion indeed of the overall healthcare budget. Consequently, on my visit the situation consistently reported to me by doctors is one where there is a serious shortage of doctors yet a lack of jobs, especially senior ones. The Indian government, however, seems to be saying something completely different: Jenkins (2004) states that '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'.

Reporting on the situation in Pakistan, Khan (2004) is strongly critical of the IFP and, in particular, the undermining of mental healthcare there by the 'poaching' of psychiatrists. The NHS, he asserts, is 'bending all kinds of rules and cutting corners to lure overseas qualified psychiatrists to work in the NHS'. Turning his attention to the role of the College, Khan concludes that 'why the College consented to go along with the scheme is beyond comprehension' and continues with other robust criticisms.

However, Khan is misleading in some of his criticisms. For one thing, the IFP has never actively recruited in Pakistan. Information is available on the internet, of course, but it has never been targeted at Pakistan. In fact, very few Pakistani psychiatrists have been recruited under the IFP. The figures cited by Goldberg (2004) indicate that just 6 of the 124 psychiatrists recruited through the IFP were from Pakistan.

More serious, though, are Khan's criticisms that the College is complicit in 'bending … rules' and 'is willing to validate an overseas psychiatrist's experience and qualifications without as much as a semblance of critical appraisal of the candidate's training programme and standard of examination in his/her home country'. The College has a trained team of staff dedicated exclusively to scrutinising applications from overseas psychiatrists. Those applying under the IFP and those who apply independently are all treated in exactly the same way. This involves checking and verifying their training and qualifications. Each case is considered individually and in detail, first by an experienced senior administrator and then by the Equivalence Committee, convened from a panel of consultant psychiatrists. Wherever possible, at least one committee member will be an expert in the

specialist training and qualifications of the candidate's home country. The College recommendations are then sent to the Specialist Training Authority (STA) of the Medical Royal Colleges. Here the application is independently scrutinised, also by experts. The STA's recommendations are then passed to the General Medical Council for further scrutiny before they are finally accepted or rejected.

Far from 'making a mockery of the whole process of senior house officer training, approved higher specialist training [and] entry to the Specialist Register', as Khan accuses the College, we are meticulous in applying precisely the same high standards when processing IFP applications as we are with all other overseas applications for specialist registration. In fact, only a very small proportion of applications go through to specialist registration and almost all of the unsuccessful applications are sifted out by the very thorough College procedures. There is absolutely no question of the College colluding with the Department of Health or any other body in obtaining specialist registration for anyone lacking the required training, qualifications and experience. Even if such a candidate should somehow pass College scrutiny, there would still be two further checks, by the STA and the General Medical Council, both, of course, independent of the Department of Health. However, it must be said that this rigour has been worthwhile because the quality of consultant psychiatrists recruited under the IFP has been very good.

Although Khan is mistaken about the standards of scrutiny observed by the College, he is absolutely correct in saying that in the past few years very considerable progress has been made both by the College of Physicians and Surgeons Pakistan and his own organisation, Aga Khan University, in improving medical education and examinations. Indeed, I have served as an educational consultant myself to both these excellent organisations and have worked with them on several occasions, helping to develop curricula and examinations, and to train staff. As Mellor (2003) reports, much of the support from the UK to promote healthcare in developing countries receives little publicity. However, it is undoubtedly provided and I very much hope that such international collaboration will long continue.

Some additional issues

Although the current debate is predominantly about the rights and wrongs of international recruitment, there are two serious underlying questions that have received little or no airing to date. First, there must surely be grounds for discussion about the willingness of doctors to leave India and Pakistan. For example, there must be major ethical concerns that both countries spend so little on the health of their citizens, yet both have nuclear weapons. Patel (2003) also highlights the 'stifling hierarchies and bureaucracies' in some developing countries, citing as an example that in India promotion is more likely to be determined by length of service than by skills and achievements. So, it is possible that the IFP might not itself be the main reason for doctors leaving, but simply the vehicle that enables them to do so.

However, government incompetence, or at least a very strange sense of priorities, is not confined to India and Pakistan. Our second underlying question might be 'Why are there so many NHS consultant posts vacant?' The UK government controls both the number of places available at medical schools and the national training numbers (NTNs) for specialist training, and both Labour and Conservative governments have been warned of the impending shortage of doctors for years. Yet, until comparatively recently, successive governments have done next to nothing about it. Even now, with an increase in the number of places allocated at medical schools, many feel that the steps being taken are quite inadequate and, in any case, it will be many years before any of today's medical students become consultants. Workforce policy seems to have been wrong for years – indeed, it has almost been a case of 'a policy of no policy'. Moreover, having exercised (or at least had) central control while the problem developed, it does seem a bit rich suddenly to use 'global market forces' as a justification for recruiting healthcare workers from poorer countries.

Perhaps we should all give more thought to how the world educates and makes the best use of its healthcare workers. If they are a global resource, which is what one justification for the IFP claims, then developed nations must do a great deal more giving, especially if they are also responsible for a lot of the taking. The need for the IFP at all is irrefutable evidence that we are not doing enough to educate and properly manage even our own healthcare workforce.

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Mental healthcare in South Korea

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The Korean peninsula is located between China and Japan. After the Second World War, the Republic of Korea was established in the southern half of the Korean peninsula. South Korea has a total area of 98 480 km^2 and a population of 48 598 175 (July 2004 estimate). The per capita gross domestic product (GDP), in terms of purchasing power parity, is US$17 700 (2003 estimate) (Central Intelligence Agency, 2004). The illiteracy rate (among those aged over 15 years) is 1.9% (0.7% for males and 3% for females) (2003 estimate). Life expectancy at birth is 75.6 years (72.0 years for males and 79.5 years for females) and the infant mortality rate is 7.2 per 1000 births (2004 estimate). The unemployment rate is 3.4% (2003 estimate). The proportion of the population aged 65 and over is currently 8.7% (2004 estimate) (Korea National Statistics Office, 2003). Over 40% of the total Korean population (i.e. some 20 million) lives in Seoul and its vicinity. South Korea is highly urbanised and modernised. Besides central government, local government is based on seven metropolitan cities and nine provinces.

Mental health services

There is one hospital bed for every 148 citizens and one psychiatric bed for every 1446. There is one physician for 830 citizens and one psychiatrist for every 19 500 (2002 estimates).

The basic healthcare needs of the Korean population are covered by universal public health insurance, funded by premiums, not taxes. This is compulsory, and there is no private health insurance. None the less, the private sector accounts for approximately 90% of mental health services, as there are too few public facilities. However, the government is responsible for free nationwide healthcare funded by taxes for the poor and aged. Thanks to an active community mental health movement in the public and private sector of psychiatry, since 1995, 242 public health centres nationwide have registered to take care of people with mental illness, including elderly people with dementia or stroke. In 2002, there were 989 specialist mental health facilities in South Korea: 46 community mental health centres, 66 social rehabilitation facilities, 74 mental hospitals, 207 general hospitals with psychiatric out-patient departments, 541 psychiatric clinics and 55 nursing homes.

