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Violence and mental health

Hamid Ghodse

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

According to the World Health Organization (WHO, 2002) over 300 000 people died in 2000 as a direct result of violent conflicts. The rates ranged from less than 1 per 100 000 population in high-income countries to 6.2 per 100 000 in low- and middle-income countries. Torture, rape and violation of human rights are also used to terrorise and undermine communities. Violence not only results in death and direct physical injury but also affects mental health and subsequent physical health (WHO, 2002). According to the WHO, an estimated 1.6 million people worldwide lost their lives to violence in 2000. About half of the deaths were attributed to suicide, nearly a third were due to homicide, and about a fifth were casualties of armed conflicts.

Destitute states whose governments have collapsed provide fertile ground for the planning and preparation of appalling acts of violence. Such events, although differing in form over the years, have a long history, perhaps dating back to the very first human societies. They undoubtedly played a role in the creation of some of the global empires of past millennia. However, the spectacular nature of recent events, with large numbers of casualties, combined with the fact that they are now vividly reported worldwide, often within minutes, has made the world community feel very vulnerable. It is clear that no one and no place is truly secure while violence is endemic in various parts of the world.

There are of course many other types of violent behaviour, within and between families, in local neighbourhoods, streets and communities. Self-inflicted injuries, suicide, homicide and other acts of violence, including those against groups perceived as particularly defenceless, such as children and the elderly, frequently occur. Although they may not be widely reported, they contribute to and accentuate feelings of insecurity and lead to fearfulness. Because these events occur so frequently they have been 'normalised', so that they are often seen as an inevitable part of the human condition and therefore not susceptible to prevention. Indeed, in general, they are often considered as 'law and order' issues.

Various explanations have been put forward for the dynamics for different types of violence, including self-directed violence, which is considered to be the fourth leading cause of death and the sixth leading cause of ill health and disability (Platt, 1984; Murphy & Wetzel, 1990; Cavanagh *et al*, 1999; WHO, 2002). There is also information on the factors that put states at risk of violent conflict (Carnegie Commission, 1997).

Whatever the causes, it is obvious that in addition to human misery, violence puts a significant burden on national economies in general and on health services in particular. In this context, it is important that the role of health professionals in dealing with the consequences of violence should be explored and accorded public health priority (Krug *et al*, 2002).

The practice of medicine has always been important during conflicts and wars and also in response to other acts of violence. The most immediate and obvious response is the provision of physical care to those who have been physically injured, but it is generally acknowledged that the associated psychological pain, anxiety and stress also demand a response. Such reactions may affect those directly involved in the act of violence, those who witness it and those who were part of the immediate, interventional response, for example those from the emergency services who attended the scene and healthcare professionals receiving casualties. Collectively, there may be so many people involved that the community as a whole suffers from the psychological impact of the event.

Although this is familiar territory to psychiatrists, the psychosocial impact on individuals, families and communities is an area that has generally been neglected, apart from during the immediate aftermath of a violent act. Then, as the event fades away from media attention it is all too easy for it to fade also from the attention of policy makers and professionals. This is an immediate issue for the Royal College of Psychiatrists and other psychiatric associations to consider when planning responses to local violence. For example, psychiatrists can contribute to preparatory training for professionals who will take on the responsibility of assessing and meeting the needs of those who have suffered directly or indirectly as a result of an act of violence. Individuals requiring support may include: those most directly involved; those who have lost a relative, a friend or a colleague; those suffering from post-traumatic stress disorders; and the family and friends of the violent individuals themselves.

In addition, attention needs to be paid to wider issues. The media play an important role, not only in reporting events but also in influencing responses to them. Judicious use of the media can therefore be vital (Njenga *et al*, 2003) in the aftermath of violent acts, and it may be appropriate for psychiatrists to offer advice and support to policy makers so that the public's natural feelings of insecurity are not increased by the hasty announcement of inappropriate actions.

Psychiatrists can contribute to preparatory training for professionals who will take on the responsibility of assessing and meeting the needs of those who have suffered directly or indirectly as a result of an act of violence.

Judicious use of the media can therefore be vital ... in the aftermath of violent acts and it may be appropriate for psychiatrists to offer advice and support to policy makers so that the public's natural feelings of insecurity are not increased by the hasty announcement of inappropriate actions.

The Royal College of Psychiatrists and similar organisations may feel that it is not appropriate to become embroiled in the social and political factors that are often cited as the cause of violence, but such detachment should not interfere with unambiguous advocacy for human rights in all circumstances.

In this context, psychiatrists may also be able to contribute to scientific research on understanding the reasons behind violence against society, including gaining an understanding of the underlying ideological motivations. This is clearly of increasing importance if we are to prevent the development of a 'sick' society – one that is imbued with bitterness, resentment, revenge, aggression and violence. Political solutions alone, however sound, will never be fully effective unless attention is paid to helping individuals within society with their own emotional responses.

Tackling this problem energetically is important. 'Sick' societies provide an environment in which organised crime can develop and flourish. Drug-related crime and the illegal arms trade, for example, are particularly well known for the way in which they can undermine the authority of the state and provide funding for politically related violence. The Royal College of Psychiatrists and similar organisations may feel that it is not appropriate to become embroiled in the social and political factors that are often cited as the cause of violence, but such detachment should not interfere with unambiguous advocacy for human rights in all circumstances. Specifically, whatever the threat of violence,

psychiatry and psychiatrists should remain focused on the needs of those who are mentally ill and should resist political pressure to treat as sick those individuals whose behaviour may be inconvenient to those in power. The Royal College of Psychiatrists can make a very positive contribution to those ideas by maintaining robust links with psychiatrists in other countries and by supporting them in difficult situations.

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THEMATIC PAPERS – INTRODUCTION

Dementia in low- and middle-income countries

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Dementia care places considerable financial burdens on families.... The idea that extended family care reduces this problem is misleading, and certainly does not apply to those families for whom survival depends on all family members working.

It is 100 years since Dr Alois Alzheimer, a German neurologist, observed changes in the brain that are now known to be the characteristic features of Alzheimer's disease, the commonest form of dementia. Until recently this condition was thought to occur only infrequently in low- and middle-income countries; now it has been realised that the prevalence is as high in these countries as in the rest of the world. Further, because of the rapidly increasing numbers of older people in low- and middle-income countries, they contain far more people with dementia: 16 million compared with 8 million in high-income nations. How can ways be found to provide adequate care for people with dementia in these countries when resources, both skilled manpower and finance, are so limited? The thematic papers that follow address this issue.

In their article 'Ageing and dementia in low- and middle-income countries', Martin Prince and Daisy Acosta point first to the degree to which the burden of disability in these countries, as elsewhere, falls disproportionately on older people, who are likely to suffer from multiple disorders. They describe the 10/66 Dementia Research Group, a remarkable collaborative

venture that aims to develop standardised diagnostic procedures, undertake comparative prevalence studies and describe care arrangements and patterns of service development in low- and middle-income countries. The links between this group and Alzheimer's Disease International (itself the subject of an article in this issue under 'Associations and collaborations') provide a bridge with the voluntary sector that allows research findings to be rapidly disseminated and utilised to the benefit of the affected populations.

Dementia care places considerable financial burdens on families. Carers are often prevented from working because of the need to provide full-time care for their affected relative. The idea that extended family care reduces this problem is misleading and certainly does not apply to those families for whom survival depends on all family members working.

In the paper on dementia care in Latin America, Aquiles Salas and Raul Arizaga describe the situation in Venezuela, where few people receive adequate non-contributory benefits; most people over the age of 65 receive only US\$35 a month. The problem is compounded by the fact that virtually all medical and day care services are privately provided. Under the

aegeis of the 10/66 Dementia Research Group a start is being made to train family carers. If it is to have an impact, this small initiative will need to generate a snowball effect. The situation described in Argentina appears to be marginally better, with slightly higher pensions and a significant contribution to the healthcare system made by public funds. Diagnostic neuroimaging and medication are available in Argentina but, clearly, many cannot afford them. Perhaps of greater significance in any case is the need for increased awareness of the condition, so that it can be accurately diagnosed and appropriate nursing and social care provided.

Finally, K. S. Shaji and Amit Dias describe the situation in India, where, despite the best efforts of the Alzheimer's and Related Disorders Society of India (ARDSI), dementia remains a largely hidden problem. It is still widely seen as part of normal ageing. The majority of people with dementia are cared for at home, with little financial, practical or emotional support. There is a government network of services,

but most people prefer to use the costly private system. Fortunately, there are several initiatives, arising from the 10/66 Dementia Research Group, by which local people are trained in dementia care. One scheme is being evaluated and has seen promising initial results.

These three articles reveal some common issues that need to be drawn to the attention of health and social policy makers in low- and middle-income countries. Endemic poverty among older people, the lack of government-funded health and social care systems and the shortage of trained personnel require urgent attention. New initiatives, especially the 10/66 Dementia Research Group, are already raising awareness among the public, health professionals and policy planners. The rapid ageing of the populations in these countries means, to quote the slogan for World Alzheimer's Day (21 September 2006), 'there is no time to lose'. Psychiatrists all over the world are urged to support their national Alzheimer's associations in all the activities they undertake to the very best of their abilities.

The rapid ageing of the populations in these countries means, to quote the slogan for World Alzheimer's Day (21 September 2006), 'there is no time to lose'.

THEMATIC PAPERS – DEMENTIA IN LOW- AND MIDDLE-INCOME COUNTRIES

Ageing and dementia in developing countries – the work of the 10/66 Dementia Research Group

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The website of the 10/66 Dementia Research Group is <http://www.alz.co.uk/1066>

Demographic ageing proceeds apace in all world regions (United Nations, 2003). The proportion of older people increases as mortality falls and life expectancy increases. Population growth slows as fertility declines to replacement levels. Latin America, China and India are experiencing unprecedentedly rapid demographic ageing (Figs 1 and 2).

In the accompanying health transition, non-communicable diseases (including heart disease, stroke, cancer, arthritis and dementia) assume a progressively greater significance in low- and middle-income countries. This is partly because most of the world's older people live in these countries – 60% now and rising to 80% by 2050. However, changing patterns of risk exposure also contribute. In the third stage of health transition, as life expectancy improves and high-fat diets, cigarette smoking and sedentary lifestyles become more common, cardiovascular diseases and associated conditions, including dementia, gain maximum public health salience (Yusuf *et al*, 2001). Non-communicable diseases are already the

leading cause of death in all world regions apart from sub-Saharan Africa (Fuster & Voute, 2005).

There are inequities in the increasing attention directed towards non-communicable diseases in low-

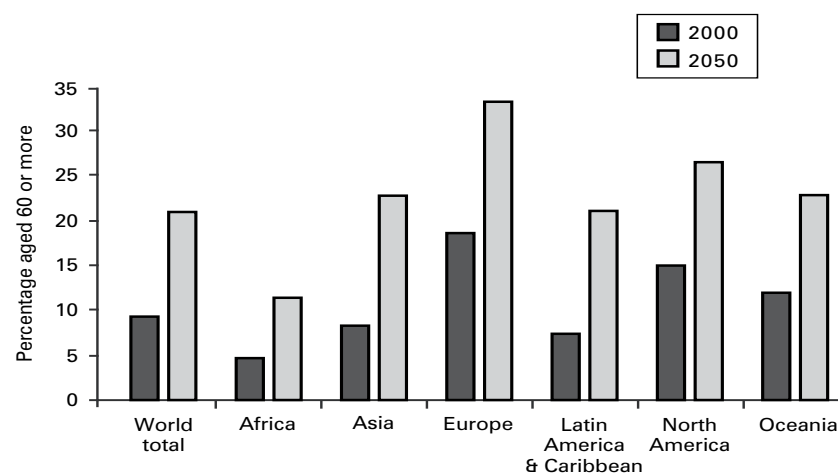


Fig. 1 Global demographic ageing: proportion of population aged over 60 in 2000 and predicted for 2050.

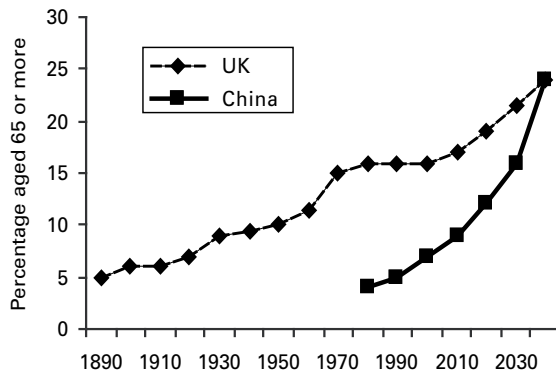


Fig. 2 Demographic transition: proportion of population aged over 65 in UK and China.

