

International Psychiatry

<i>Editorial</i>	
Smoking and mental health	1
Hamid Ghodse	
<i>Thematic papers – The mental health of refugees</i>	
Introduction	2
David Skuse	
Refugee mental health challenges in Africa	3
Frank G. Njenga	
Sudanese refugees: sufferings and suggested management	5
Nasser Loza and Nael Hasan	
Post-traumatic stress disorder among Afghan refugees following war	7
Khalid A. Mufti, Farooq Naeem, Haroon Rasheed Chaudry, Asad Haroon, Farida Saifi, Siama Mahmood Qureshi and Saif ur Rehman Dagarwal	
<i>Country profiles</i>	
Malawi	9
Felix Kauye and Chitsanzo Mafuta	
Mental health and psychiatry in Thailand	11
Pichet Udomratn	
Lebanon	14
F. Antun, Charles Baddoura and Mounir Khani	
<i>Special papers</i>	
Reform of the mental healthcare system in Greece, 1984–2006	16
Michael G. Madianos and George N. Christodoulou	
Attitudes towards mental illness in Uganda: a survey in 18 districts	19
Vuokko Wallace, Jed Boardman and James Walsh	
<i>Point of view</i>	
Doctors' values, resilience and professionalism	21
Richard Williams	
<i>News and notes</i>	23
<i>Correspondence</i>	24
<i>Forthcoming international events</i>	26

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Smoking and mental health

Hamid Ghodse

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Smoking affects everyone. It is a major cause of death and disability, with five million worldwide dying prematurely each year as a result of smoking. For those who live with smokers, there is a significantly higher risk of developing heart disease or lung cancer. The economic costs are high, too, and billions of pounds are spent each year from National Health Service budgets on treating diseases caused by smoking.

On the face of it, it is difficult to understand why so many people do smoke. Given all the evidence, why don't they just stop? A full answer to this apparently simple question would involve a complex exploration of pharmacology and an understanding of psychological dependence, but the simple answer is that people smoke because it is extremely difficult to quit. However, quitting is not impossible, and this is borne out by the thousands of smokers who do manage to quit each year, often making use of whatever stop-smoking services are available to them.

It is widely acknowledged that smoking is a preventable cause of death and disability. This is reflected in the very large number of signatories to the World Health Organization (WHO) Framework Convention on Tobacco Control, which came into force on 27 February 2005. This is the only convention to have received more than 170 national signatories. It expresses concern about the devastating worldwide health, social, economic and environmental consequences of tobacco consumption and exposure to tobacco smoke, and recognises that the spread of the tobacco epidemic is a global problem with serious consequences for public health. It emphasises the burden being placed on families, on the poor and on national health systems, particularly in low- and middle-income countries, by the increased consumption of tobacco products and it calls for the widest possible international cooperation and the participation of all countries in an effective, appropriate and comprehensive international response (see <http://www.who.int/tobacco/framework/en/>).

This excellent initiative of the WHO, supported by the international community, has moved the issue of smoking cessation up the agenda of health services in many countries, although in some this has been with more urgency than in others. Within this context, there are important and specific implications for those with mental illness, who are a particularly vulnerable group in terms of the effects of smoking. Smoking rates are at least twice as high among people with mental health problems as in the general population (Meltzer *et al*, 1995), with nearly 45% of all cigarettes consumed being smoked by individuals with a psychiatric disorder (Lasser *et al*, 2000). One possible explanation is that many mental health patients effectively self-medicate with tobacco, using nicotine to alleviate their symptoms. For example, nicotine has been found to stimulate neurotransmitters (such as dopamine) in the same way that many antidepressant

medications do (Le Houezec, 1998). Another theory is that the propensity to smoke among these patients is mediated by their social circumstances. Smoking has been found to be strongly associated with social deprivation in terms of low income, poor accommodation, unemployment and so on (Jarvis & Wardle, 1999), and deprivation, in turn, is related to the presence of psychiatric disorder (Rasul *et al*, 2001).

Contrary to common assumptions, recent surveys in the UK have reported that around half of smokers with mental health problems are concerned about their smoking and want to stop (McNeill, 2001). However, they have expressed dissatisfaction with the support they receive from mental health professionals in relation to quitting. It has been claimed that psychiatrists rarely discuss patients' smoking and that local services rarely support smoking cessation, for example by offering nicotine replacement therapy. Historically, too, little attention has been paid to the psychiatric patient group in smoking cessation research. In a recent review of the literature on hospital-based smoking cessation (Rigotti *et al*, 2003), a wide range of healthcare areas were considered but studies of patients admitted with psychiatric disorders were excluded.

However, patients with mental health problems have as much right to be helped to overcome their addiction to tobacco as any other individuals and there is, indeed, some evidence to suggest that smoking cessation interventions can be as useful for people with mental health problems as for the rest of the population (El-Guebuly *et al*, 2002). It is interesting that researchers have reported a sense of exclusion from mainstream cessation programmes among mental health patients (Lawn *et al*, 2002). Psychiatrists and other members of mental health teams therefore have a particular responsibility to establish policies that will help their patients to quit and to provide individuals with assistance whenever this is needed.

The issue of prohibiting smoking in public places has been widely discussed in many countries – and has been implemented in some. Although the adoption of smoke-free policies in healthcare settings is generally a popular move, it is often suggested that psychiatric hospitals should be exempted. This appears to be based on a perception that psychiatric settings are difficult places within which to implement smoking restrictions. This may be related to the unique place occupied by smoking within the practice and culture of psychiatric care. For example, smoking is often a major source of structure and activity to the patient's day and may also feature strongly in the social club of mental health units (Lawn & Pols, 2005). Studies have also reported that mental health staff often use cigarettes to appease or engage patients (Mester *et al*, 1993). The arguments for exempting mental health units from smoke-free policies also make reference to human rights, in the context that many patients are

resident in hospitals for extended periods and often against their will.