Table 1 shows the progress in the public mental health project run by the Korean government. Both community and institutional care programmes provide long-term care. Home help services and delivered meals, adult day care, short-stay and respite care and a visiting nursing programme are also available to people with mental illnesses, including elderly people with a mental disability. Table 1 shows that care capacity is being substantially increased. The proportion of the population in need of community care who could be catered for by the maximum community care capacity will increase from 4.7% in 2003 to 72.2% in 2011, and the equivalent

Table 1. Projected estimates of the provision for community and institutional mental healthcare in Korea

Year	2003	2005	2007	2009	2011
Community care					
Number of home help centres	120	470	1 020	1 770	2 769
Number of day care centres	166	416	866	1 516	2 561
Number of short-term care centres	32	131	356	681	1 079
Total number of community care facilities	318	1 017	2 242	3 967	6 409
Maximum community care capacity, *n*	15 200	52 700	114 700	200 700	319 930
Number of patients who need community care	320 974	353 080	387 528	416 319	442 925
Community care capacity rate (%)	4.7	14.9	29.6	48.2	72.2
Institutional care					
Number of residential homes (capacity)	161 (11 270)	245 (17 150)	325 (22 750)	405 (28 350)	488 (34 160)
Number of nursing homes (capacity)	120 (8 400)	192 (13 440)	264 (18 480)	355 (24 850)	454 (31 780)
Number of dementia care hospitals (capacity)	37 (3 852)	51 (4 952)	65 (6 052)	79 (7 152)	93 (8 252)
Total number of institutional care facilities	318	488	654	839	1 035
Maximum institutional care capacity	23 522	35 542	47 282	60 352	74 192
Number of patients who need institutional care	77 836	84 838	92 347	98 624	104 423
Institutional care capacity rate (%)	30.2	41.9	51.2	61.2	71.0

Source: Ministry of Health and Welfare (2003, personal communication).

proportion of those in need of institutional care from 30.2% in 2003 to 71.0% in 2011 (see Table 1).

To meet the demand for institutional care arising from the increasing numbers of cases of dementia and stroke, special units in nursing homes and dementia care hospitals are being constructed all over South Korea.

A multidisciplinary community-oriented approach has been adopted and close working relationships have been maintained with various professionals caring for people with mental illnesses. In general, each team has a catchment population of about 50 000–200 000, which would include some 3500–14 000 people aged 65 and over. The staff usually comprise one consultant psychiatrist (generally part-time), one community psychiatric nurse, one social worker or psychologist and several volunteers. They draw on a variety of community resources in devising the most effective care pathway for people with mental illnesses and focus on enabling them to stay longer in their own homes. They have responsibility for registration, case management and education. Some of them run day care programmes for schizophrenia, alcohol dependence or dementia. The public sector has been more active in home-visiting outreach activities, while the private sector has been promoting day care rehabilitation. These movements in South Korea have been instrumental in developing infrastructure and providing mental health services.

Psychiatric treatments

The predominance of the private sector and the relatively generous reimbursement of public health insurance have made Korea a large and early market for novel drugs in psychiatry, although reimbursement for novel drugs has now become subject to much stricter regulation. Atypical antipsychotics and novel antidepressants are much more widely used in South Korea than are traditional antipsychotics and tricyclic antidepressants. Electroconvulsive therapy also has been frequently used; there is no special limitation on its use. Psychoanalysis, psychodynamic psychotherapy, cognitive–behavioural therapy, group therapy and even hypnosis are applied on in-patient wards and out-patient clinics in psychiatry.

Training

Basic undergraduate training in psychiatry forms part of the curriculum in medical school. Postgraduate training comprises a 4-year residency in psychiatry, in which both the theoretical and the clinical aspects of psychiatry are covered. This leads to the psychiatric board examination. Training programmes are accredited under the auspices of the Korean Neuropsychiatric Association, which is also the medical body that deals with all academic issues.

Epidemiological issues

There have been several community-based epidemiological studies on the prevalence of mental disorder in South Korea (Cho *et al*, 1998; Suh *et al*, 1999*a*, 2003; Suh & Shah, 2001). Epidemiological data on the prevalence of mental health problems help to determine the need for care. Dementia and depression are the most common mental disorders and the most severe public health problem, especially in the older population. Korean reports have been comparable to those of Western studies. Suh *et al* (2003) interviewed 1037 people aged 65 and over, and found a prevalence of dementia of 6.6% (Alzheimer's disease 4.2%, vascular dementia 2.4%). A nationwide survey examined the prevalence of depressive symptoms in the Korean population. The prevalence rates using a cut-off score of 16/17 on the CES-D (Center for the Epidemiologic Study of Depression) scale were 23.1% of male adults, 27.4% of female adults and 24.3% of the elderly population (Cho *et al*, 1998; Suh *et al*, 1999*a*). A community-based survey reported a prevalence of 'the wish to die' within last 2 weeks among elderly respondents of 14.6% (Suh *et al,* 1999*b*).

A total of 788 000 persons, equivalent to 21% of the South Korean elderly population, were in need of long-term care in 2001. Of these, at least 74 000 needed institutional care, while the remainder required community care. The number of patients with dementia and disturbed instrumental activities of daily living has been estimated at 186 000, and this group will require institutional care at some point (Sunwoo, 2001).

Problems in mental healthcare in South Korea

There are several problems in mental healthcare in South Korea. First, medical, psychiatric and social welfare services are separate, which means that integrated care is not available. This separation originated from an artificial distinction between 'treatment' and 'care'. Second, subacute care facilities are too scanty: there are generally only acute care and chronic care facilities. Differentiation of function in facilities is necessary, for example 'hostel' for mild cases and 'nursing home' for severe cases. Third, public care facilities are too few (less than 10% of the overall mental healthcare provision). Most facilities are private and this leads to frequent conflict between consumers, government and suppliers. However, the Korean government has substantially increased its expenditure on healthcare and social welfare to meet the unmet need. It is also actively considering the adoption of a long-term care insurance system, similar to those that have been adopted in Germany and Japan.

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Conclusion

The private sector provides approximately 90% of mental health services in South Korea. These services are in short supply for the population, despite the relatively high number of psychiatrists. Thanks to an active community mental health movement in the public and private sectors of psychiatry and the long-term care plan being implemented by the Ministry of Health and Welfare, better care provision is expected. Although services have

actively been trying to move away from institutionalisation to community-based care, the inadequate number of fully qualified community mental health professionals, prejudice towards mental illnesses among the general population and less active participation of board-certified psychiatrists make this move difficult. However, a large investment in infrastructure, the development of programmes for community care, upgraded training and active research will lead to a more modern, community-based, multidisciplinary approach to healthcare in South Korea.

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COUNTRY PROFILE

Psychiatry and geriatric psychiatry in Romania

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Romania is now in a period of transition from communism to democracy. Geographically, Romania, like other Eastern European countries, is on the border between the Western world and the Middle East and Asia; until December 1989 it was behind the 'Iron Curtain'.

It covers 237 500 km^2, divided into 42 districts. In 2002 it had a population estimated to be 21 795 000. The unemployment rate was 10.5%. Fourteen per cent of the general population were over the age of 65. The infant death rate was 17.3 per 1000 and life expectancy at birth was 67.6 years for males and 71.1 years for females. The gross domestic product per capita (GDP) expressed in purchasing power parity (PPP) is US$6041, and total health expenditure is 2.60% of GDP. The proportion of the national budget spent on the health system is 4%, and around 2% of the total health budget is for mental health. There are 189 physicians per 100 000 population.

Only recently has Romania tried to add community mental healthcare services to the traditional system of active psychiatric hospital care. This started by radically reducing the number of beds, but unfortunately without ensuring adequate community care programmes and services.

Mental health services

Nationally, there are 908 psychiatrists (4.16 per 100 000 population), of whom 260 are child psychiatrists (1.19 per 100 000 population). They all work in the public health sector, although some also work in private ambulatory clinics. There are also psychologists and social workers in the mental healthcare system.

Most psychiatric services are provided by hospitals and out-patient clinics attached to the Ministry of Health. There are 38 psychiatric hospitals and many psychiatric departments in the general hospitals (a total of 17 079 beds) as well as day hospitals (1222 beds) to care for patients with both acute and chronic mental illnesses; in addition there are 166 beds for patients with drug dependency. There are also 65 mental health centres for adults and children with mental illness. There are no private psychiatric hospitals.