Carer strain is as evident in the developing world as it is in high-income countries, despite extended family networks.

and middle-income countries. The needs of younger people are prioritised and relatively little research, policy or practice is directed towards older adults. Premature mortality is given more attention than living with disability. Disability falls disproportionately upon older people, who are particularly likely to have multiple physical, mental and cognitive disorders. Dementia has a uniquely devastating impact on capacity for independent living, yet its global public health significance is under-appreciated.

The 10/66 Dementia Research Group

The title of the 10/66 Dementia Research Group (10/66 Dementia Research Group, 2000a,b; Prince *et al*, 2003, 2004) is a reference to the 66% of people with dementia who live in low- and middle-income countries and the less than one-tenth of population-based research carried out in those settings. It is a collaboration of over 130 academics and clinicians, linked to Alzheimer's Disease International (ADI). We attempt to redress the research imbalance through south-south and south-north research collaborations. Measures, protocols, manuals and training materials have been translated into many languages. Fifteen publications have appeared in international and regional peer-reviewed journals.

Table 1 Overview of 10/66 population-based surveys

Country	Catchment area	Target sample	Start date	Finish date
Cuba	Havana (urban)	2100	6/03	12/05
	Matanzas (urban)	900		
Brazil	Sao Paulo (urban slum)	2000	5/03	7/05
Dominican Republic	Santo Domingo (urban)	2000	11/03	12/05
Venezuela	Caracas (urban)	2000	9/04	6/06
Mexico	Mexico City (urban)	2000	1/06	10/06
Peru	Lima (urban)	1000	4/05	6/06
	Canete (rural)	1000		
Argentina	Cañuelas (rural)	2000	4/05	6/06
China	Beijing (urban)	1000	3/04	9/05
	Daxin (rural)	1000		
India	Chennai (urban)	1000	2/04	2/06
	Vellore (rural)	1000		

Our first symposium, in Cochin in 1998, during the 14th international conference of ADI, established clear priorities (10/66 Dementia Research Group, 2000a), which have guided our subsequent research programme.

Developing and validating diagnostic procedures

Our pilot studies in 26 centres in Latin America and the Caribbean, Africa, India, Russia, China and South-East Asia demonstrated the feasibility and validity of a one-stage diagnostic protocol for population-based research (Prince *et al*, 2003; Liu *et al*, 2005). This protocol is sensitive to both culture and education (10/66 Dementia Research Group, 2000b).

Description of care arrangements

Carer strain is as evident in the developing world as it is in high-income countries, despite extended family networks (Choo *et al*, 2003; 10/66 Dementia Research Group, 2004; Dias *et al*, 2004). Carers often cut back on work to care (10/66 Dementia Research Group, 2004). There is a lack of awareness of dementia and health services are unresponsive (Patel & Prince, 2001; Shaji *et al*, 2002a; Dias *et al*, 2004). Behavioural symptoms are common, distressing for carers and lead to stigma and accusations of neglect or ill treatment (Ferri *et al*, 2004).

Service development and evaluation

Community health workers in Brazil (Ramos-Cerqueira *et al*, 2005) and India (Shaji *et al*, 2002b) have been trained to identify people with dementia in the community. We developed a low-level, brief carer education and training intervention, administered by community health workers, and evaluated it in nested randomised controlled trials (RCTs) in Moscow and Goa (the 10/66 population-based studies).

The 10/66 population-based research programme

In October 2002, the Wellcome Trust funded cross-sectional surveys in admixed populations in Cuba and Brazil to estimate the prevalence of dementia and to test the hypothesis that African ancestry was inversely associated with risk for dementia/Alzheimer's disease. Seven further 10/66 studies have since been funded, by the World Health Organization (the Dominican Republic, India and China), the US Alzheimer's Association (Peru, Argentina and Mexico) and the Venezuelan government (Venezuela) – see Table 1.

Each 10/66 population-based study has the same design – a comprehensive one-phase catchment

area survey of all residents aged 65 and over, with a minimum sample size of 2000 in each of the nine countries, for a total sample of 19 000 individuals distributed in 13 catchment areas (see Table 1).

All participants are interviewed with a socio-demographic, risk factor and health behaviours questionnaire, a cognitive test battery and a structured clinical interview. A physical and neurological examination follows, with anthropometry and phlebotomy. An informant is interviewed for evidence of cognitive and functional decline, care arrangements, and onset and course of any possible dementing illness. Fasting blood samples are taken at baseline from participants in Cuba, the Dominican Republic, Venezuela, Peru, Mexico and Argentina. Frozen serum has been saved for further biochemical analyses. DNA is available for testing in seven of the nine countries. The size, scope and extent of the 10/66 surveys make this one of the largest cross-national studies of ageing populations in developing regions, with the potential to inform well beyond the bounds of dementia. In seven of the countries – Cuba, the Dominican Republic, Venezuela, Mexico, Peru, Argentina and China – we shall be carrying out an incidence phase follow-up 3 years after baseline.

Initial analysis of the data generated from this programme will focus on the following areas.

The prevalence of dementia

Considerable uncertainty still exists as to the prevalence of dementia, and hence the numbers affected, in many regions of the world (Ferri *et al*, 2005). Latin America has, until now, been particularly poorly covered by research studies, with only one high-quality study to date, from Brazil (Herrera *et al*, 2002; Nitrini *et al*, 2004). The evidence base from India and China is more substantial, but no previous studies have allowed such direct comparison using cross-culturally validated methodology. Effectively disseminated data on prevalence raise awareness and inform policy-making and planning.

The impact of dementia

At the population level we will assess, and compare between centres, the independent contribution of dementia to disability and dependency and associated economic costs. In low- and middle-income countries the responsibility for care falls disproportionately upon family carers, who, given the limited services and low levels of community awareness that prevail, do not tend to receive the support from others that they need and deserve. We will describe care arrangements for people with dementia, and the psychological, practical and economic strain they experience. In traditionally orientated societies, governments often stress the informal role of families while eschewing state involvement in providing or financing care. Understanding of the consequences of this policy may assist the debate in each country regarding the role of state and family in care provision.

Intervention

Nested within the population surveys, we are testing the effectiveness of training community health and social care providers as a method for identifying people with dementia in the community. In these settings, there is very little understanding of dementia as a health problem and very little help-seeking. We are also testing, in an RCT, the effectiveness of a simple, low-level, five-session intervention designed to inform carers about dementia and to train them in care techniques, particularly for the behavioural problems linked to dementia (Ferri *et al*, 2004).

Disseminating the results

An action research programme of this kind stands or falls upon its ability to inform and encourage policy development on the basis of the evidence accumulated through its activities. The 10/66 Dementia Research Group recently held a 1-week workshop at the Rockefeller Center in Bellagio to address the need to exploit to the full the potential created by the 10/66 population-based and intervention studies. Dissemination through a peer-reviewed scientific journal is but one important element of this process. Our challenge is to use our findings to raise public awareness, stimulate local clinical training and practice, and influence social welfare and healthcare policy at the national and international level.

In these respects, our relationship with ADI is crucial. ADI is affiliated to the World Health Organization. The needs of people with dementia in low- and middle-income countries is now a major priority for ADI, and our findings are disseminated on its website, at its conferences and in its regular newsletters and World Alzheimer's Day bulletins, distributed to its 76 member associations worldwide. In turn, the national Alzheimer associations are able to use our materials for local publicity, and to influence national policy makers as part of their lobbying activities. Other committed non-governmental organisations (NGOs) may have a key advocacy role to play, and we will need to work intersectorally to maximise dissemination and policy impact. Dementia is one of many health conditions in the developing world characterised by lack of awareness, stigma, limited help-seeking, few services and much unmet need. The evidence provided by research, disseminated actively by committed NGOs, can be a powerful argument for change.

At the Bellagio meeting we devised a strategy for dissemination focusing upon:

- identifying key stakeholders
- designing and conducting local workshops
- forging links with policy makers, understanding their preoccupations and preparing policy briefings in each of the countries/regions where we are working
- linking with the print and radio news media in low- and middle-income countries, and understanding how their support may be elicited in raising awareness
- exploiting links between 10/66 researchers and national Alzheimer associations

In traditionally orientated societies, governments often stress the informal role of families while eschewing state involvement in providing or financing care. Understanding of the consequences of this policy may assist the debate in each country regarding the role of state and family in care provision.

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- forming intersectoral links with other relevant NGOs, such as HelpAge, Save the Children (for the cross-generational effects) and Oxfam (for the economic impact of care and poverty reduction).

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THEMATIC PAPERS – DEMENTIA IN LOW- AND MIDDLE-INCOME COUNTRIES

Dementia care in Latin America – country profiles from Venezuela and Argentina

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Across Latin America, fewer than 30% of older people receive old-age pensions.

Demographic ageing is proceeding especially rapidly in Latin America. Those aged 65 years and over will increase from 33.3 million (6% of the total population) in 2005 to 56.3 million (8.5%) in 2020 and 110.2 million (14.7%) in 2040. A recent review drew attention to the relatively small number of population-based studies of dementia in Latin American countries (Ferri et al, 2005). Estimates based on the literature suggested 1.8 million people with dementia in 2001 increasing to 4.1 million by 2020 and 9.1 million by 2040. The increase, more than a doubling of the number of people with dementia between 2000 and 2020, was the most marked for any world region. Arguably, health and social finance systems are not well placed to meet the needs of the growing numbers of frail and dependent elderly people.

Across Latin America, fewer than 30% of older people receive old-age pensions. Most countries have moved towards multi-pillar schemes based on private, defined contribution schemes, with some bolstering by more limited public benefit elements. Brazil alone has a comprehensive non-contributory scheme, paid to 5.3 million older Brazilians at a cost of 1% of gross domestic product. Women, and those many Latin Americans who have worked in the informal sector, are disadvantaged by schemes based on defined contributions. Non-contributory schemes have been shown to be highly effective at alleviating wider poverty – they are typically shared within households, reduce vulnerability and increase economic stability.

Most Latin American countries have mixed national health systems in which public sector institutions play a relatively minor role; less than one-third of the

population is covered by mandatory social health insurance systems and private, out-of-pocket expenditure is high. A few countries, such as Mexico, have national health insurance systems in which social insurance institutions play a major role in the provision of healthcare (often in partnership with private institutions) and statutory social insurance systems cover 50% or more of the total population. Across the continent, private income pays for more than half of all healthcare. Coverage is strongly linked to income, with an estimated 70% of the region's 200 million poor lacking access to basic healthcare.

In this paper we review the health and social care services available for people with dementia in two contrasting Latin American countries, Venezuela and Argentina.

Venezuela

The Venezuelan population is 27.0 million, of whom 1.3 million (4.8%) are aged 65 years or more. Life expectancy at birth is 71.0 for men and 77.0 for women. Most older Venezuelans subsist on defined benefit pensions provided by the state – 790 000 funded by the National Institute of Social Security and 104 000 (those living in poverty) provided by the National Institute of Geriatrics and Gerontology. Those aged 60 years or more are eligible. Although coverage is high, the pensions are meagre, rarely exceeding US\$35 per month. Consequently, many older Venezuelans are still reliant on their families for economic support.

In a mixed health system, public institutions have a limited role in providing care for the elderly; in particular, they lack any specialised services for dementia care. Care is therefore mainly informal and is provided by family carers, without training and support. In the Venezuelan arm of the 10/66 pilot study of care arrangements for people with dementia (10/66 Dementia Research Group, 2004), we found that 80% had used private medical services and 15% public services; 20% had a paid carer while 7–10% of carers had stopped or cut back their work in order to care. As an index of strain, half of all carers were found to have common mental disorders.

As yet, there are no estimates of the prevalence of dementia in Venezuela. This will be rectified by the 10/66 Dementia Research Group's survey recently completed in the capital, Caracas, and an ongoing longitudinal study of 3500 persons aged 55 and over in the second city, Maracaibo, in the west of the country (Maestre *et al*, 2002). Alzheimer's Disease International's recent estimate of the prevalence of dementia in Latin America (Ferri *et al*, 2005) applied to the Venezuelan population would imply 92 000 cases of dementia in 2000, rising to 464 000 by 2040. This challenge will be difficult to meet given the current lack of formal care services. There are just 28 public nursing homes in the country, supported by the National Institute of Geriatrics and Gerontology.

In addition, several private nursing homes deliver care for private, fee-paying residents and some whose care is funded by the National Institute of Social Security. Neither public nor private care homes are well resourced to provide quality care for people with dementia. Care in the community is provided only by private doctors and few of these have specific training or expertise.

The Alzheimer National Foundation has been delivering support for people with dementia and their families for the past 15 years. The Foundation delivers a year-long programme, which includes courses (of 1–2 days) for families four times a year, a day care centre and psychological support for carers. It has been disseminating information and awareness about the importance of dementia as a social, family and public health issue. Scarcity of funds has necessarily limited the scope and coverage of these activities. However, the Foundation has been building links with government agencies. A trial of the 10/66 carer intervention was due to start in August. The intervention involved training local community health workers to educate and train 30 family carers identified during the population-based survey in Caracas. This project was presented to the National Institute of Geriatrics and Gerontology, which will consider it as a pilot study with potential to be rolled out nationwide.

Argentina

Argentina has a population of 38.4 million, of whom 9.9% are aged 65 and over. Life expectancy at birth is 73.7 years (70.0 for men and 77.5 for women). Demographic ageing is already well advanced – between 1950 and 2000 the population aged over 65 years grew threefold and the population aged over 80 grew seven times faster than the general population over the same period (Arizaga, 2002). Accordingly, there are already relatively large numbers of people with dementia (315 000) but future increases will be slightly less marked than in Venezuela and other, more typical Latin American countries, but still more than doubling, to 769 000, by 2040 (Ferri *et al*, 2005).

Men retire at 65 and women at 60 years. Retirement benefits are proportional to earnings, but with a minimum income of US\$140 a month. Those who have never worked receive a pension of US\$80 a month at 70 years of age.

Argentina has a mixed health system: public (county and provincial hospitals) and private (provided by prepaid health organisations, unions' health services and strictly private practice). Eighty per cent of the elderly population is covered by the different private health systems, with the remainder relying on the public system.

The Instituto Nacional de Servicios Sociales para Jubilados y Pensionados (INSSJP; National Institute of Social Services for Retired and Pensioners), created in 1971, provides social and medical attention for 3.2 million retired and pensioned persons.

Across the continent, private income pays for more than half of all healthcare.

Coverage is strongly linked to income, with an estimated 70% of the region's 200 million poor lacking access to basic healthcare.

We found that 80% had used private medical services and 15% public services; 20% had a paid carer while 7–10% of carers had stopped or cut back their work in order to care.

As an index of strain, half of all carers were found to have common mental disorders.

Awareness of dementia is generally low; many general practitioners believe that memory loss or other cognitive deficits are part of normal ageing.... Consequently, specialist referral generally occurs at an advanced stage of the disease.

There is neither a national programme for dementia nor programmes in the different health systems. The INSSJP pays for more than 15 000 mental health beds and 15 000 long-term care beds. Many people with dementia receive institutionalised care through these facilities. Specialists (neurologists, psychiatrists and geriatricians) are concentrated in the major towns and there is a lack of access to their services for far-flung rural communities (Sarasola et al, 2006). There are as yet very few dementia or memory centres with a multidisciplinary specialised team (three in public general hospitals, four in private hospitals in Buenos Aires and three in private hospitals in large provincial cities). Several of these have day care and memory training programmes (Sarasola et al, 2006).

In Argentina, as in nearly all South American countries, the full range of auxiliary diagnostic tools is available, including laboratory tests, neuroradiology and estimation of some genetic markers. However, access can be a problem, depending upon location, type of healthcare system, costs and eligibility for reimbursement (Arizaga, 2002). ANMAT, the regulatory agency that approves the use and sale of new drugs, has approved donepezil, rivastigmine, galantamine and memantine for use in dementia. These are subject to 30–70% reimbursement, depending on the drug and the patient's healthcare system (Arizaga et al, 1999).

Awareness of dementia is generally low; many general practitioners believe that memory loss or other cognitive deficits are part of normal ageing (Mangone & Arizaga, 1999; Mangone et al, 2000). Consequently, specialist referral generally occurs at an advanced stage of the disease (Arizaga, 2002).

The Asociación de Lucha contra el Mal de Alzheimer (ALMA; Association for the Fight Against Alzheimer's Disease) was founded in 1987. The Association is very active, providing information and support, and running a day centre in Buenos Aires for patients and families.

A basic infrastructure for research is now established in Argentina. The Consortium Argentino para el Estudio de la Demencia (CAED; Argentine Consortium for Dementia Research) agreed upon the criteria for the diagnosis of dementia and Alzheimer-type dementia (CAED, 1995) and added some modifications (CAED, 1998) to the NINDS–AIREN criteria for vascular dementia (Roman et al, 1993). The Mini Mental State Examination (Grupo de Trabajo de Neuropsicología Clínica de la Sociedad Neurológica Argentina, 1999), the Alzheimer's Disease Assessment Scale (ADAS; Mangone et al, 1995) and the Boston Naming Test (Allegri, 1997) have been translated, validated and harmonised (Grupo de Trabajo de Neuropsicología Clínica de la Sociedad Neurológica Argentina, 1999).

Annual direct costs of the disease were estimated and were found to increase with cognitive deterioration, from US\$3240 in mild to US\$9658

in severe Alzheimer's disease, and with institutionalisation (US\$3189 in community patients versus US\$14448 in institutionalised patients). Most direct costs were paid by the family (Allegri et al, 2006a). Neuropsychiatric symptoms – including delusions, hallucinations, restlessness, anxiety, euphoria, disinhibition, unusual motor behaviour, sleep disturbances and appetite alterations – are the best predictors of carer burden (Allegri et al, 2006b).

There are no population-based epidemiological studies of dementia in Argentina. Cañuelas, a rural city 60 km from Buenos Aires, is one of the centres for the 10/66 population-based study, with recruitment of 2000 persons aged 65 and over due to be completed in 2006. One previous survey in Cañuelas showed a prevalence of cognitive impairment of 23% in people 65 and older (Arizaga et al, 2005).

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Dementia care in India: a progress report

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According to the 2001 census, India is home to more than 76 million people aged 60 years and over. This age-group, currently only 7.4% of the population, is expected to grow dramatically in the coming few decades. Analysis of the census data shows substantial variation in the rate of demographic ageing across India: at present, 10.5% of Kerala's population is older than 60 years, while in Dadra and Nagarhaveli this proportion is only 4%. Regions with more favourable health indicators seem to be ageing faster and the demand for specialist services will soon be evident in such places. There is a growing realisation that the care of older people with disabilities makes enormous demands on their carers. Terms such as 'dementia' and 'Alzheimer's disease' are now better understood. This was not the case when the Alzheimer's and Related Disorders Society of India (ARDSI) initiated awareness programmes. However, dementia remains a largely hidden problem in those disadvantaged parts of India where poverty and illiteracy remain prevalent.

Magnitude of the problem

Prevalence studies have indicated a lower prevalence of dementia in India than in high-income countries. The reported rates vary widely, from 1.4% to 4.4% (Shaji *et al.*, 1996, 2005; Rajkumar & Kumar, 1996; Rajkumar *et al.*, 1997; Chandra *et al.*, 1998; Vas *et al.*, 2001). It is estimated that there are already about 1.5 million people with dementia in India (compared with 2.9 million in the USA), but this number is likely to increase threefold over the next four decades (Ferri *et al.*, 2005). This estimate is based on the premise that the Indian incidence rates are relatively low and will remain stable over time.

The relatively high prevalence of smoking and the high and rising prevalence of type 2 diabetes are matters of concern in India. These, coupled with anticipated lifestyle changes, could affect the incidence rates and lead to a higher than expected prevalence in the near future. The prevalence of vascular dementia and the importance of vascular risk factors for dementia need to be addressed in future research.

Care of older people

Public awareness of the mental health problems of old age remains low. People do not differentiate between normal ageing and phenomena that are secondary to

conditions such as dementia (Patel & Prince, 2001). Dementia is not usually identified as a health condition. Even when it is identified, it does not lead to carers receiving practical advice or longer-term support (Shaji *et al.*, 2003).

Most people with dementia are cared for at home, by their families. Most families cannot afford institutional care, which is, in any case, unavailable in most parts of the country. It is still generally considered culturally unacceptable. Most carers are women (10/66 Dementia Research Group, 2004) and caring is associated with economic and psychological strain. Caring can also have an adverse impact on the mental health of the carer (Shaji *et al.*, 2003; 10/66 Dementia Research Group, 2004; Dias *et al.*, 2004). The relative absence of pensions means that older people are financially dependent on their children. Although schemes intended to provide financial assistance for widows and the elderly poor are available in most states, they tend not to be accessed. People with dementia are also eligible for a disability pension under the Disabilities Act, but again there seems to have been very little take-up (10/66 Dementia Research Group, 2004).

In India there is a large network of government-run primary health centres and hospitals. These work side by side with extensive private healthcare and not-for-profit providers. Staff shortages and poor infrastructure are common in the government system. Although the services are free, many people choose to seek care under the costly private system (10/66 Dementia Research Group, 2004; Dias *et al.*, 2004). Unfortunately, it is difficult to influence practice, introduce reforms or provide training in the private healthcare sector, given its fragmentary nature. Most private doctors work independently and in relative isolation.

Primary care doctors do not encounter many people with dementia in their practice (Patel & Prince, 2001). However, people with dementia are increasingly seen at general hospitals, especially those in urban areas. A diagnosis of dementia is often made by physicians, neurologists or psychiatrists. Follow-up care is difficult in the absence of outreach services. Following the announcement, in 1999, of the National Policy for Older People, the government has taken some initiatives in this area. Project NICE (National Initiative on Care for the Elderly) aims to enhance the delivery of care to older people in the community. Two training courses have been established: one a 6-month certificate course in geriatric care and the other

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a 1-year postgraduate diploma course in integrated geriatric care.

Dementia research

The networking of Indian dementia researchers began in 1998 at Cochin, with the formation of the 10/66 Dementia Research Group. Seven groups of researchers from six centres in India took part in two pilot studies (Prince *et al*, 2003; 10/66 Dementia Research Group, 2004). The Indian network developed a community-based intervention programme that takes into consideration the realities of resource-limited settings. A case-finding method was developed that facilitated identification of older people with dementia in the community by health workers after brief training (Shaji *et al*, 2002). In principle, these health workers could be given more training to provide simple home-based interventions.

The intervention includes provision of information and education about dementia, sustained carer support, and guidance in managing symptoms of dementia. The Goa chapter of the ARDSI recently carried out an innovative intervention trial using a similar strategy (see <http://www.dementiagoa.org/research.htm>). It recruited local people with no prior experience of dementia care and trained them using locally available resources. This was supported and supervised by local psychiatrists and counsellors. There was provision for both pharmacological and psychosocial interventions. The goal was to meet the health needs of the carer and the person with dementia. Early results from this trial seem promising. More interventions are needed that emphasise the use of locally available human resources that are feasible, acceptable and lead to significant improvements in carer mental health, and that are capable of reducing the burden on carers.

Service structures and developments

The ARDSI, founded in 1993, continues to facilitate service development. Its 14 chapters across India function as a link between families and service providers. Although coverage is minimal, facilities for day care, as well as long-term care facilities, are now available in India. Many more centres offer out-patient services for dementia assessment and care. These are usually designated as 'memory clinics' or more specifically as 'dementia clinics'. These services have become popular and are already much sought after by families in regions where they are operating. Apart from providing valuable local services, these clinics can provide excellent opportunities for training undergraduate and postgraduate medical students.

Geriatrics and geriatric psychiatry are slowly emerging as recognised specialties in India. The government has decided to start geriatric medicine units in all medical colleges in the country, which is a prerequisite for the training of future cadres of general practitioners

in the assessment and long-term care of their older patients. Recently, a separate geriatric psychiatry unit was established by the government in the Medical College at Lucknow. All of this indicates the willingness of administrators and policy makers to develop new services for older people. It is important to establish and strengthen centres capable of imparting training in dementia care. These centres can also provide leadership in research and service development.

Dissemination of research findings and the encouragement of research have been identified as important tasks by the Geriatric Psychiatry Specialty section of the Indian Psychiatric Society (Shaji *et al*, 2004). The Indian Association of Geriatric Mental Health, a newly formed multidisciplinary organisation, shares a similar vision, and is now affiliated to the International Psychogeriatric Association. The efforts of these two organisations, coupled with the advocacy of the ARDSI, can be expected to gather more support in the next few years. This seems likely to create a climate that favours the funding and development of community-based services that better meet the needs of older people with dementia and their families. Researchers have a key role in informing and guiding evidence-based service development in India.

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Many more centres offer out-patient services for dementia assessment and care. These are usually designated as 'memory clinics' or more specifically as 'dementia clinics'. These services have become popular and are already much sought after by families in regions where they are operating.

Mental health services in Iraq: past, present and future

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Iraq is known to be the cradle of civilisation – a country with a rich history. Present-day Iraq occupies the greater part of the ancient land of Mesopotamia, the plain between the Euphrates and Tigris rivers. Some of the world's greatest ancient civilisations arose in this area, and Iraq possesses a huge number of historical monuments and archaeological sites.

Modern Iraq has a geographical area of just under 440 000 km² and a population of just over 27 million. The main languages spoken in the country are Arabic, Kurdish and Turkman. The two main religions are Islam and Christianity. The country is in the lower middle-income group (according to World Bank criteria).