The special needs of people with mental illness have not always been recognised and respected by the generic health services. However, a mental health law was passed in Romania only in August 2002 (Monitorul oficial al Romaniei, XIV, 589). This was the first step towards reform of the mental health services and care system. In chapter 4 of the law, the forms of specific mental health services existing in Romania are listed, along with care standards for people with mental disorders. Only recently has Romania tried to add community mental healthcare services to the traditional system of active psychiatric hospital care. This started by radically reducing the number of beds, but unfortunately without ensuring adequate community care programmes and services. Many long-stay psychiatric wards were transferred to the

social services. In the district of Bihor alone, 178 psychiatric beds out of 900 were transferred from Nucet Psychiatric Hospital (accountable to the Ministry of Health) to the social services (accountable to the Department of Labour and Social Protection).

Stigma remains an obstacle in ensuring access to care for patients who are mentally ill. Stigma leads to the development of negative attitudes (including those of professionals), poor quality of treatment services and inadequate funding at both national and local level.

Standards need to be raised in basic mental healthcare, and in relation to patients' basic needs and quality of life (accommodation, food, sheltered housing, sheltered workplaces and community involvement).

In-patient services

People with acute or chronic mental disorders are treated in:

- psychiatric hospitals (for those with acute mental disorders)
- day hospitals
- long-stay accommodation
- psychiatric wards in general hospitals (when psychiatric hospitals are not locally available)
- the consultation–liaison psychiatry department in Bucharest University General Hospital
- psychiatric departments in geriatric hospitals
- sheltered homes (for patients with schizophrenia) founded by non-governmental organisations (NGOs).

These kinds of services are available in most but not all districts.

Out-patient units

In Romania out-patient services are available in only a few districts because there is still a severe lack of resources. The following types of service are usually available:

- out-patient or community assessment units
- day care centres
- primary care
- community mental health centres (which serve as a link between patients and their families, general practitioners and hospitals for acutely or chronically mentally ill people) (Tataru, 1997)
- community and social support services (organised by NGOs and churches in almost all districts).

Day programmes contribute to reducing stigma and discrimination against people with mental disorders by reducing their isolation and increasing the patients' abilities to face daily life.

Home care

In 2003, a programme began of follow-up home care for all patients, including elderly people with mental disorders and dementia. The programme consists of medical treatment and domiciliary services, such as home-helps and meals-on-wheels, and other help to enable patients to remain at home. There is also some financial support from the Department of Labour and Social Protection to compensate the families or carers of people who are chronically ill and those with handicaps (including those with dementia) who are treated at home.

Mental health programmes

A national mental health programme has been developed in recent years for the treatment of schizophrenia and depression, to provide free medication for patients from the onset of their illness, and also medication for in-patients in forensic psychiatric units. The national programme for elderly people with a mental illness is lacking financial support at present.

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Education

In 1989 Romania had six schools of medicine; now there are 10. Medical education in psychiatry begins with a half-year programme during the last year of undergraduate study, which comprises theoretical and practical courses, seminars and training in psychiatric hospitals or psychiatric departments in general hospitals. These studies include basic knowledge of child and adolescent psychiatry. The curriculum is based around the nosographic criteria of ICD–10 and the classical clinical presentation of mental disorders. The main goal is to give doctors the capacity to recognise, diagnose and care for people with mental health problems.

The educational programme for psychiatrists continues with 5 years of postgraduate medical education, comprising: courses, workshops, mental health examinations, psychiatric interviews, case presentations and training in psychiatric hospitals with a senior consultant psychiatrist or professor of psychiatry. The curriculum for psychiatrists respects the ICD–10 and DSM–IV criteria for the diagnosis of mental disorders. Psychiatry residents are obliged to use the most well known American and English psychiatric books. During these 5 years, the residents can attend a fee-paying training programme or courses and workshops on different forms of psychotherapy, usually run by psychotherapists from Western European countries. The current demand for training in psychotherapies, especially from recent generations of residents, is a consequence of the prohibition of these approaches (on ideological grounds) up to 1990.

Programmes in continuing medical education comprise postgraduate courses lasting 2–3 months and training in university psychiatric hospitals, as well as participation in national and international psychiatric congresses and conferences. There are also more specialist postgraduate training courses for child psychiatrists, geriatric psychiatrists and psychologists.

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Professional associations and publications

Mental health professionals are organised into many scientific associations and societies, most of them founded after 1989. The largest of these is the Romanian Association of Psychiatry, of which nearly all Romanian

psychiatrists are members. Others include the Romanian Mental Health League, the Romanian Alzheimer Society, the Romanian Association of Geriatric Psychiatry, the Romanian Association of Free Psychiatrists, the Romanian Association of Neuropsychopharmacology, the Romanian Association of Psychotherapy and the Romanian Association of Toxicology–Dependence. These associations organise annual local and national scientific meetings and conferences and stimulate their members to participate in national and international congresses.

Some European congresses have been organised in Romania: in 2000 the Romanian Association of Geriatric Psychiatry organised the 28th European Congress of Geriatric Psychiatry in Oradea; in 2001 the Romanian Alzheimer Society organised the 10th European Conference on Alzheimer's Disease in Bucharest; and the 2002 meeting of the European College of Neuropsychopharmacology was held in Bucharest.

The Romanian Association of Psychiatry works in partnership with other European and international psychiatry associations to improve mental healthcare in Romania and is an active member of the World Psychiatric Association (there are 250 paying members). One of its initiatives has been to translate into Romanian many important documents, psychiatric books and diagnostic guidelines (e.g. ICD–10 and DSM–IV). The Romanian Association of Psychiatry publishes the *Romanian Journal of Psychiatry* (four issues a year) and the Romanian League for Mental Health publishes the *Romanian Journal of Mental Health* (three issues a year) and together with the Mental Health League in Moldavia publishes *Psychiatry Today* (three issues a year). There is also the *Romanian Journal of Child and Adolescent Psychiatry*.

Geriatric psychiatry

Old age psychiatry has become a basic discipline for all socio-medical providers as well as a specialty for some physicians and health workers (World Health Organization, 1996). In Romania, old age psychiatry has been officially recognised as a sub-specialty of psychiatry since 2001. As in other Eastern European countries, geriatric psychiatry is still not well represented. Scientific organisations such as the Romanian Alzheimer Society (established 1996), the Romanian Association of Geriatric Psychiatry (1999), the Romanian Medical Society of Research of Cognitive Disorders and Alzheimer's Disease (2001) try to improve this situation by organising postgraduate courses for young psychiatrists and general practitioners so that better care of the elderly will be provided.

The number of professionals working in the field is still very low, and they are therefore unable to satisfy the need for care of elderly people with mental disorders. A postgraduate 1-year course is run in Bucharest for a diploma in psychogeriatrics for psychiatrists, geriatricians and medical residents (Camus *et al*, 2003). In addition, an annual summer course on geriatric psychiatry is organised in Romania for psychiatrists from all Eastern European countries. These courses are organised as an Eastern European Initiative by the International Psychogeriatric Association, together with the Romanian Association of Geriatric Psychiatry.

General practitioners and community nurses are also involved in the care of the elderly and so an educational programme has been initiated that includes courses for family doctors.

The Romanian Association of Geriatric Psychiatry and the Romanian Alzheimer Society also participate in the pilot studies on Alzheimer's disease and suicide organised by the World Health Organization.

Mental health services for the elderly

Elderly people with acute and chronic mental disorders, as well as those with dementia, are taken care of both in psychiatric short- and long-stay hospitals and in social services. The latter are not well placed to care for these patients, as there are insufficient staff with professional qualifications in social work or in geriatric psychiatry. Unfortunately there is not a clear picture of all geriatric services, nor are there epidemiological studies in this field. Certainly, as yet there are few psychogeriatric services and even fewer specialist care services for dementia patients.

The extension of outreach services to nursing and residential homes in conjunction with day care centres, day hospitals and residential care could be a valuable alternative to the high degree of institutionalisation of Romanian elderly people, with or without mental disorders.