The proportion of the population under the age of 15 years is 41% and the proportion of those over 60 years is 5%. Life expectancy at birth is 59.1 years for males and 63.1 years for females. Healthy life expectancy at birth is 49 years for males and 52 years for females. The literacy rate for men is 54.9% and for women is 23.3%.

The healthcare system in Iraq is centralised and provided free of charge at the point of delivery. The Minister of Health is supported by three deputies and a number of directors and advisors, each having responsibility for a directorate. There is a plan for the new Iraq to look at devolution, with the governorates having some form of independence, as well as looking at private–public partnerships. Social services are provided by the Ministry of Labour and Social Affairs, and there is a close working relationship between the two ministries to provide social care alongside healthcare.

History of mental health services

Pioneers like Al-Razi (865–925) and Ibn-Sina (Avicenna, 980–1037) established the first mental hospitals and applied humane treatments. Indeed, the first mental hospital in the world was built in Baghdad in 705. The region then entered the dark ages and it was not until the middle of the 20th century that modern psychiatric services appeared in Iraq. In the early 1950s, Dr Jack About and Dr Ali Kamal led in establishing Al-Rashid and Al-Rashad mental hospitals (the former was later replaced by Ibn Rushid State Hospital). The 1960s and 1970s saw the development of mental health

centres and units in general hospitals, school mental health programmes and public awareness campaigns. Strategic short-term and long-term plans were established. However, from the mid-1980s onwards mental health services experienced a significant deterioration, with an exodus of psychiatrists, due to a poor (even intimidating) working environment, shortages of medication, lack of information systems and a lack of educational opportunities. This situation was compounded by three disastrous wars, 12 years of sanctions and the recent fall of the regime, followed by the continuing violence. In addition, there was widespread looting of medical facilities.

In the past, mental health planning was run within the Primary Care Directorate of the Ministry of Health by a physician, who was supported by an advisory committee of four psychiatrists, although they had very little influence. The group ran limited activities of public education, refresher courses for general practitioners and lectures for school teachers in an attempt to increase public awareness.

Recent developments: governance and accountability

In July 2003 the East Mediterranean Regional Office (EMRO) of the World Health Organization (WHO) held a meeting in Cairo as one of the WHO initiatives to support mental health in Iraq (see WHO, 2003). The new Iraqi government was appointed in September 2003. The Minister for Health declared that mental health was a priority, and appointed a National Advisor, who, with the support of colleagues, formed the National Mental Health Council (the first in the history of Iraq). The Council included

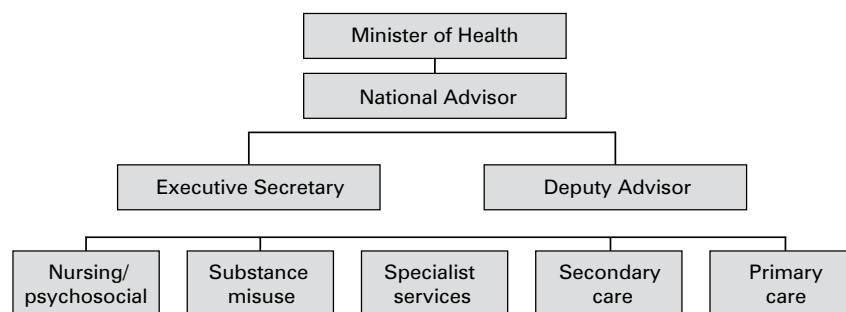


Fig. 1 The approved structure for the National Advisor's office.

The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributors. Please contact Shekhar Saxena (email saxenas@who.int).

The National Council engineered the return to work of psychiatrists, psychologists and social workers who had been unemployed or dismissed for political reasons, and those who had left their jobs in the past because of poor pay and working conditions.

representation from all relevant ministries and non-governmental organisations (NGOs) and there are plans to include service users. The Council had its inaugural meeting in March 2004. In June 2005 the Minister approved the structure for the National Advisor's office shown in Fig. 1.

The National Advisor, with members of the National Council, has conducted field visits to oversee developments in mental health across Iraq as well as to lend support to colleagues.

National Strategy for Mental Health and Mental Health Act

The first priority the National Council set for itself was to draw up the National Strategy for Mental Health (a copy is available on request). Previous attempts by colleagues to do so over the past 20 years were blocked by the previous regime. Those attempts were revived and the National Council held a workshop to discuss and finalise the Strategy on 21 and 22 June 2004. The Mental Health Act was approved by the Cabinet in October 2004. A draft Code of Practice is out for consultation and is awaiting final approval.

Facilities

Iraq has two mental hospitals, both in Baghdad: Al-Rashad, with 1200 beds, and Ibn Rushid, with 70 beds. There are also four units in general hospitals in Baghdad and eight more units in other governorates. All facilities have limited resources. Multidisciplinary working is not practised.

The National Council has established ten outreach clinics and psychosocial support centres in Baghdad.

Workforce

In December 2005 the National Mental Health Council, in partnership with the WHO, completed the Assessment Instrument for Mental Health Systems (WHO, 2005). This showed that there were 1.6 professionals in mental health facilities, including private practice, per 100 000 population. Table 1 breaks this down further according to profession.

The National Council engineered the return to work of psychiatrists, psychologists and social workers who had been unemployed or dismissed for political reasons, and those who had left their jobs in the past because of poor pay and working conditions.

The National Council, with the support of the Japan International Cooperation Agency and the

WHO, ran training programmes for Iraqi nurses, held in Egypt (two 6-week courses in September and November 2004 for 40 senior nurses). Another 2-month course started in Bahrain in April 2006.

Academic activities

The National Council has organised a number of multidisciplinary educational activities for mental health workers. Dr Sadik has been appointed Visiting Professor in Psychiatry at Baghdad University and has become a member of the Iraqi Scientific Council for Postgraduate Studies and the Arab Board in Psychiatry.

Research and publications

Fifteen pilot studies have now been completed and a full research programme was expected to be concluded in April 2006, when reports on individual projects were to be submitted for publication.

A special issue on Iraq of the *Muslim Mental Health Journal* was planned for October 2006.

Drug misuse

A National Council for Drug Misuse was re-established in 2004 but in February 2006 it joined the National Council for Mental Health to become the National Council for Mental Health and Substance Misuse. It is chaired by the Minister of Health and has representatives from the Ministry of the Interior, the Ministry of Social Welfare and other committees within the Ministry of Health.

A programme to address drug misuse has been agreed in collaboration with the regional WHO team (a copy is available on request) and a drug control law has been submitted to the Cabinet for approval.

Iraq is now a member of the United Nations Office on Drugs and Crime.

Child mental health

The National Council supported the formation of a multidisciplinary Child Mental Health Association. Registered with the Arab Psychiatric Association (APA) and the World Child Mental Health Association, the Iraqi Child Mental Health Association has been asked to lead on educational activities as well as to draw up a strategy for child mental health.

Non-governmental organisations

The National Council has supported various activities headed by NGOs, including:

- the Heartland Alliance's Integrated Torture Treatment project
- a psychosocial support project for children in Baghdad, run by MOVIMONDO of Italy
- a psychosocial support project for children and families in Babylon, run by the organisation 'Together' from Slovenia – this has now been extended to Baghdad

Table 1 Total numbers of workers in mental health facilities

Discipline	Percentage of workforce	Number
Psychiatrists	33	91
Other medical doctors (i.e. non-psychiatrists)	2	7
Nurses	53	145
Psychologists	5	16
Social workers	9	25
Other mental health workers	47	128

- a psychotherapy service with a focus on children, provided by Diaconia, a Swedish organisation that operates offices in Dahouk, Erbil and Suleymania (the Heartland Alliance has collaborated with staff from Diaconia to deliver Heartland Alliance training in Dahouk)
- the rehabilitation of Ibn Rushid Hospital, supported by the Japanese government
- the rehabilitation of Al-Rashad Hospital, funded by the Red Cross.

World Health Organization

The EMRO of the WHO has supported the planning and training activities of the National Council. This included finalising the National Strategy. More recently, the National Mental Health Council in partnership with the WHO completed the Assessment Instrument for Mental Health Systems mentioned above. Further work has now started on a national screening programme for mental health.

In collaboration with the WHO, the following activities have been approved for funding, to start in the near future:

- a needs assessment workshop (as part of a national mental health survey, which was due to start in June 2006)
- rebuilding of mental health facilities (work on 12 units has already been completed)
- building of new mental health units in general hospitals (six in total: two have been completed, work has begun on two and work is yet to start on the remaining two; in addition, approval for another six units has recently been given)
- a national epidemiological survey with the Composite International Diagnostic Interview (CIDI) (this has just started).

Partnerships

The National Council has established a working partnership with the US Substance Abuse and Mental Health Services Administration (SAMHSA), through regular teleconferencing as well as participation in stakeholder events. A planning group formed of international experts connecting with SAMHSA's support has been invaluable in securing training curricula and opportunities, service development and planning and drawing in international expertise.

With the support of the SAMHSA, the WHO, the UK Department of Health and the World Bank, the First Action Planning Iraq Mental Health Conference was held in Amman, Jordan, in March 2005 (a copy

of the proceedings is available on request). A second conference was held in March 2006 in Cairo, Egypt.

The WHO has been instrumental in supporting all of the above activities and developments.

The Royal College of Psychiatrists has supported:

- the Iraqi Mental Health Forum (IMHF) in the UK
- representation of Iraqi mental health professionals at its annual and regional meetings
- the formation of a subcommittee of the Board of International Affairs to address and support Iraqi mental health services and training needs.

The UK Department of Health has provided financial support to address service development and training needs.

In a recent meeting of Iraqi psychiatrists a committee was elected to prepare for and oversee fair and free elections for the Iraqi Psychiatric Association. Close liaison continues with:

- the American Psychiatric Association
- the International Institute for Mental Health
- the Kent and Medway NHS and Social Care Partnership Trust
- the United Nations Office on Drugs and Crime.

Challenges

The potential to achieve a high standard of comprehensive community-based mental health services in Iraq is a reality. However, the ongoing violence and poor security, coupled with bureaucracy and political instability, have hindered progress. Progress has been very slow on developing an efficient and effective information system, in establishing performance management and in applying healthcare standards. The distribution of medicines and equipment, the movement of staff and the organising of training events remain high-risk activities. Recent improvements in the pay and conditions for staff working in higher education have led many health service professionals to switch to teaching. Furthermore, physical threats to doctors have forced many to leave the country.

In spite of these difficulties, the achievements of the National Council for Mental Health and Substance Abuse in such a short period and its continuing activities have been a landmark in Iraq's recent health services history.

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European Commission Green Paper – an update

The European Commission is establishing a strategy on mental health. The Commission's Green Paper 'Improving Mental Health of the Population' invited comments from European institutions, governments, health professionals, stakeholders and the research community about the relevance of mental health for the EU, the need for an EU strategy and its possible priorities. On 8 June 2006 a public hearing was held in the European Parliament. The presentations and the report from John Bowis MEP, Rapporteur for the European Parliament, are available at http://www.johnbowis.com/health_mentalhealth.htm. — John Henderson.

Psychiatry in the Sultanate of Oman

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Many people with psychiatric illness are still unlikely to seek psychiatric help until they have reached an advanced stage of irreversible pathology or until 'treatment shopping' from complementary and alternative medicine has failed to provide any benefit.

The Sultanate of Oman is located in the south-east of the Arabian Peninsula. It has a distinctive history and subcultures. Its seafaring tradition has endowed the country with various ethnic and linguistic groups, with Arabic being a dominant language and Ibadhi being the dominant sect of Islam (Al-Nami, 1971). Oman in the 1970s saw rapid development, triggered by the discovery of oil, which took place under enlightened new political leadership.

Attitudes to mental illness

As in many traditional communities, modern psychiatric services have yet to play a dominant role in the care of people with psychiatric disorders. Mental illness was largely the preserve of traditional healers, and many people with psychiatric illness are still unlikely to seek psychiatric help until they have reached an advanced stage of irreversible pathology or until 'treatment shopping' from complementary and alternative medicine has failed to provide any benefit (Al-Adawi *et al*, 2002a).

More positively, however, because an altered mental state is attributed to *jinn* (and religious teaching affirms the existence of such agents), there is little evidence of pervasive stigma towards people with mental illness in traditional Omani society (Al-Adawi *et al*, 2002a).

Common psychiatric illness

Although no formal epidemiological study of psychiatric illness has yet been conducted, anecdotal and impressionistic reports suggest that many types of mental disorders encountered in other countries are common in Oman, although with culturally determined differences in the types of reaction and the incidence (Al-Adawi *et al*, 1997, 2001, 2002b; Chand *et al*, 2000).