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Psychiatry and human rights

The protection of human rights and the dignity of persons with mental disorders has a relatively short history in Romania, although in 1652 Matei Basarab, the *voivode* (governor) of Walachia, in his *Letter to My Son*, wrote promoting the abolition of punishment for individuals with mental disorders and recommended their living in monasteries while they were ill.

Generally, Romania's legislation is in keeping with principles set out by the World Health Organization, United Nations and so on concerning the protection of people with a mental illness. The legislation calls for adequate treatment and respect for the human rights of people with mental disorders.

Standards and practice regarding involuntary commitment in a psychiatric department have been improved since the introduction of the new mental health law in 2002 (see above). Criminal Code 114 relates to forensic psychiatry. Also in 2002, Decree 313 was introduced, which pertained to the prevention of individuals with mental disorders becoming dangerous; this decree has recently been improved.

Involuntary commitment to a psychiatric department or involuntary treatment in an ambulatory setting of individuals with mental disorders is now established; which of the two orders is used depends on the mental state and the degree of danger. There are legal and ethical

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limits to involuntary commitment; for example, it may not be indefinite (as it was before the 1960s).

There is no legal discrimination against people with mental disorders but they are nevertheless discriminated against in other ways. Since 1990, because of financial problems, few patients have been able to find employment. The tolerance of society has decreased. Since 1990 it has been necessary to create committees to investigate abuse during involuntary commitment. On the other hand, before 1990 some individuals with (and even some without) mental disorders were committed to a psychiatric department to protect them.

Conclusions

- In Romania, there is a push to re-orientate mental services from being centred on hospitals towards a community care focus.
- People with chronic mental disorders, including dementia, are taken care of both in long-stay psychiatric hospitals and by social services, where the personnel are inadequately trained to care for them.
- Stigma remains an obstacle in ensuring access to care for patients with a mental illness. The battle against stigmatisation needs to be prioritised.
- There is considerable room for improvement in education and training in psychiatry, in research, and in the promotion of mental health and illness prevention.
- It is important for the future development of community services to distinguish between care and treatment.
- The basic quality of care for those who are mentally ill needs to be improved by: developing a community psychiatric network based on geographical catchment areas; developing a complex rehabilitation programme with more substantial social and financial support; involving the community, carers and users more; and involving the government and local authorities in mental healthcare.

In Romania, as in all former communist countries, there are economic problems and a need for national fund-raising to support national psychiatric organisations and services.

There is no legal discrimination against persons with mental disorders but they are nevertheless discriminated against in other ways. Since 1990, because of financial problems, few patients have been able to find employment. The tolerance of society has decreased.

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COUNTRY PROFILE

Mental health services in Uganda

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Uganda is a landlocked developing country in East Africa with an estimated population of 24.8 million people (2002 census). At independence (in 1962) Uganda was a very prosperous and stable country, with enviable medical services in the region. This, however, was destroyed by a tyrant military regime and the subsequent civil wars up to 1986, when the current government took over the reigns of power.

The 2000/2001 Uganda Demographic and Health Survey (UDHS) and the 2002 census report revealed several poor demographic and health indicators. The data showed a high population growth rate (in excess of 3% per annum) due to the high fertility rate, estimated at seven children per woman. The age structure is therefore young, with about half the population below 15 years of age. The infant mortality rate was 88 per 1000 live births and maternal mortality rate 50.4 per 10 000 live births. Life expectancy was 43 years. Gross domestic product (GDP) per capita was around US$300.

By the mid-1980s, the economy had been destroyed and many of the medical personnel had left the country. The net effect was the current low GDP and poor health indices, which, however, have gradually improved over the last decade or so. The continuing civil wars in the north and north-eastern parts of the country continue to drain valuable national resources, and the affected areas have very poor socio-demographic and health indices. The net effect has been a dilapidated infrastructure and psychosocial problems, mainly manifesting as post-traumatic stress disorders.

Uganda is one of the countries in sub-Saharan Africa that was hard hit by the HIV/AIDS epidemic; however, with a sound government strategy and a timely response, HIV infection has been reduced from a prevalence of 20–28% in the mid-1980s to the current 5.6%. Uganda

Uganda … was hard hit by the HIV/AIDS epidemic; however, … HIV infection has been reduced from a prevalence of 20–28% in the mid-1980s to the current 5.6%. Uganda stands as one of the few developing countries that has succeeded in reversing the tide of the HIV epidemic.

stands as one of the few developing countries that has succeeded in reversing the tide of the HIV epidemic (UNAIDS, 2004).

Health reforms

The government has developed a new health policy (1999) and health sector strategic plan (2000), for which primary healthcare (PHC) was the basic philosophy and strategy for national health development, so that equitable services could be offered to the population. The policy emphasises a strong partnership approach between the public and private sectors, non-governmental organisations (NGOs) and traditional practitioners, while safeguarding the identity of each stakeholder. Under the health policy, a basic minimum healthcare package was formulated, in which mental health was a key element, to be delivered at all levels of the health service.

Brief history of mental health services

Uganda has been offering some care for people with a mental illness since the 1920s. Initially these were rudimentary services based on custodial confinement in the south-western part of the country. Better care was started in the capital, Kampala, in the 1930s, followed by modern psychiatric services at the then newly built national referral psychiatric hospital, Butabika Hospital, on the outskirts of the capital in the mid-1950s.

Mental health programme and services

The current challenges to Ugandan psychiatry and the delivery of mental health services include the continued civil wars in the north and north-eastern parts of the country (where the prevalence of post-traumatic stress disorders is very high) and the psychosocial effects of HIV/AIDS (Boardman & Ovuga, 1997). There is rapid migration of people to urban areas but no corresponding job opportunities. The poverty levels and illiteracy rates are high as well. Consequently, the country experiences a high burden of psychosocial problems in addition to traditional mental health disorders. However, the government attaches great importance to improving mental health services so as to address the burden of mental health problems.

The mental health programme was formulated in 1996 and revised in 2000, following the above health reforms. Its main objective is to provide improved access to primary mental health services for the entire population and to ensure ready access to quality mental health referral services at district, regional and national levels. The strategy incorporates both a remodelling of the infrastructure and the provision of the required human resources through the training of specialists and retraining of general health workers.

Mental health services have been decentralised and also integrated within the general healthcare delivery systems and primary health care. The result has been a structure that promotes equity of access by all Ugandan citizens to some mental health interventions, including preventive and rehabilitative services. The process encourages orderly referrals from village level (health centre I), through parish (health centre II), sub-county (health centre III) and county (health centre IV) to district hospitals and regional referral hospitals up to the national referral teaching hospitals at Butabika and Mulago.

At the lower levels (up to the district hospital), clients requiring mental health services are generally managed together in an integrated way, with all other patients, at both out-patient and in-patient facilities. Specialisation and separation begin at the regional referral hospitals, where both physicians and psychiatric clinical officers are usually available. At the regional referral hospitals, 22–32 beds are available, as are an out-patient department and community outreach services.

At the apex of mental healthcare delivery are Butabika and Mulago hospitals, and the Division of Mental Health at the Ministry of Health. Butabika Hospital is the national referral mental hospital, and therefore offers tertiary mental health services. These include curative, preventive and rehabilitative psychiatric services. Mulago is the national referral general hospital. It has a 50-bed psychiatric ward run by the department of psychiatry, which offers active in-patient and out-patient care. There is also a consultation–liaison psychiatric service in the general wards. The Division of Mental Health at the Ministry of Health headquarters, headed by a principal medical officer, coordinates all the mental health activities in the country.

There is, though, an imbalance in the deployment of specialist personnel. All 18 psychiatrists are deployed in the capital city, save for one at Mbarara University. The situation is the same for the few psychologists and psychiatric social workers in the country. This is in the process of being revised: a policy has been developed to post those psychiatrists and social workers who are about to complete their postgraduate courses to all 11 regional mental health units.