The Omani population is undergoing a 'demographic transition', with declining death rates complemented by high birth rates. This is likely to be accompanied by an increase in the number of people with psychiatric disorders. There is also an indication that the country is bracing itself for the social and economic consequences of a more youthful population, with far more job-seekers than the labour market can absorb. The traditional passage to adulthood is also changing, as youngsters are expected to marry

late and to have children when they are well into their 20s. However, the 'adolescent turmoil' seen in Western societies is not evident in Omani society, which emphasises family obedience.

Some maladjustment indicators of youth are becoming increasingly common. Firstly, the incidence of deliberate self-harm increased from 1.9 cases per 100 000 in 1993 to 12.8 per 100 000 by 1998 among female adolescents (Zaidan *et al*, 2002). Secondly, there has been an increase in the numbers of addicts seeking rehabilitation, drug overdoses and drug-related deaths; there has also been a rise in drug shipments confiscated by law enforcement officers (Al-Harhi & Al-Adawi, 2002). The popular mind-altering substance in Oman appears to be cannabis, although the extent of its use is hard to quantify. Finally, there is evidence that the traditional admiration of a plumpish figure is eroding, and that eating disorders are becoming increasingly common in young Omanis (Al-Adawi *et al*, 1999).

Psychiatric services

Psychiatry in Oman is generally based on the Anglo-American model. The first steps towards instituting a system in Oman of biomedical care for psychiatric patients were taken in the mid-1970s in a missionary hospital, Al-Rahma Hospital, located in the capital, Muscat, in the northern part of the country. An Indian psychiatrist dispensed out-patient services, which later developed into the provision of custodial care for people with acutely disturbed behaviour. Parallel services evolved in the late 1970s in the southern part of the country.

The first specialised psychiatric hospital, Ibn Sina, was opened in 1983. It started with two wards, one for male and the other for female patients; custodial care was provided for severely disturbed patients and there were also out-patient services. The one hospital catered for the needs of the whole population (then nearly 1.5 million). In the early 1990s, a psychiatric teaching service was initiated within the teaching hospital of Sultan Qaboos University.

There is a universal free mental health service for Omani nationals. Although the majority of patients with a psychiatric illness are likely to 'somatise', individuals whose lives are compromised by psychological disorders are entitled to disability benefits, which are dispensed by the Ministry of Social Affairs.

The World Health Organization (2005) rated the healthcare system of Oman the most efficient in the world. Despite this, as elsewhere, mental health services have been inadequately addressed. There are fewer than 15 registered mental health professionals for a population of nearly 3 million people scattered over 300 000 km². Most services are dispensed within general tertiary hospitals, but there are two specialised centres, both in the capital city. Most psychiatrists have been recruited from abroad, although some have been naturalised. Apart from the teaching hospital, the multidisciplinary infrastructures often essential for psychiatric services have remained rudimentary, owing to a lack of suitable staff. There are substandard facilities for occupational therapy and psychiatric rehabilitation remains basic.

The first point of contact for those who seek biomedical care is meant to be the primary care clinics, from where most common psychotropic medications are readily available. However, because of a lack of awareness and of suitable health education, as well as the lack of a close, informed and consistent relationship with professional care providers, there is a tendency for people to seek primary care at tertiary centres. A study has suggested that the majority of these patients present with 'unidentified medical illness' (Al Lawati *et al*, 2000).

To help non-specialist physicians in primary care clinics to recognise mental disorders, the Ministry of Health, the main provider of healthcare in Oman, has instituted regular training for primary health workers in the recognition of psychiatric disorders, and accompanying manuals are available to help in this endeavour.

Child psychiatry

Even though Oman's postnatal coverage is the highest among Arab nations (Sulaiman *et al*, 2001), with the 'baby boom' and a relatively high prevalence of consanguinity the country is also experiencing an upsurge in many childhood disorders (Kenue *et al*, 1995). Disorders characterised by marked regression in a variety of cognitive, motor and social skills after apparently normal development are also on the rise, with all the consequences for the parents and society of having to care for children with pervasive developmental disorders (Al-Sharbati *et al*, 2003).

The Ministry of Education coordinates special education and rehabilitation programmes for children with communication disorders, physical disabilities and learning disorders (Ministry of Education, 2002). The government is training school health workers to identify and intervene on behalf of vulnerable children, and some teachers are taking an active part in this campaign. As diverse organisations and professionals provide care for children, there is a need both to standardise taxonomy and to enhance cross-disciplinary communication. To this end, specialised centres for the behavioural and emotional problems of children will be essential.

Policy and legislation

Mental health policies and legislation have been forthcoming in recent years, with a decree to promulgate a substance misuse policy and a law on the control of narcotics and psychotropic medication. Furthermore, a national mental health programme has been established (World Health Organization, 2005).

Education

Undergraduate education

The duration of general medical training in students at Sultan Qaboos University is 7 years (4 years pre-clinical, 3 years clinical). Graduates then spend 1 year on internship, rotating between three out of four specialties (internal medicine, general surgery, child health, obstetrics and gynaecology).

Behavioural science, which encompasses diverse disciplines, including sociology, anthropology and psychology, is taught in the second and third years of the pre-clinical course, in order for Omani trainees to appreciate the social and cultural aspects of illness and well-being. In their sixth year, clinical students spend 8 weeks on a clinical clerkship in psychiatry, which is their first exposure to psychiatry. The 8-week programme includes supplementary lectures on various aspects of clinical psychiatry and allied fields, patient case presentation, case histories and clinical interview.

Postgraduate education

The psychiatry residency programme was introduced in 1999 under the auspices of the Oman Medical Board, which oversees postgraduate training. The average duration of the training is 4 years, during which the trainee will complete different modules each year before taking the membership examination relevant to his or her specialty.

The psychiatry residency programme did not attract applicants until recently. Five Omani doctors have now completed their residency training in psychiatry (two of whom completed their training in the UK and obtained the MRCPsych). In 2004 two new graduates started their psychiatry residency, followed by three more in 2005. Two more have enrolled in an institution of higher education in the UK, to pursue academic programmes in substance misuse and child and adolescent psychiatry.

Challenges to psychiatry

Traditional value systems in Oman are collectivist in orientation. In communal society, from birth children are brought up in an environment that ushers them into the collective mind-set; the development of self-hood is generally discouraged, as is expression of emotions. Depending on the level of education, difficulties are attributed to *jinn* and distress is communicated in psychosomatic rather than psychological ways (Al-Adawi *et al*, 2002a). The fact that traditional Omanis

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With modernisation, the social status of Omani individuals has undergone some notable changes. These have been brought about by unprecedented prosperity, expansion of educational opportunities and, most importantly from the point of view of psychiatry, an increased preference for an individualistic rather than the traditional collectivistic mind-set and social behaviour.

attribute ill-health to external agents has two particular implications for psychiatry. When a social impropriety occurs, an individual is likely to attribute his or her difficulty to external forces like *jinn*, the 'evil eye' or witchcraft. It is not surprising, therefore, that many psychiatric problems are first brought to the attention of traditional healers. The second implication is that distress in Oman is not perceived in psychiatric parlance, as intra-psychic conflict. A psychiatric attempt to heal the 'self' is always going to be difficult in a society where development of the self is not lauded.

A survey of Oman's trainees' interest in psychiatry (Al-Adawi et al, 2006) has suggested that the attitudes towards psychiatry and psychiatric services appear to be positive. However, there is little interest in psychiatry as a career. Within the context of increasing mental health problems, this is likely to represent a challenge for the country. At the moment, overseas psychiatrists are filling the gap. However, expatriate health personnel may not be well versed in local traditions and languages.

Unless the profession institutes mechanisms to decode local idioms of distress rather than adhering to biomedical models of mental illness (Littlewood & Lipsedge, 1997), psychiatry is likely to be perceived as medicine for 'crazy people'.

Despite these caveats, within the last two decades, rapid acculturation has occurred in Oman. With modernisation, the social status of Omani individuals has undergone some notable changes. These have been brought about by unprecedented prosperity, expansion of educational opportunities and, most importantly from the point of view of psychiatry, an increased preference for an individualistic rather than the traditional collectivistic mind-set and social behaviour. With these expected changes, psychiatry will have fertile ground on which to flourish.

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COUNTRY PROFILE

Psychiatry in Qatar

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The State of Qatar is a peninsula overlooking the Arabian Gulf, with an area of 11 400 km². The Al Thani family has ruled the country since the mid-1800s. The population of just over 860 000 is of a multi-ethnic nature, and predominantly resides in the capital, Doha. Only about 20% of the population is Qatari. Around 73% of the population are between the ages of 15 and 64 years. Life expectancy at birth is 74.8 years for

males and 73.8 years for females. The literacy rate is 94.9% for men and 82.3% for women. Arabic is the official language and English is a common second language. The economy is dominated by oil and natural gas, and the country has one of the highest per capita incomes in the world. The per capita government expenditure on health is \$574 (international dollars), which is among the highest in the region.

Historical background

In the Arab world, and Qatar is no exception, the belief in possession by a spirit (*jinn*), the evil eye and sorcery or witchcraft as the cause of mental disorders was quite strong. The notion continued from pre-Islamic into Islamic periods. These beliefs, and a lack of proper psychiatric care, constituted fertile ground for native and traditional healers (*Motawwa*) to dominate the scene and become the sole source of care for those who were suffering from emotional and behavioural problems.

The first general hospital (Doha Hospital) in Qatar was built in 1948 and it accepted psychiatric patients. In 1956, another general hospital (Rumailah) was built and there general practitioners looked after psychiatric patients. Before their management in Doha Hospital, people with a psychosis used to be restrained at home or in prison, according to their family's status and resources. Some of them were sent abroad for treatment, especially to Egypt or Lebanon.

Modern psychiatric services were established in 1971, shortly after the country's independence. They were based at Rumailah Hospital. In 1994 the department moved to its current position, at the old Women's Hospital, which is a separate building away from the general hospital that has been specially adapted for the purpose.

Service provision

The psychiatry department is the main provider of mental health services for the entire population of Qatar. It works with three other psychiatric services, those of the school health system, the armed forces and the police force. The service provides in-patient, out-patient and community care. The emphasis is on general adult psychiatry. However, subspecialties are gradually expanding.

Liaison services are covered on an on-call basis. The psychiatry department is located at a distance from the general hospital, which hinders the development of separate liaison psychiatric services.

Drug dependency is dealt with by the general psychiatric service. There is a plan to establish a purpose-built drug dependency unit for detoxification and rehabilitation. Alcohol dependency is the commonest substance misuse problem and its prevalence is rising.

Child and adolescent psychiatry is provided by the school health system, which has its own child psychiatrists. The psychiatry department functions as a tertiary service, receiving referrals of more difficult cases.

Forensic psychiatry is another independent area, provided by psychiatrists at the medical division of the Ministry of Interior, who work in close collaboration with the department's forensic psychiatrist. Referrals to the department are often for admission, or for the provision of medical reports at the request

of the courts, the Attorney-General or the police. The service also provides expert witnesses for relevant authorities. The lack of a medium-secure unit is hampering the delivery of high-quality care for this cohort of patients.

In addition, there are satellite clinics located at other hospitals, namely psychosomatic, dermatology, psycho-oncology and psychogeriatrics.

A recently opened hospital in the north of Qatar has one consultant psychiatrist and a specialist providing the care required.

There is a specialised centre for children and adolescents with learning difficulties and autism. Adults with the same conditions come under general psychiatry.

There is a small private sector, with just four clinics, either stand-alone or within a private hospital setting.

Community psychiatry

Day care psychiatric services were initiated in 1998, as part of occupational therapy services. Before that, a single nurse was responsible for conducting all home visits and crisis intervention, at an informal level. Community care as a separate entity started in 2001. It includes day care, home visits and crisis intervention. The service has proved invaluable to patients and relatives. The focus is on rehabilitation. Crisis intervention has been introduced more recently, delivered through a multidisciplinary team. Crisis intervention work is currently limited to office hours, although there is an intention to make it a 24-hour service. Several obstacles prevent this service achieving its full potential, stigma being one of the main barriers.

Resources

The Hamad Medical Corporation, the primary healthcare provider, employs five consultant psychiatrists. This amounts to one consultant psychiatrist per 170 000 population. The total number of non-consultant medical staff is 21. The services are based on a multidisciplinary approach; there are seven psychologists (one based at the oncology hospital), two mental health occupational therapists and three occupational therapy technicians. There is a significant shortage of staff in the social services, with only two social workers for the entire service.

The in-patient bed capacity is currently 56 in total, with separate wards for male and female patients. This is set to increase by 20. The number of out-patient visits per day fluctuates between 70 and 120.

Training and education

The residency training programme has been focused on the Arab Board examination. It is a 4-year

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The extended family influence minimises the need for compulsory admission and treatment. It is of great interest to note that even those who are mentally ill respect family authority to a large extent.

programme, aimed at achieving parts I and II of the Arab Board examination in psychiatry. It started in Qatar in 1994.

Until 2004, there was no medical school in the country. Students were sent abroad on government scholarships, or at their own expense, to study medicine. Weill Cornell Medical College, based at New York, opened its Qatar branch, and the medical programme started in the autumn of 2004. Hamad Medical Corporation became affiliated with the College, and there were subsequent changes in both the undergraduate and the postgraduate training programmes. Although the specialist qualification remains that of the Arab Board, the programme needs to reflect the requirements for the examination and adhere to the College's postgraduate training requirements. This has been rather a challenge. The department will start having a regular influx of medical students on clinical and pre-clinical attachments.

As part of the training programme, regular bedside teaching, weekly case presentations and journal clubs are held, in addition to symposia, often in collaboration with other medical specialties.

Mental health legislation

The National Mental Health Programme was introduced in 1990. It focuses on raising awareness of mental illness at the levels of legislation, counselling programmes, family involvement and primary health-care. The Mental Health Policy and Substance Misuse Policy were both formulated in the 1980s.

However, there is no Mental Health Act as yet. The extended family influence minimises the need for compulsory admission and treatment. It is of great interest to note that even those who are mentally ill respect family authority to a large extent. This system relies on psychiatrists to do their best in working with families in order to admit those who need to stay against their will. There have been serious discussions over the past 2 years to have a Mental Health Act that will be applicable to the six Gulf Cooperation Council countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates).

At present some mentally ill offenders can be kept in the psychiatric in-patient unit for 2–6 weeks, based on a written order from the Attorney-General. Patients with drug dependency problems can also be admitted for treatment by court order.

Research

The psychiatry department at Rumailah Hospital gives special consideration to research. Epidemiological studies that produce prevalence data are the greatest priority and this is the current focus of research.

Prospects

Qatar is rapidly growing in terms of its economy, population and infrastructure. There is already a shortage of psychiatric hospital beds and this is expected to rise acutely in the near future. A plan to build a new hospital to reflect this rapid growth is in progress. Attempts are also being made to incorporate psychiatric wards within general hospitals. Fortunately, there has been increasing focus on psychiatry from the Corporation's management. This has resulted in the expansion of the existing structure, as a short-term measure to regulate the services and prevent a bed crisis. Community care has been a focus for improvement, with an ongoing plan to expand services and to build larger facilities to accommodate the growing demand. There is also a plan for a new drug dependency unit.

The Corporation as a whole is working towards accreditation with the Joint Commission on Accreditation of Healthcare Organizations. The process has proved very costly and time and energy consuming, but should ultimately result in medical practice being at an internationally accredited standard.

Web sources

Further information on Qatar is available at two websites of the World Health Organization:
<http://www.emro.who.int/MNH/WHD/CountryProfile-QAT.htm>
http://www.who.int/mental_health/evidence/atlas/index.htm

African psychiatry

During recent years, the World Psychiatric Association (WPA) and College members have done much to facilitate the organisational representation and structures of African psychiatry. The WPA Congress in Cairo in September 2005 with its 6000 attendees was the first to be held on the African continent. The Association of African Psychiatrists and Allied Professions (AAPAP) has been holding annual conferences in different countries for the past 4 years. This year it was held in Addis Ababa and next year it will be hosting the WPA Regional Conference in Nairobi, Kenya, 21–23 March 2007 (contact fnjenga@africaonline.co.ke) and it is hoped that there will be many participants from the College and its African International Division.

Hosting conferences plays an important part in facilitating the development of effective networks and there is now early discussion of how networks can be more active in leaning on governments to develop effective mental health policies.

The College has its own African International Division for College members residing in Africa. The Division intends to work closely with the AAPAP, and Division members have contributed actively to two important recent books on African psychiatry: *Essentials of Clinical Psychiatry for Sub-Saharan Africa*, edited by Dr Frank Njenga *et al*; and *The African Textbook of Clinical Psychiatry and Mental Health*, edited by Professor David Ndetei *et al*.

Australia's national mental health strategy in historical perspective: beyond the frontier

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The history of Australian psychiatry is entwined with the impact of European (British) invasion and settlement, initially in 1788, to form penal colonies to alleviate the overcrowding of English jails, which generated a masculine-dominated, individualistic culture. As European settlement in Australia expanded, the colonisers tried to come to terms with this remote, vast landscape and fought over land and resources with the original Aboriginal inhabitants, who had been there between 40 000 and 60 000 years. Australian psychiatry was profiled in a previous article in *International Psychiatry* (issue 10, October 2005).

Deinstitutionalisation

Australia's first large institution opened in 1838, with many more emerging over the next 100 years.

The development of psychiatric in-patient units at local general hospitals initially did not shift the concentration of work with in-patients with severe mental illness from the psychiatric hospitals, as the units were initially highly selective and would not take involuntary patients.

Australia also developed a substantial private medical sector, funded publicly through the Health Insurance Commission as well as through private health insurance schemes, although the sector has increasingly dealt with less severe disorders.

Meanwhile, from the early 1970s, some community health teams were put in place nationally, but they were often idealistically focused on primary prevention, and offered mainly generic services within office hours only.

Recent national developments

The National Mental Health Policy (1992) was endorsed by all Australian health ministers. It provided transitional funding in the national budget through the accompanying National Mental Health Strategy to shift services from institutions to local communities (see Fig. 1). This strategy has enjoyed bipartisan political support, although the federal funding has been reduced in recent years. There have been three distinct phases of the National Mental Health Strategy (Department of Health and Aging, 2005).

First National Mental Health Plan (1993–98)

In the First National Mental Health Plan, services were to be shifted from stand-alone psychiatric hospitals to

become largely community-based, 'mainstreamed' services, that is, integrated with and accessible via general health services, although remaining distinct as specialised mental health services. These included seven day and night per week mobile community-based mental health crisis intervention services, assertive community treatment teams, a range of supervised community residential facilities, community vocational rehabilitation services and social recovery services, integrated with local psychiatric in-patient units based in general hospitals. They were to develop strong links with groups of consumers, families, general practitioners, the non-government service organisations, and other non-health services, such as housing, disability services, social security and employment. Initiatives included:

- promoting consumer and carer participation in policy and planning at every level, including direct ministerial access
- a Mental Health Category Classification and Costing Study (MHCASC) of whole episodes of psychiatric care, as an alternative or adjunct to hospital-based case mix (Buckingham *et al.*, 1998)
- a community awareness mass media campaign and studies of community and staff attitudes to people with mental illness (Rosen *et al.*, 2000)

Meanwhile, from the early 1970s, some community health teams were put in place nationally, but they were often idealistically focused on primary prevention, and offered mainly generic services within office hours only.

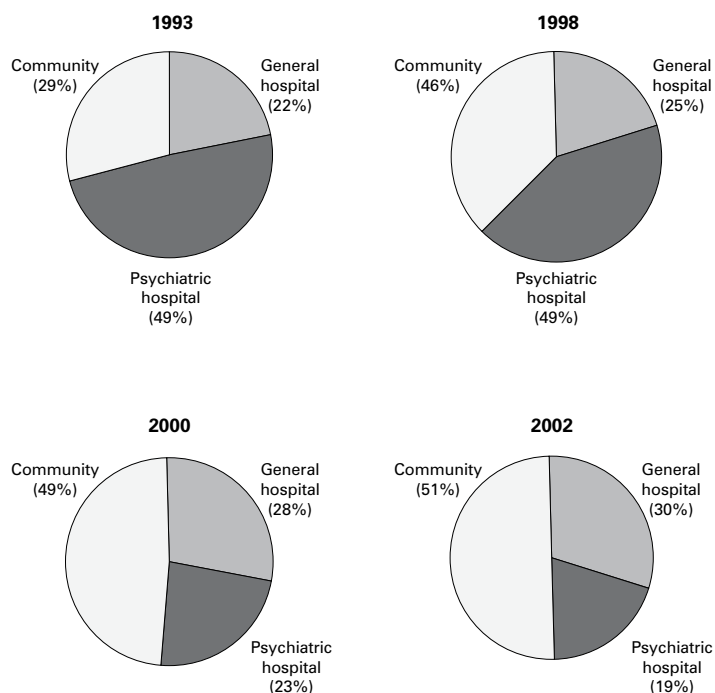


Fig. 1 Change in the composition of public mental health expenditure, 1993–2002.

- developing national mental health standards (Gianfrancesco *et al*, 1996), which are now being used as the basis for accreditation surveys.

In relation to the last point, most Australian mental health services have now been surveyed for accreditation with the standards at least once. The adoption of the standards by the largest independent organisation for accreditation of healthcare services, public and private, has entailed the training and participation of paid consumer and family carer surveyors among the network of health professional surveyors.

Second National Mental Health Plan (1998–2003)

The Second National Mental Health Plan focused on the principles of mental health promotion, prevention, partnerships with other (non-health) providers of services, and quality. Initiatives included the following.

- Principles were developed for workforce planning, and more recently national workforce standards, defining the core practical skills all mental health professionals should have and use (Department of Health and Family Services, 2002).
- Further anti-stigma strategies were put in place, such as the dissemination of media kits (now called Mindframe) to assist the press to put a more constructive 'spin' on suicide and mental illness stories, a 'Mind Matters' programme of mental health and illness education for all school students, and a manual for consumer advocates. Rotary International local branches now sponsor mental health community awareness workshops throughout Australia, and 'beyondblue' provides a national depression awareness campaign (<http://www.beyondblue.org.au>).
- Early prevention, improved detection, early intervention and shared mental healthcare were encouraged on the part of general practitioners, for patients in all age-groups and with all mental disorders, but particularly for depression and psychosis in young people, and others at risk of suicide. Dedicated 'early intervention in psychosis' teams have developed throughout Australia following the pioneering lead of McGorry *et al* (<http://www.orygen.org.au>).
- A National Mental Health and Well-being Community-wide Survey was undertaken for both high- and low-prevalence psychiatric disorders

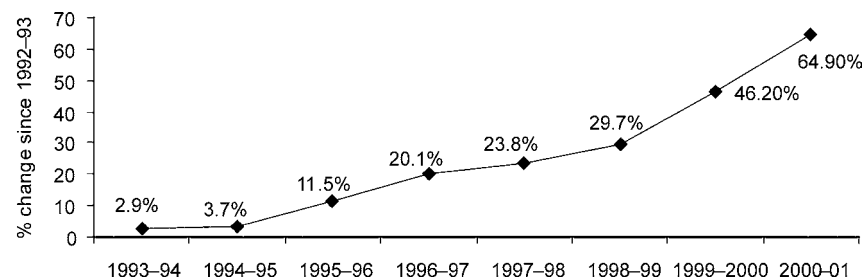


Fig. 2 Growth in total recurrent spending on specialised public mental health services (however, by comparison, the growth in general health spending over the same period was 66.1%).

Box 1 Achievements of the First and Second Australian National Mental Health Plans

- Australian government recurrent spending on mental health services (2002–03), public and private, including pharmaceutical subsidies, was A\$3183 billion, or A\$156 per capita (A\$1 is US\$0.7, €0.6).
- Average state spending on mental health services by 2003 was A\$100.02 per capita, a 32% increase (1993–2003) once adjusted for population growth and 2003 currency (see also Fig. 2).
- Public sector psychiatric beds decreased from 45/100 000 in 1993 to 31.4/100 000 in 2003, a 31% decrease overall, including a slight increase since 2001.
- Psychiatric beds in psychiatric hospitals as a percentage of total in-patient beds decreased from 76% in 1993 to 39% in 2003, a 48.6% decrease overall, although they began to increase again after 2001–02.
- Consumer participation in decision-making, in terms of the percentage of mental health service organisations with formal participation mechanisms for specific mental health consumer representation, increased from 33% in 1993 to 68% in 2003.
- 'Level 1' consumer participation (i.e. employing someone in local services to represent the interests of mental health consumers and carers with service management) improved from 17% in 1993 to 53% in 2003.
- Direct care staffing (in full-time equivalents) increased by 27% from 1993 (14 050) to 2003 (17 950), with in-patient staffing decreasing by 10% and ambulatory and residential care staffing increasing by 120%, to 87.1/100 000.

Source: National Mental Health Report, 2005, from <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-nmhr05>

(Whiteford & Buckingham, 2005), which demonstrated that most psychiatric care is still inequitably distributed by general practitioners.

- A national suite of clinical, functional and self-report outcome measures was mandated for use in all public and private mental health services and facilities, with a national training and data management network (<http://www.mhnocc.org>).

The achievements of the First and Second National Mental Health Plans are summarised in Box 1 and Figs 1 and 2.

Third National Mental Health Plan (2003–08)

The Third National Mental Health Plan was recently adopted by all the Australian federal and state governments (Australian Health Ministers' Advisory Committee, 2003). It is to be guided by four priority themes: promoting mental health and preventing mental health problems and mental illness; increasing service responsiveness; strengthening quality; and fostering research, innovation and sustainability.