In addition to the above government structure is a large support system throughout the country based on NGO health facilities (hospitals and dispensaries) as well as non-facility NGOs. These are encouraged and supported to offer mental health services within their catchment areas, such as supportive psychotherapy and counselling services, in addition to the usual treatment programmes.

All psychiatric patients seen in the public sector receive free psychiatric services, including the basic psychiatric drugs.

Because of stigma and discrimination in the past, many Ugandans had been denied mental healthcare by their relatives or carers and the system, which was not welcoming. This is no longer tolerated. Mental health advocacy is offered by several consumer organisations, and this is gradually coming to play a significant role, though its effect is still generally seen only in urban areas.

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All psychiatric patients seen in the public sector receive free psychiatric services, including the basic psychiatric drugs.

Psychiatric education and research

Psychiatric education in Uganda started in the early 1960s, with the training of psychiatric nurses initially at enrolled level and later at registered level. This was done at Butabika Hospital, to which the School of Psychiatric Nursing was attached. In the late 1960s, the University department of psychiatry was started at Makerere Medical School, where much research was undertaken. The education of undergraduate medical students has, since then, continued with guided transformation. Psychiatric postgraduate training started in 1974. Recently, a new medical school was opened in western Uganda and its department of psychiatry offers undergraduate psychiatric teaching.

Undergraduate training at the universities offers opportunity for students undertaking the MB ChB degree to learn behavioural sciences in the first and second years, and theoretical and practical psychiatry in the third year to fifth years, with 10 weeks' resident clerkship during the fourth year. The clerkship offers clinical skills training, with supervised interviews, case presentations, ward rounds, tutorials and so on. Administrative psychiatry and the management of psychiatric problems within primary healthcare are also covered.

Postgraduate training in psychiatry has been ongoing at Makerere Medical School but with relatively few enrolments, as most resident doctors have preferred to specialise in other branches of medicine. This situation has begun to change in recent years. Enrolment is open to holders of the MB ChB degree, who must have completed their internship and had at least one year's experience as a practising doctor. Postgraduate training is a 3-year full-time programme leading to the award of a master of medicine degree in psychiatry (MMed Psych). It is designed to produce skilled specialists who are able to offer specialised mental health services. It also teaches students to provide leadership skills in community mental health services.

The postgraduate programme is organised in semesters. There are two semesters per year, and there are recess semesters in the first and second years. Much of the training involves clinical apprenticeship, whereby each student is required to carry out psychiatric interviews, do investigations, and to offer treatment and psychotherapy under supervision. The other methods of teaching are lectures, tutorials, interactive discussions and individual study, assignments, seminars and case presentations. Courses are offered in: advanced anatomy, neuropathology, and psychopharmacology, as well as experimental psychology, medical sociology and anthropology, clinical neurology, and health systems management. Also taught are child and adolescent psychiatry, critical skills appraisal, clinical skills and phenomenology. Courses are also offered in psychological therapies, forensic/administrative psychiatry, organic psychiatry, old age psychiatry, addiction psychiatry, community psychiatry, general adult psychiatry and consultation–liaison psychiatry. Research methods and epidemiology are also taught.

The child and adolescent psychiatry course for postgraduates teaches clinical description, aetiology, recognition, diagnosis and specialist management of the various psychiatric disorders encountered among children and adolescents. The course covers practical skills, including investigations, psychotherapy, drug treatment and mental health promotion in children and adolescents.

The course on psychological therapies teaches the principles and practice of psychological methods of treatment in general terms, but also highlights specific psychotherapies found to be relevant to Uganda (i.e. behavioural therapy, marital therapy, family therapy, supportive psychotherapy and child psychotherapy). Classical psychoanalysis is covered theoretically.

Research in psychiatry has been undertaken over the years in epidemiology, clinical psychiatry and social psychiatry. Current research areas include the epidemiology of suicide in Uganda, prenatal depression, psychosocial effects among the displaced population in northern Uganda, and alcohol and drug use among the secondary-student population in the central region of Uganda (to mention but a few). There is also collaborative research being undertaken in HIV/AIDS with Case Western Reserve University.

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Psychiatric association

The Uganda Psychiatric Association (UPA) has been in existence since 1996 and members have regularly met at its scientific congresses, sometimes with other regional associations. Membership includes all psychiatrists practising in Uganda, while other mental health workers, such as psychiatric clinical officers, psychologists and psychiatric social workers, have been accorded associate membership status. The UPA carries out a number of education activities and anti-stigma programmes, in collaboration with mental health consumer groups and NGOs, such as Mental Health Uganda, the Uganda Epilepsy Support Association and the Uganda Schizophrenia Fellowship.

The UPA is a member of the World Psychiatric Association (WPA) and its current President is also the WPA representative for Zone 14 (Eastern and Southern Africa) to the WPA executive committee.

Mental health law reform

Uganda has had a Mental Health Act since independence in 1962; it was revised in 1964. The main emphasis was custodial care, safeguarding the security of patients and the public, and the protection of the property of people who have a mental illness. The Act is currently being reviewed by a select ministerial committee, to bring it in line with modern mental health legislation. Two members of this team attended a series of workshops on mental health legislation organised by the World Health Organization (WHO) in North Africa and Geneva. The new Bill has as its guiding principle the human rights of those who are mentally ill, including privacy, consent to treatment and conditions for involuntary admission. It

gives experts a bigger role in decision making based on professional psychiatric assessment, without compromising the rights of the patient. It establishes an independent mental health tribunal, a national mental health coordination committee and district mental health coordinating committees. The role of the judiciary and the police is clearly defined. The passing of this Bill will greatly enhance psychiatric care and safeguard the rights of people who are mentally ill.

Conclusions

- Uganda is a low-income country that has recently begun to emerge from decades of civil strife and wars.
- It has a high level of poverty and low literacy rates, as well as a high proportion of young people.
- There is a significant burden of mental health problems, worsened by the psychosocial effects of civil wars and the HIV/AIDS pandemic.
- Health reforms in the past 5 years or so, together with formulation of the national mental health policy, have led to a sizeable investment in education and training as well as infrastructure in the mental health sector.
- The challenges that remain concern: the integration of mental health into primary healthcare, which has to overcome some resistance and issues of stigma; the inadequate number of specialists (psychiatrists, clinical psychologists, psychiatric social workers); the limited availability of newer psychiatric drugs; mental health promotion and prevention; improved education and training in psychiatry; and the limited awareness of mental health consumers of their rights.

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SPECIAL PAPER

Some cultural aspects of the Arab patient–doctor relationship

This paper was presented at the annual meeting of the Royal College of Psychiatrists, Harrogate, UK, 2004.

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Culture is a socially shared, trans-generationally transmitted system of implicit values, beliefs and attitudes and explicit behavioural practices (Kroeber & Kluckhohn, 1952). It includes religion. Culturally based assumptions infiltrate the patient–doctor relationship.

The doctor as the 'other'

Patients transfer to doctors culture-based attitudes related to the doctor's gender and age. A female patient may avoid eye contact with a male doctor because this is culturally polite and respectful. A male patient may not report any weakness (e.g. fears, tearfulness or sexual inadequacy) to a female doctor. During family therapy for intergenerational conflict (El-Islam *et al*, 1986), children are likely to expect the doctor to have the same attitudes as their parents, and members of the parental generation are often surprised when the doctor does not oppose children's attempts to depart from their cultural heritage. Good doctors are generally expected to be authoritarian to some extent and their instructions directly advisory rather than a choice or an invitation to reflect (e.g. about alternative methods of treatment). Patients expect doctors to take their side in conflicts with family members, employers and public authorities.

Supernatural versus medical explanations of illness

Arab patients and their families may attribute behavioural symptoms to bad spirits (*jinn*) or attribute undesirable thoughts and wrongdoings to temptation by the devil (El-Islam, 1998). This contrasts with doctors' psychobiological attributions to stressful environmental events and mediating neurotransmitter, transporter or messenger mechanisms.