There is now broad agreement that the Third Plan is far too superficial, provides few incentives to the states, even to ensure that they complete the first two Plans, and lacks real accountability mechanisms. Accordingly, the substantial early achievements

of the National Strategy are beginning to fray, and gaps in services are appearing as evidence-based community services are diluted and/or retracted increasingly to hospital sites. There has also been an unanticipated growth in acute presentations of comorbid drug misuse and mental illness (Gurr, 2005), leading to access block in emergency and inpatient departments.

Media glare on the human consequences of these problems has led recently to serial national inquiries by the Mental Health Council of Australia (Groom et al, 2003), the Human Rights and Equal Opportunity Commission (2005) and the Australian Senate (2006). This pressure prompted the prime minister to announce a substantial injection of funding, largely to privatised services for higher-prevalence mental health disorders, and to challenge the states politically to match it with enhancements for core public services for lower-prevalence severe conditions, which they are unlikely to attempt more than gesturally. Further attention is likely to be paid to early intervention in suicide prevention with young people.

Forums for reform

The Mental Health Services Conference of Australia and New Zealand (<http://www.themhs.org>) is a strong independent movement (Andrews, 2005) comprising all mental health professions, managers, consumers, family and indigenous networks. It organises binational forums for evidence dissemination and debate, to promote mental health service reform.

Conclusions

Firstly, we should acknowledge that there is common ground between all people of all cultural backgrounds in Australia – we have all had the experience of living on the margins at some stage, or in some generation of our family lives in Australia. This requires supporting the struggle for full citizenship and rights for people who are still on the margins of society, including Aboriginal people, detained asylum seekers and people living with mental illnesses (Rosen, 2006).

Secondly, it is clear from the Australian example that sustained national mental health reform is achievable; that structural reform of mental health services is easier to achieve than improvements in service quality; and that the support of clinicians, consumers and carers is a critical factor in the success of mental health reforms (Whiteford & Buckingham, 2005).

Mental health reform in Australia looks good on paper, has been heading broadly in an appropriate direction and has achieved international recognition. However, these reforms are already losing momentum. Core local mental health services are being eroded or have never developed widely enough. After a period of sustained growth in spending on mental health services (Fig. 2), Australia now lags behind similar Western countries in terms of

the proportion of gross domestic product and health budget spent on, and government funding of, mental health services (Rosen et al, 2004; Hickie et al, 2005; Rosen, 2006), and will still do so, even with recently announced enhancements.

There is further concern that the closing of institutions in Australia has been half-hearted and incomplete; that it has not been accompanied by full transfer of real investment in mental health services and facilities; and that under-resourced services are again being expected to be everything to everyone (Rosen et al, 2004; Hickie et al, 2005; Rosen, 2006).

Finally, there is a need for more coherent coordination of mental health services at one level of government (Andrews, 2005) and an independent National Mental Health Commission (Rosen et al, 2004; Hickie et al, 2005) similar to the potent standing commission operating in New Zealand, to monitor reforms externally, to cost the gaps in services, and to represent mental health service use needs directly to government.

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Acknowledgements: I am grateful to the Australian National Mental Health report 2005 for data in Box 1 and Figs 1 and 2; to *Acta Psychiatrica Scandinavica* for permission to use some material included in Rosen (2006), to Sylvia Hands for the typing and Karen Signorio and Kingsley Waterson for organising Box 1 and Figs 1 and 2; and also to Professor Bruce Singh, Melbourne, and Viv Miller, Sydney, for assistance with the content.

Alzheimer's Disease International

Elizabeth Rimmer

Executive Director, Alzheimer's Disease International, 64 Great Suffolk Street, London SE1 0BL, UK

For more information please visit <http://www.alz.co.uk>

It was in the late 1970s when the first Alzheimer associations began to form. At that time there was no public awareness about Alzheimer's disease. Doctors had little information and only a few recognised that Alzheimer's disease is not a natural part of ageing.

Alzheimer's Disease International (ADI) is the international federation of 75 Alzheimer associations throughout the world and is in official relations with the World Health Organization. ADI was established to raise awareness about dementia, strengthen Alzheimer associations and provide a platform for the exchange of knowledge with the ultimate goal of improving the quality of life of people with dementia and their families.

It was in the late 1970s when the first Alzheimer associations began to form. At that time there was no public awareness about Alzheimer's disease. Doctors had little information and only a few recognised that Alzheimer's disease is not a natural part of ageing. Families had nowhere to turn to when the disease was diagnosed.

By 1980 there were four national associations, in Canada, Australia, the USA and the UK. Their first priorities were providing information to raise awareness and supporting families.

Recognising that Alzheimer's disease does not discriminate in any way and that it presents a health and social care challenge worldwide, representatives of the first Alzheimer associations began to discuss their concerns about the global impact of dementia. In October 1984, the Alzheimer's Association in the USA helped to launch ADI by organising a meeting in Washington, DC, with the support of the World Health Organization, to bring together all the emerging Alzheimer associations around the world at that time. These associations wanted to ensure that families coping with Alzheimer's disease would have access to information and support.

Dementia: the scale of the problem

There are currently 24 million people living with dementia worldwide. The numbers of people affected will rise to 81 million by 2040, 71% of whom will live in low- and middle-income countries. With rapidly ageing populations, the rate of increase in the number of people with dementia is predicted to be three to four times higher in these countries than in their high-income counterparts. ADI has grown into a truly global organisation, with members in every world region. Most members are now in low- and middle-income countries, reflecting the global burden of dementia.

Dementia is a major cause of dependency in older people and yet most low- and middle-income countries have little health or social care resources devoted to it. The resources that are available focus on basic

healthcare needs such as maternal and child health and infectious diseases. However, the health and social needs of the large and rapidly growing numbers of people with dementia should be a matter for concern for policy makers in developing regions.

The need for care

Creating the climate for change is essential to achieving progress in dementia care. Lack of awareness of dementia is one of the key problems. Distorted perceptions lead to dementia being stigmatised and in many countries means that people with dementia and their families are often reluctant to seek much-needed help and support. When they do seek help they are often excluded from residential care and denied access to hospitals.

It is widely believed that extended families care for their own older people in low- and middle-income countries. Research shows that in many places this is not true; with an increase in urbanisation and greater mobility in populations, grown up children often leave their parents. There is a danger that the care of older people will be made a low priority by governments because of these falsely held views about extended families and that those with dementia will be neglected.

National Alzheimer associations are the main source of information and support for people with dementia and their families – in some countries they are the only source. It is because of these associations that people with dementia and their carers have been and are able to exert a powerful voice about their needs. Some associations also provide services, fund research and provide education and training. There is great diversity within ADI's membership, from the large established organisations that founded ADI to the new members such as Iran, Lebanon and China.

ADI aims to achieve its mission of improving the quality of life of people with dementia and their carers by:

- encouraging the development of Alzheimer associations
- promoting public awareness about dementia globally
- informing, educating and disseminating information to interested individuals and associations
- collaborating with other international organisations with similar interests
- encouraging research into the impact of dementia worldwide.

ADI's work focuses on stimulating and encouraging international exchange of information about dementia

care, raising awareness about the impact of dementia globally and developing effective Alzheimer associations. ADI's activities are outlined below.

Supporting Alzheimer associations

ADI believes that a strong, effective national Alzheimer association is better able to meet the needs of people with dementia and their carers. This belief led to the development of the Alzheimer University, a capacity-building programme designed for Alzheimer associations. The programme is a series of workshops and residential training courses to equip staff and volunteers of Alzheimer associations with the skills to develop their organisations. Topics have included leadership, strategic planning, communications, effective governance, and recruiting and supporting volunteers. A special Alzheimer University programme, 'Building an Alzheimer Association', is offered to new associations in developing countries. This year ADI launched the first Alzheimer University programme on advocacy and provided training on how to make dementia a healthcare priority with governments; it featured case studies from successful dementia advocacy campaigns. To date, over 60 countries have participated in the Alzheimer University.

ADI encourages partnerships between Alzheimer associations and has a twinning programme, where formal two-way collaborations to share information and skill between associations are established. ADI provides resources and support to enable twins to visit each other and develop a work plan; ADI then monitors progress.

Annual international conference

ADI's annual conference was the first international conference on dementia and is the longest running. Each year ADI's member groups and others come together to exchange information and to learn and share with one another. The ADI conference is unique in that it brings together a wide range of individuals and groups with an interest in dementia. Updates on research and the latest strategies for good dementia care are highlighted from around the world. A special feature of the conference is the involvement of people with dementia in plenary sessions and workshops speaking out about their experience of living with dementia. A different ADI member hosts the conference each year. The 2006 conference will be held in Berlin, Germany, on 12–14 October (see <http://www.alzheimer2006.de>) and will be marking the centenary of when Dr Alois Alzheimer first described the disease that would bear his name.

Raising awareness

Recognition of dementia as a disease and raising awareness are important priorities for each country. Dementia is surrounded by myth. For example, in

Nigeria a study of ten religious ministers in Anambra found that all ten believed that dementia was caused by evil spirits and the treatment used by the churches included fasting, prayers, beating, exorcism and dancing. The role of an Alzheimer association is critical in dispelling such myths. The provision of accurate and reliable information is a proven route to greater understanding and recognition.

World Alzheimer's Day, on 21 September each year, is ADI's annual awareness-raising campaign. ADI coordinates World Alzheimer's Day and produces and distributes publicity materials to its members and other interested parties. Last year 60 countries participated. This year the theme is 'No time to lose' and is a call for action for governments to prepare their health and social systems for the consequences of dementia and for individuals and organisations to work together to make dementia a global health priority.

ADI produces booklets, factsheets and videos on a variety of dementia-related topics in English and Spanish. ADI maintains a website and produces an international newsletter, *Global Perspective*. ADI members have access to an intranet site that provides information and resources from Alzheimer associations worldwide. ADI has a distinguished international medical and scientific advisory panel.

Supporting research

ADI's 10/66 Dementia Research Group trains researchers, particularly in low- and middle-income countries, on how to assess the impact of dementia nationally, and how to enable primary healthcare workers to diagnose and manage dementia. 10/66 gets its name from the fact that less than 10% of all population-based dementia research is directed towards the 66% or more of all people with dementia who live in low- and middle-income countries.

10/66 is supported by the World Health Organization and is a collaboration between ADI and the Institute of Psychiatry, London. Currently 10/66 is conducting population-based studies on prevalence and risk factors for dementia in China, Russia, Brazil, India, Cuba and Venezuela, and has recently been awarded a large grant from the Wellcome Trust to carry out incidence studies in these countries. When completed, this will be the largest international dementia data-set. 10/66 research results are disseminated at ADI conferences and symposia at other related international conferences and in research journals.

Conclusion

ADI has developed from its early beginnings in 1984 into a worldwide movement representing the voice of people with dementia and their families. ADI is committed to working with members to ensure that people with dementia and their families are able to access support and information to enable them to meet the demands of living with dementia.

ADI encourages partnerships between Alzheimer associations and has a twinning programme, where formal two-way collaborations to share information and skill between associations are established.

Recognition of dementia as a disease and raising awareness are important priorities for each country. Dementia is surrounded by myth.

For contributions to the News, Notes, Events column, please contact Brian Martindale, South of Tyne Early Intervention in Psychosis Service, Northumberland Tyne and Wear NHS Trust, Monkwearmouth Hospital, Newcastle Road, Sunderland SR5 1NB, UK, email Brian.Martindale@stw.nhs.uk

Activities of the European International Division of the Royal College of Psychiatrists

The Division has been in correspondence with its members asking for collaboration. It has also organised a number of symposia:

- 'Royal College of Psychiatrists Travels Overseas', at the WPA Regional and Intersectional Congress in Athens (March 2005)
- 'European Division: Launching and Perspectives', during the 13th World Congress of Psychiatry (September 2005)
- 'European Division of the Royal College of Psychiatrists: Activities and Perspectives', during the 19th Panhellenic Congress of Psychiatry in Athens (May 2006)
- participation in a symposium organised by the Pan-American Division of the College in Toronto, Canada, on Migration and Mental Health (May 2006)
- 'Psychiatric Education in Europe' at the College annual meeting in Glasgow and participation by the Division chair at the College's World Psychiatric Association Liaison Meeting (July 2006).

A major aim of the Division will be the provision of educational opportunities and expertise on the organisation of mental health services for psychiatric associations and individual colleagues in Eastern Europe. Joint activities with the Psychiatric Association for Eastern Europe and the Balkans (affiliated with the World Psychiatric Association) will be scheduled and experts from Western Europe will provide teaching and direct courses in Eastern Europe.

George Christodoulou
Chair, European International Division

The International Divisions at the College annual general meeting

All six International Divisions contributed well received symposia to the Glasgow meeting in July:

- The European Division took part in the trainees' day and the speakers (Christodoulou, Lindhardt and Bomba) covered themes ranging from the values of psychiatry from antiquity, to the European-wide training recommendations for psychiatry from the European Union of Medical Specialists (UEMS) and the specific developments in Poland integrating historical and European trends.
- The African Division speakers (Zabow, Ndetei and Olugbile) gave insightful and informative papers on areas of conflict and complementarities between African traditional healers and psychiatry.
- The theme of alternative and complementary medicine in relation to psychiatry was continued

by the Pan-American Division (Kisely, Meehan) and then the potential role of anti-oxidants in schizophrenia was outlined by Fernandez.

- The Western Pacific and South Asia Divisions joined to focus on the need to develop effective training and interventions in primary and community care, including inter-regional cooperation (Deva, Rajkumar, Javed, Mufti, Mendis and Chaudhry).
- The Middle East Division (Kamel, Taha and El-Gaddal) focused on several aspects of the family in working with drug misuse, schizophrenia and attempted suicide as well as post-traumatic stress disorder.

The organisation of the symposia this year allowed for greater dialogue with those attending.

Association of European Psychiatrists conference, 2007

It is our pleasure to invite you to attend the 15th European Congress of Psychiatry on European Psychiatry, Science and Art, in Madrid, Spain, 17–21 March 2007, organised by the Association of European Psychiatrists. The high-quality scientific programme will open new perspectives on the science and art of psychiatry and on issues related to treatment and patient care through state-of-the-art lectures, plenary lectures and core symposia. The Congress will also serve the educational mission of the Association through a variety of courses (continuing medical education with accreditation from the European Union of Medical Specialists), workshops, lectures and symposia. Information, proposals and registrations are available at <http://www.kenes.com/aep2007>.

Henning Sass
AEP President

Juan J. Lopez-Ibor
Local Organising Committee Chairman

WPA Permanent Secretariat

The World Psychiatric Association (WPA) now has a Permanent Secretariat with its headquarters based in Geneva. The contact details are: World Psychiatric Association Secretariat, Psychiatric Hospital, Pavillon Les Voirons, 2, Chemin du Petit Bel-Air, 1225 Chêne-Bourg, Geneva, Switzerland, tel. +41 22 305 5737, fax +41 22 305 5735, email wpasecretariat@wpanet.org. Members of the College are very welcome to visit the offices in Geneva. Anna Engstrom is the Administrator and Pamela Atiase the Deputy Administrator. The WPA website is <http://www.wpanet.org>, where contact details can be found for the extensive range of scientific sections of the WPA, all of which would welcome personal communications and contact from individual College members.

Psychiatry in Africa

Sir: The Royal College of Psychiatrists is about to pilot a project for psychiatry specialist registrars to spend 3 months working in Africa as part of their training. In April 2006, I attended the African Psychiatric Association and Allied Professional Conference 'Mental Health in Africa: Time for Action', in Addis Ababa, Ethiopia, on behalf of the College. While attending the conference, I was asked to look at the feasibility of registrars working in an African country such as Ethiopia.

The number of professional psychiatrists in African countries is very low, which creates a need for the training of more nurses and health workers in basic and practical methods for assessing patients and providing treatment. At the conference a repeated suggestion was to use traditional healers as part of an integrated mental health service, as this would represent a pragmatic, low-cost, psychosocial, community-based approach.

Ethiopia is five times the size of the UK and has a population of approximately 75 million. There are 14 psychiatrists in the country, who all work in the capital, where there is one psychiatric hospital, with 360 beds. The first psychiatry training programme was established in 2003 between the Universities of Addis Ababa and Toronto. The University of Toronto has provided contextually relevant mental health education 3 months a year to seven Ethiopian doctors, who were due to complete the full programme in July 2006.

In further discussions with several local psychiatrists, it was agreed that a specialist registrar in Ethiopia could be well utilised in a supervisory teaching capacity, focusing on complementing the existing didactic teaching by developing clinical skills, providing psychotherapy supervision and problem-based learning, presenting at journal clubs and developing presentation skills and expertise in the use of information technology. The post holder could visit regional centres and supervise staff there, and might also have the opportunity to supervise research and encourage audit. If such placements were of longer duration, say of 6–12 months, this would minimise registrars draining local resources and they could be in a position to facilitate visits by other UK psychiatrists for shorter periods.

Such a programme would also offer significant benefits to the UK in terms of specialist registrars developing managerial skills, managing limited resources more innovatively and developing awareness of cultural issues, which would be relevant when returning to work, particularly in areas with large diasporic populations.

Dr Jonathan Campion

Specialist Registrar on St George's Psychiatry
Training Scheme, London, UK

International recruitment: a Pakistani perspective

Sir: Chaturvedi, in his article entitled 'What is important for quality of life of psychiatrists?' (*International Psychiatry*, vol. 3, no. 2, April 2006, p. 20), raised some important issues in relation to the international recruitment of psychiatrists from India. He highlighted the fact that there are unfavourable aspects of work in India for psychiatrists and that an opportunity to work in a high-income country can benefit doctors. Here, I wish to relate the situation in Pakistan.

First, the law and order situation in Pakistan has now deteriorated to such an extent that personal safety is not guaranteed: there are frequent bomb blasts, suicide bombings, lootings and kidnappings. Some psychiatrists have been threatened and have left the country on the advice of the security services.

With such a huge population and so few psychiatrists, psychiatrists should be in high demand. However, this is not the case. In Pakistan, alternative practitioners see a large proportion of those who are mentally ill. General practitioners do see the majority of the patients, but their referral to specialist services is inhibited by the patients' reluctance to see a psychiatrist; hospital consultants also tend to look after the mental health of their patients, perhaps for similar reasons. The Pakistan Medical and Dental Council (PMDC) gives psychiatry low priority. There is therefore no pressure to recruit more psychiatrists.

As far as the public sector medical schools are concerned, active recruitment, despite vacancies, is not in evidence. There are several reasons for this: fear of loss of authority by the existing chiefs; posts being advertised only for rural areas; and various hidden agendas and political machinations. Furthermore, the private sector will be unable to provide employment for the psychiatrists being trained locally and those who are returning from abroad. In any case, the option of private practice is not always appealing. One has to have institutional support to build a bank of patients. Some non-governmental organisations run clinics but the remuneration is meagre.

Low pay scales in an era of high inflation is another factor that is a source of great dissatisfaction to psychiatrists. Moreover, it is strange, within public sector appointments, that a psychiatrist working in one province cannot apply for a job in another province.

Finally, exposure to sub-specialties is almost non-existent.

The migration of a few psychiatrists would not cause any problem but could help them to advance professionally, and give them a better quality of life.

Dr Amin Muhammad Gadit

Professor of Psychiatry, Memorial University of
Newfoundland, Canada

Correspondence is welcome on any of the articles or issues raised in *International Psychiatry*. Letters of no more than 500 words should be sent to the Editor, Hamid Ghodse, email hghodse@sgul.ac.uk

Forthcoming international events

17–19 November 2006

Second International Conference, South Asian Association for Regional Cooperation (SAARC) Psychiatric Federation
Kathmandu, Nepal
Contact: Prof. Mahendra K. Nepal or Prof. Roy Abraham Kallivayalil
Email: mhp@healthnet.org.np or ktm_roykalli@sanchanet.in

23–25 November 2006

Regional Meeting of the Middle East Division of the Royal College of Psychiatrists
Beirut, Lebanon
Contact: Dr Fuad T. Antun
Email: antun@cyberia.net.lb

29 November–1 December 2006

6th International Forum on Mood and Anxiety Disorders
Vienna, Austria
Email: ifmad@publications.com
Website: <http://www.aim-internationalgroup.com/2006/ifmad>

30 November–3 December 2006

WPA Regional Meeting with the Peruvian Psychiatric Association
Lima, Peru
Contact: Dr Marta Rondon, Dr Gabriela Kuroiwa
Email: app@apperu.org

15–19 January 2007

Encountering the Spirit of Community in Narrative Therapy and in Cuba Programs for People
Organised by WPA Zone 3 with the Cuban Society of Psychiatry and the International Federation of Social Workers
Havana, Cuba
Contact: Dr Cristobal Martinez Gomez
Email: info@narrativecuba.com
Website: <http://www.narrativecuba.com>

23–24 January 2007

WPA Regional Meeting and Hungarian Psychiatric Association
Budapest, Hungary
Contact: Dr Tury Ferenc
Email: tury@axelero.hu
Website: <http://www.mpt.iif.hu>

13–16 February 2007

Psyche and Art Seminar
WPA Section on Art and Psychiatry, with Schattauer Verlag Publishers
Djerba, Tunisia
Contact: Dr Hans Otto Thomashoff
Email: thomashoff@utanet.at

15–19 March 2007

Psychiatry in Developing Countries
WPA section; South Asian Forum; RCPsych South Asian Division; BIA; WAPR; WFMH
Lahore, Pakistan
Email: Afzal.javed@ntworld.com

19–20 March 2007

Working with Families – Developing Caring Partnerships
Stratford-upon-Avon, UK
Email: meridenconference@conferenceline.co.uk
Website: <http://www.meridenfamilyprogramme.com>

22–24 March 2007

WPA Regional Meeting and Kenya Psychiatric Association
Nairobi, Kenya
Contact: Dr Frank G. Njenga
Email: fnjenga@africaonline.co.ke

29–31 March 2007

8th London International Eating Disorders Conference
Website: <http://www.mahealthcarevents.co.uk>

18–21 April 2007

WPA Regional Meeting and the Korean Neuropsychiatric Association
Seoul, Korea
Contact: Dr Young-Cho Chung
Email: kpa3355@kornet.net

22–25 April 2007

Third International Congress on Hormones, Brain and Neuro-psychopharmacology
WPA Section on Interdisciplinary Collaboration
Marakkosh, Morocco
Contact: Dr Uriel M. Halbreich
Email: urielh@acsu.buffalo.edu

16–19 May 2007

New Treatment Methods in Psychiatry in a Challenging World
15th World Congress for Dynamic Psychiatry
St Petersburg, Russia
Email: congress2007@dynpsych.de

6–8 June 2007

Coercive Treatment in Psychiatry: A Comprehensive Review
WPA thematic conference, Eunomia Study Group in collaboration with the Czech Psychiatric Society
Dresden, Germany
Email: cstolz@intercom-dresden.de
Website: <http://www.wpa2007dresden.org>

19–22 June 2007

Royal College of Psychiatrists annual meeting
Edinburgh, UK
Email: conference@rcpsych.ac.uk
Website: <http://www.rcpsych.ac.uk>

25–28 July 2007

Remembering, Repeating and Working Through in Psychoanalysis and Culture Today
International Psychoanalytical Association Congress
Berlin, Germany
Website: <http://www.ipa.org.uk>

25–29 August 2007

Bridging the Gaps, Integrating Perspectives in Child and Adolescent Mental Health
European Society for Child and Adolescent Psychiatry
Florence, Italy
Email: escap2007@newtours.it
Website: <http://www.escap-net.org>

20–23 September 2007

WPA Regional Meeting
Shanghai Mental Health Center, China
Contact: Dr Zeping Xiao
Email: xzpdgj@online.sh.cn

21–25 October 2007

XIX World Association for Social Psychiatry Congress
WPA co-sponsored conference (Zone 9) with World Association for Social Psychiatry
Prague, Czech Republic
Contact: Dr Shridhar Sharma
Email: wasp@nda.vsnl.net.in

23–28 October 2007

Annual Meeting of the International Society Of Addiction Medicine (ISAM)
WPA co-sponsored conference (Zone 11) with the International Society of Addiction Medicine (ISAM) in collaboration with the WPA Section on Addiction Psychiatry
Cairo, Egypt
Contact: Dr Nady El-Guebaly
Email: nady.el-guebaly@calgaryhealthregion.ca

24–26 October 2007

XIV Congress of the Argentinean Association of Psychiatrists
WPA co-sponsored conference (Zone 5) organised by the Argentinean Association of Psychiatrists (AAP)
Buenos Aires, Argentina
Contact: Dr Nestor F. Marchant
Email: aap@aap.org.ar
Website: <http://www.aap.org.ar>

28 November–2 December 2007

Working Together for Mental Health: Partnerships for Policy and Practice
WPA international congress
Email: wpa2007melbourne@meetingplanners.com.au
Website: <http://www.wpa2007melbourne.com>

16–20 March 2008

3rd World Congress on Women's Mental Health
Melbourne, Australia
Website: <http://www.iawmhcongress2008.com.au>

19–25 September 2008

14th World Congress of Psychiatry
Prague, Czech Republic
Website: <http://www.wpa-prague2008.cz>

1–4 April 2009

Treatments in Psychiatry: A New Update
WPA International Congress
Florence, Italy
Contact: Professor Mario Maj, President-Elect, WPA
Email: majmario@tin.it