Doctors should adopt a subjective ('emic') approach to understand supernatural beliefs and attitudes within a culturally shared context. If they adopt an objective ('etic') approach or an ethnocentric approach (where they employ their own culture's criteria) they not only lose rapport with their patients but also arrive at erroneous clinical conclusions.

Patients and their relatives are usually happy if traditional or religious healers collude with their projection of responsibility for disorder on to supernatural agents and include the healthy and sick in rituals aimed at neutralisation of these agents' adversity. In contrast, by attributing symptoms to the patient's own mind, doctors try to undo this projection and should be careful not to blame the patient or relatives for symptom genesis instead of supernatural agents.

The patient–doctor–family triangle

Culture makes the Arab patient–doctor relationship triangular rather than diadically linear, as there will be two-way communications between the patient, the doctor and the family. Relatives may ask for interviews with the doctor in order to provide information before the patient is seen by the doctor, or in order to obtain information after the patient is interviewed. Although most patients give doctors permission to talk to their next of kin, the latter should have no access to personal details that the patients may consider embarrassing or to information that the patient wants held in confidence by the doctor.

Tactful handling of relatives by doctors is essential for their psycho-education about psychiatric illness and for sustenance of their care for patients (El-Islam, 1979). Both relatives and patients are reluctant to reveal to doctors what they regard as family secrets, such as sexual life, history of abuse, illegal activities and details of family income (El-Islam, 2001).

Collaboration with families

Although some degree of personal independence is allowed, interpersonal concern and interdependence with minimal 'social distances' are the norm in Arabian families. The doctor is not expected to encourage adolescents to achieve Western-type full independence from their parents. Not only is this culturally undesirable but there are also no socio-economic provisions for adolescents to live outside their families. Arab doctors encourage the sustenance of the interdependence group ego. The Arab family runs the affairs of its healthy and unhealthy members alike.

The decision to seek the help of professionals or traditional healers is one made by the family. In Arabian Gulf countries, the collaboration of doctors with families has made it unnecessary to introduce mental health legislation. Compulsory hospital admission of patients who do not see their need for hospitalisation is arranged with the approval of a first-degree relative on the advice of a psychiatrist. Although all patients are informed of their right to appeal against compulsory admission or detention in hospital, no such appeals were made over a 25-year period in two Arabian Gulf countries (El-Islam, 1994).

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Symptom appraisal

Somatic symptoms call for the attention of doctors, who are believed to be concerned only with the body. Pains, aches and fatigue are symptoms commonly presented. Somatically oriented doctors collude with patients' somatic orientation and resort to physical examinations, investigations and treatments without exploring the psychosocial emotional factors underlying somatisation. Through excessive investigation, doctors may inadvertently promote the development of iatrogenic hypochondriasis. Their patients may believe they have mysterious or serious disease because the doctors are looking for something they cannot find.

Emotional symptoms (e.g. fears, worries or low spirits) are culturally attributed to weakness of personality or weakness of faith of affected individuals. Patients can readily accept and internalise this notion if they are depressed, and this is likely to lower their self-esteem further. Patients with predominantly somatic symptoms expect physical treatments and patients with predominantly emotional symptoms may ask for psychological treatments. Since most doctors use both medication and supportive therapy, in various proportions, they should explain that the targeted mechanisms are the same in all forms of therapy.

The third group of symptoms, overtly disturbed behaviour, is frequently attributed by patients and their families to the adverse influences of *jinn*. Socially disinhibited, embarrassing or aggressive behaviour, which is usually interpreted in this way, is the most shameful and stigmatising. The help of traditional healers is often sought to deal with the culprit supernatural agents. Without dismissing these culturally shared beliefs, doctors explain that medication influences the brain mechanisms of disturbed behaviour, irrespective of the factors which have caused it. The doctor should approve the patient's resort to religious methods of self-help (autoreligious therapy) rather than traditional healers' help, as the latter sometimes includes beating the patient or the administration of toxic herbs.

Although some degree of personal independence is allowed, interpersonal concern and interdependence with minimal 'social distances' are the norm in Arabian families. The doctor is not expected to encourage adolescents to achieve Western-type full independence from their parents.

Psychotherapy and recent developments

Some patients who have access to information about psychiatric treatments (e.g. via the internet) are particularly

worried about the risk of drug dependence. They are likely to ask for psychological treatments, which are considered safer and more radical in dealing with the root cause of their illness. However, the majority of Arab patients have much less confidence in psychological or 'talking' therapies than in physical therapies.

During individual psychotherapy, it is advisable to punctuate individual sessions with Arab patients by joint sessions with key family members. This avoids the sabotage of any improvement of the individual by family members who have cast the patient in the sick role. In joint sessions with family members they are helped to accept the patient's assertiveness as a healthy development and are urged to continue supportive family relationships.

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ASSOCIATIONS AND COLLABORATIONS

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

Twelve years old: the European Federation of Psychiatric Trainees (EFPT)

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The European Federation of Psychiatric Trainees (EFPT) is an independent federation of national trainee associations; it represents over 12 000 trainees in 19 member countries across Europe. It is run by an annually elected board, comprising the President, Secretary-General, Treasurer, President elect and past President, and is governed by a written constitution.

The EFPT organises an annual forum, hosted by the current President, which is the policy-making body of the EFPT and which provides an opportunity for work on EFPT projects, academic discussion, networking and social interaction. Two official delegates represent each member country at the annual forum and each country has one vote. Other trainees may attend and participate as observers.

EFPT website: www.efpt.org

How did the EFPT start?

In early 1992, a few members of the Collegiate Trainees' Committee (CTC) of the Royal College of Psychiatrists decided to build links between psychiatric trainees across Europe. They wrote to the embassies of all European countries to ask for information about trainee organisations. It became apparent that only three countries had a national psychiatric trainee association. However, contact was made with individual trainees in many countries and this led to an initial meeting in late 1992 in London. Sixteen trainees from nine different countries attended this informal meeting. A decision was taken to create the EFPT at an inaugural meeting in Utrecht, The Netherlands, in March 1993.

Aims and objectives

Although the aims and objectives of the EFPT have changed slightly over the years, the organisation was founded in order to do the following:

- promote representation of all psychiatric trainees
- build national trainee organisations
- provide a forum in which to learn about the diversity and richness of the current training of psychiatrists in Europe
- explore ways in which trainees can promote and improve their own training
- promulgate the opinion of the forum to relevant bodies
- promote the highest possible standards of treatment and care in psychiatry
- promote opportunities for trainees to do parts of their training, with full accreditation, in other European countries (the Exchange Programme)
- to develop policy, EFPT statements, by consensus on matters relevant to trainees.

EFPT development

The official launch of EFPT in Utrecht in 1993 was followed by annual forums in Cork, Ireland (1994); Copenhagen, Denmark (1995); Lisbon, Portugal (1996); Athens, Greece (1997); Ghent, Belgium (1998); Tampere, Finland (1999); Berlin, Germany (2000); Naples, Italy (2001); Sinaia, Romania (2002); Paris, France (2003) and Cambridge, UK (2004).

EFPT policy statements have been agreed and revised over the years on:

- general medicine and neurology in psychiatric training (1994)
- experience in research (1994, 1997, 2001)
- part-time training (1994)
- national trainees' organisations (1995)
- exchange of trainees between different countries (1995, 2001, 2002, 2003)

- evaluation of knowledge (1995, 1999, 2000)
- quality of training – supervision and evaluation (1995, 2001, 2002)
- training in child and adolescent psychiatry (1996, 2002)
- psychotherapy training (1996, 1999, 2001, 2002, 2003)
- requirements for teachers (1996)
- quality assurance in training – independent inspection in training institutions (1997)
- log books (1997, 1998)
- removal of trainees from training (1998)
- mental health promotion (1999)
- independent appeal procedures for trainees (2002)
- training in community-based psychiatry (2002)
- old age psychiatry (2003)
- 'common trunk' (i.e. core training for all branches and specialties within psychiatry) (2004)
- the EFPT's relationships with other organisations (2004).

The EFPT's achievements

The establishment and long survival of the EFPT as an effective, growing and resilient independent European trainee organisation is the greatest achievement. There is no comparable international organisation of trainees in any other specialty.

The EFPT continues to establish links and collaborative working with the Union of European Medical Specialists (UEMS) through its participation in: the UEMS Board and Section of Psychiatry; the UEMS Section for Child and Adolescent Psychiatry; the Association of European Psychiatrists (AEP); and the joint World Psychiatric Association (WPA)/World Health Organization (WHO)/UEMS/AEP/EFPT Taskforce for European Leaders in Psychiatry.

At an international level, EFPT members have played a central role in the WPA Young Psychiatrists Council (WPA–YPC), founded in 2004, and the independent World Association of Young Psychiatrists and Trainees (WAYPT), founded in 2003.

Many EFPT policies have been adopted in the training programmes of European countries. While the EFPT certainly cannot take all the credit, it has been an influence in this process of improving training quality and conditions across Europe. Examples include EFPT policy (1996) on training in child and adolescent psychiatry for general psychiatrists, which was adopted in the UK in 1998; EFPT policy (1997) on the independent inspection of training institutions, which was piloted in Germany 2004; and EFPT policy (1996) on psychotherapy training, which is reflected in Chapter 6 of the UEMS Charter on Specialist Training (2003).

There were three national trainee associations in Europe in 1992. This has now increased to 19 national trainee associations, directly due to the influence of the EFPT. Our 19 full member countries are: Austria, Belgium, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Latvia, The Netherlands, Norway, Romania, Slovakia, Spain, Sweden, Turkey and the UK.

Good practice has spread as we have learnt from each other; for example, the national introductory welcoming meeting for new trainees to psychiatry, long established in France, has inspired the launch of similar meetings in Ireland and the UK.

The EFPT has built a structure in which it is safe to disagree, while at the same time serving as a thriving model of international cooperation and collaboration. It has also actively developed leadership in psychiatry, with several former members of the EFPT now active on the boards of their national associations; one former EFPT President represents his/her country on the UEMS Board and Section of Psychiatry; and several present and former EFPT members are involved in the WPA–YPC and WAYPT, including in leadership roles.

EFPT challenges – past, present and future

The EFPT has developed from an organisation with typewritten documents, no email and no website, which communicated by telephone and post, into today's EFPT with a website (www.efpt.org), an open access listserve (efpt@yahoogroups.com) for quick and simple discussion, and documents produced with word-processing software.

Money is always a problem, partly because the EFPT is an independent organisation that does not accept money directly from pharmaceutical companies, and partly because of the vast differences in salaries across countries. Trainees in Europe earn monthly salaries ranging from about €40 through to about €7500, depending on where they work.

Trainees soon complete their training and therefore leave the EFPT. Despite this, the EFPT's structure and practice have been effective in ensuring the right mix of experience and continuity, along with recruitment of new representatives.

English is used as the official language. This can impede discussion at times, although member countries tend to select delegates who are multilingual. Wording of policies has to be very carefully thought through and debated to ensure that the meaning is the same for all.

The EFPT's approach to differences in training is that we greatly value the diversity of training experiences in Europe, but we strive for the harmonisation of the *quality* of training. We are currently undertaking a Europe-wide 'Satisfaction Survey' to look at both the content and the experience of training from the point of view of trainees. We hope that this will provide really useful information that will help improve the quality of training.

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News and notes

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Identity of the European psychiatrist

Since 2001 there have been annual meetings between leaders of European national psychiatric organisations and leaders of the European-wide psychiatric organisations – the World Psychiatric Association (WPA) in Europe, the Association of European Psychiatrists (AEP) and the Union of European Medical Specialists (UEMS) Section and Board of Psychiatry, together with the World Health Organization's European Regional Adviser for Mental Health. In these meetings, nearly all psychiatric leaders have spoken of various difficulties and perhaps threats to the identity of the psychiatrist in contemporary Europe.

Current difficulties connected with the professional identity of psychiatrists stem, on the one hand, from anxieties resulting from the growth, organisation and practice of different modalities of psychotherapy by practitioners who are not psychiatrists and, on the other hand, by reports that the treatment repertoire of other disciplines in the mental health field could include freedom to prescribe certain medications.

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An important meeting of leaders took place in Geneva in May 2004. There was an assumption that the community will be the central focus for mental health services. The meeting directly addressed the changes in approaches and training needed to equip psychiatrists in their role as key members of mental health teams and their development.

A consensus statement was reached as a result of the meeting and subsequent exchanges. It is hoped that the statement will be of assistance:

- in furthering the status and core identity of psychiatry in European countries
- in developing training to provide the necessary skills as psychiatrists carry out their roles with renewed pride, satisfaction and confidence.

The statement, reproduced below, should also assist in developing the contents of programmes of continuing medical education (CME) and lifelong learning, and the development of all psychiatrists.

Consensus statement. Psychiatric services focused on a community: challenges for the training of future psychiatrists

Contextual issues

Throughout Europe, psychiatry in the community continues to evolve both conceptually and in practice, leading to considerable changes of emphasis:

(1) A much greater emphasis is on providing services that respond to (and are organised around) the needs of service users and family and carers (in contrast to their needs having to adapt to settings and frameworks dictated by services).
(2) Services therefore need to be mobile and flexible.
(3) In-patient services or alternative residential treatment settings are part of and back up community services (rather than being at the centre).
(4) Mental health services have become multidisciplinary and multi-agency, with several disciplines and agencies possessing specific skills and competencies.
(5) Community-based treatment services should cover the full spectrum of mental illnesses and disturbances.
(6) Surveys have shown that patients do not always receive sufficient respect from psychiatrists, who tend to be more distant than other mental health professionals. Mental health professionals themselves (irrespective of discipline) show some features of stigma towards patients. These findings have considerable training implications and need to be acknowledged for both clinical purposes and for the favourable development of the identity of the profession.
(7) Modern psychiatrists need to be highly trained in all three of the bio-psycho-social aspects of mental health and illness. Biological knowledge and physical treatments are one core component of the psychiatrist's skills. Knowledge of social determinants of illness is a second core component. The third is being able to maintain an ability to relate well to patients and carers and to be skilled and knowledgeable in a variety of psychotherapeutic techniques. (Basic science knowledge has increased considerably in recent years and neuropsychiatry will inform important aspects of all psychiatric practice; however, what follows will focus more on the context and psychosocial aspects of the identity and training.)

The competencies of psychiatrists therefore come under a number of headings:

- Clinical treatments
- Clinical management
- Education and training
- Operational management
- Research and evidence-based practice
- Joint working
- Leadership.

Training implications

(1) The emphasis of the training of the psychiatrist in the community will vary somewhat according to the resources of the country:

- In countries with the least resources, most mental healthcare should be provided in primary care, and psychiatrists should train personnel in primary care as well as providing consultation. The psychiatrist will be more centrally involved in complex cases in the community as well as being trained in hospital or alternative residential care.
- In countries with more resources the support and training of primary care workers remain important, but mainstream

mental health services should include out-patient clinics and community mental health centres and day care.

- In countries with the most resources, additional community psychiatry resources will be added to the above. These will include specialist and differentiated mental health facilities focusing on specific problems, such as eating disorders and addiction problems, as well as early-intervention services and assertive community treatments and a variety of vocational training programmes. There will be more sophisticated alternatives to acute hospital beds (crisis and home treatment teams) and for those needing long-term care (hostels and residential homes).

(2) Psychiatrists' training needs to take place in a variety of community settings, especially in primary care, so that they will become confident at working flexibly in different environments with colleagues and with the patients and their families. Psychiatrists should be familiar with the legal aspects of community work.

(3) Psychiatrists need to be trained to acquire skills at multidisciplinary practice and in multidisciplinary teamwork and in working with other agencies. This involves understanding and being able to manage group dynamics and to know how to partake in shared, non-hierarchical decision-making.

(4) Psychiatrists need to train so that they have good skills at negotiating with patients, and are able to address and coordinate therapeutic responses to patients' needs and disabilities as well as symptoms.

(5) Psychiatrists need to train so that they have good skills at engaging families and assessing their burdens and strengths.

(6) Psychiatrists need a good training in the core psychotherapeutic skills that enable respect and accurate empathy for patients and their families. They should be familiar with and able to manage their own particular emotional reactions to a wide range of personalities, behaviours, feelings and other phenomena encountered in clinical work. Psychiatrists should ensure that psychological treatment skills are available and appropriately organised in the community to treat the whole range of mental disorders that benefit from such approaches.

(7) Psychiatrists should engage with public groups in discussions that inform them of how their attitudes to patients and families are perceived. Psychiatrists need to be aware of any tendencies in themselves and colleagues to stigmatise patients. Surveys and audit by patients and families and other professionals may be valuable tools for ongoing assessment.

(8) Psychiatrists should be good at teaching individuals from other disciplines and the public.

(9) Psychiatrists should on the one hand know how to contribute to assessing the mental health needs of a particular population and on the other be familiar with issues connected with globalisation.

(10) Psychiatrists should be good negotiators of resources for mental health services. The proportion of disability-adjusted life years (DALYS) that are due to neuropsychiatric disorders is on average 20% worldwide, but this is expected to rise considerably in the next decade. The proportion of health budgets allocated for these disorders is far less.

(11) Psychiatrists need to be well trained in evaluating service provision from two domains – that of evidence-based medicine and that of the views of users and carers.

(12) Psychiatrists should participate in lifelong learning and develop CME training plans that cover the full range of their roles.

(13) There is a danger that working in some communities in mental health teams could lead to the professional isolation of psychiatrists. Programmes will need to attend to this without encouraging defensive retreat into hospital settings.

(14) Working in the community must not lead to loss of skills of psychiatrists in contributing to effective and therapeutic wards, residential settings and other alternatives to hospital, nor lead to a restriction of the scope of psychiatry as a discipline and a profession (e.g. an exclusive focus on psychotic disorders).

(15) Community psychiatrists need the skills to work well with patients with psychosomatic problems and with colleagues to whom such patients may present, as well as with the psychiatric complications of medical disorders.

(16) The organisation and definition of sub-specialties within psychiatry will vary from country to country, as will the organisation of services according to different age groups of patients.

Brian Martindale

(We are greatly indebted to Professors Thornicroft and Roessler for presentations that set the scene for our discussions and helped crystallise many of the ideas expressed.)

Island of Kos Declaration (on Iraq)

The participants of the Panhellenic Congress of Psychiatry meeting on 14–18 May 2004, on the Hippocratic Island of Kos,

In the company of leaders of the World Psychiatric Association, of the American Psychiatric Association, and of over 20 other national psychiatric societies from Eastern Europe, the Balkans and beyond,

Upon receiving a report presented by the president and the secretary general of the Iraqi Society of Psychiatrists expanding on international media reports,

And in line with our professional and ethical responsibilities to protect and promote mental health across the world,

(1) Express concern about the recently documented abuse of detainees at Iraqi prisons, involving deeply humiliating and culturally degrading interrogation and mistreatment practices. There is well-established evidence of the long-standing harm of such practices to the mental health of victims and perpetrators and their families and communities;

(2) Also express concern about the amply documented loss of life and threat to general and mental health of the Iraqi population;

(3) Express solidarity with our colleagues of the Iraqi Society of Psychiatrists, who have reported the deeply disturbing conditions of insecurity and deprivation of professional means, including basic medicines, currently prevalent in Iraq, which are impeding their minimally meeting professional obligations with the population at large;

(4) Call on all governments involved to act urgently to stop the degrading practices at the Iraqi prisons, and the World Health Organization, World Psychiatric Association Member Societies, and other pertinent mental health organisations to assist our Iraqi colleagues with the basic professional means they require for the fulfilment of their fundamental responsibilities.

The College has given its full support for the Island of Kos Declaration.

Forthcoming international events

3–5 February 2005
Biensestar y Calidad de Vida en el Siglo 21: WPA Section on Mass Media and Mental Health
Tuxtla, Mexico.
Contact: Dr Miguel A. Materazzi.
Email: materazzi@arnet.com.ar.

7–11 February 2005
Psyche and Art Seminar: WPA Section on Art and Psychiatry
Djerba, Tunisia.
Contact: Dr Hans Otto Thomashoff.
Email: thomashoff@utanet.at.

12–15 March 2005
Advances in Psychiatry: State of the Art
Meeting of the WPA Scientific Sections and WPA Regional Meeting.
Athens, Greece.
Contact: Prof. George Christodoulou.
Email: gchristodoulou@ath.forthnet.gr or info@era.gr.
Website: www.era.gr/wpa2005athens.htm.

16–18 March 2005
Costa Rica Psychiatric Association's 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. Seventh Workshop on Costs and Assessment in Psychiatry
Organised by the International Center for Mental Health Policy and Economics, sponsored by the WPA Section on Mental Health Economics.
Venice, Italy.
Tel/fax: +39 02 5810 6901.
Email: info@icmpe.org.

1 April 2005
Controversies in Old Age Psychiatry
One-day University of Melbourne symposium.
L'Unica Reception Centre, Brunswick, Victoria, Australia.
Contact: Marilyn Cain.
Email: cain@unimelb.edu.au.

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.

21–24 April 2005
WPA Regional Meeting and XXI Congreso Argentino de Psiquiatria
Organised by the Association of Argentinean Psychiatrists (APSA).
Mar del Plata, Argentina.
Contact: Dra. Graciela Lucatelli.
Email: apsa@apsa.org.ar.
Website: www.apsa.org.ar.

12–13 May 2005
Balanced Care. Innovative Perspectives on Psychiatric Rehabilitation
Geel, Belgium.
Contact: Lieve Van de Walle.
Fax: +32 (0)14 58 0448.
Email: Congres2005@opzgeel.be.
Website: www.opzgeel.be.

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

12–15 June 2005
First IASSID Asia-Pacific Regional Congress
The International Association for the Scientific Study of Intellectual Disabilities (mental retardation and related developmental disabilities) Life Course Perspective of Research on People with Intellectual Disabilities Global Trends and Local Strategies.
Howard International House, Taipei, Taiwan.
Email: iassidoffice@aol.com.
Webiste: www.iassid.org.

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

17–20 June 2005
Quality and Outcome Research in Psychiatry
WPA thematic conference, Spanish Foundation of Psychiatry and Mental Health.
Valencia, Spain.
Contact: Dr Carmen Leal.
Email: Carmen.Leal@uv.es.

18–21 June 2005
9th European Conference on Traumatic Stress (ECOTS)
European Society for Traumatic Stress Studies (ESTSS), Swedish National Association for Mental Health (SFPH) in cooperation with the National Centre for Disaster Psychiatry (KCKP).
Themes: Effects of Disasters and Terrorism, Neurobiology and Trauma, Memory and Trauma, Children and Effects of Early Traumatisation, Sexual Exploitation and Trauma, PTSD and Complex Traumatisation, Exile Trauma, The Impact of Prevention and Acute Interventions.
Stockholm, Sweden.
Website: www.stocon.se/ecots2005.

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

11–12 July 2005
Second International Conference on Conflict-Culture and Mental Health: The Contribution of Psychiatry and Psychotherapy to Conflict Resolution and Harm Reduction
Institute of Psychiatry, London, UK.
Contact: Rachel Jenkins.
Email: Amy.Blakey@leedsmh.nhs.uk.
Website: www.leedsmentalhealth.nhs.uk/andrew-sims/.

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