Clearly, these are thorny issues. However, mental health patients have the same right as any other patients to access to health promotion and to protection from the harmful effects of smoking. In this complex environment, the attitude of mental health professionals is likely to be of great importance and a recent survey revealed that mental health staff have significantly less positive attitudes towards providing smoking-related intervention to their service users than general medical staff (McNally *et al*, 2006). There is also some evidence that smoking-related attitudes differ across professional groups. For example, in one study doctors ranked smoking cessation as more important than nurses did (Braun *et al*, 2004). However, it appears that once smoke-free policies have been in place for some time, staff develop much more positive attitudes towards smoking cessation. This shift in opinion may flow from the fact that smoking bans have rarely been found to lead to increased aggression and adverse incidents and, in fact, have even had a positive effect on ward functioning in many cases (Lawn & Pols, 2005).

It is clearly important that patients with psychiatric disorders are not deprived of their right to a smoke-free environment because of unwarranted assumptions about what can and cannot be implemented within a hospital setting. Also, many mental health patients are now cared for in the community, where these arguments are irrelevant. It is therefore essential that psychiatrists exercise their duty of care and leadership in promoting smoking cessation at both individual patient level and within their institutions, to protect their patients from the serious consequences of smoking.

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THEMATIC PAPERS – INTRODUCTION

The mental health of refugees

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Concerns about the fate of refugees, displaced because of war or famine and in some cases by genocide, are now expressed almost daily in news broadcasts and other media. This is a global problem, but currently there is a particular focus on the needs of Africa, and the terrible internal conflicts that are occurring in countries such as Sudan and Somalia. In our thematic section for this issue, we present three papers that express concern about the mental health of refugees.

In a series of polemical statements, Dr Njenga sets out the urgent challenges facing the international community. He discusses the former genocide in Rwanda and the scale of the conflict in Somalia, from which thousands of refugees are fleeing to Kenya, to escape a civil war between Islamists and warlords, thereby putting pressure on the fragile mental health infrastructure of that country. He

mentions the high rates of post-traumatic stress disorder among refugees in Sudan. The failure of the world to take action to prevent the incipient genocide of the displaced peoples in Darfur has been described by President George Bush as putting the credibility of the United Nations at stake.

The suffering of the people of Sudan is the subject of the article by Drs Loza and Hasan, from Egypt. The south of Egypt borders Sudan, and many refugees have moved north. The number of displaced persons is so large that pressure is being put on the reception facilities in Egypt that are endeavouring to cope with them. Drs Loza and Hasan point out that not only do refugees have experiences of murder, rape and torture to come to terms with, psychologically, but also, in the foreign country to which they have escaped, they are likely to face racial discrimination and invariably

will experience cultural dislocation. Both articles discuss the potentially beneficial role of traditional healers in assisting refugees. It would be interesting to learn more about the interface between traditional healing practices and psychiatric disorders associated with displacement and trauma. In this context, we need to be particularly vigilant about the needs of refugee children, whose development may have been harmed not only by their experiences but also by the associated famine and illness.

Finally, we have an article by Dr Mufti and colleagues concerning a chronic problem: refugees from the many years of conflict in Afghanistan who have moved across the border into Pakistan. The authors conducted a systematic study of

refugee mental health in camps in Peshawar. They comment on the stress the large number of refugees has put on the fragile health service infrastructure in the host country, and they commend Pakistan for its positive response. The article reports a preliminary investigation that aimed to identify the prevalence of post-traumatic stress disorder. Rates were very high: indeed, most refugees seemed to be affected. This represents a similar story to that described in our papers on African refugees. There can be no doubt about the scale of the problem. Now, as psychiatrists who care about refugees within the international community, we should be working with our colleagues in the host countries to find the most efficient way of addressing it.

THEMATIC PAPER – THE MENTAL HEALTH OF REFUGEES

Refugee mental health challenges in Africa

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Nearly all low-income countries are either just themselves emerging from conflict or neighbour a country that has just emerged from one. According to the Office of the United Nations High Commissioner for Refugees (<http://www.unhcr.org>), of the 38 million uprooted people in 2003 worldwide, Africa played host to 13 million internally displaced persons and 3.5 million refugees.

The world's refugee burden is carried by the poorest countries. Significantly, of the 127 wars since the First World War, 125 have been fought in low-income countries, and 16 of the 20 poorest countries in the world have had a major conflict in the past 15 years. It is now accepted that, in Africa, conflict causes as many deaths as epidemic diseases. In addition, most of sub-Saharan Africa is listed by the World Bank as existing below the poverty line. It is therefore precisely these poor countries that have to share meagre resources with refugees and internally displaced persons. Given the link between psychological trauma, poverty and mental disorder, it is to be expected that refugee camps would have high rates of mental illness.

Other contributors to the challenge

Following political independence, many African countries enjoyed high levels of social and economic growth, before plunging into states of conflict, poor governance, corruption and, in some, total collapse of the central government authority – in the case Somalia for the past 13 years. In 1994, Rwanda experienced a genocide that lingers in the minds of all witnesses, African and non-African alike. Natural calamities such as droughts, famine, floods and earthquakes further contribute to high social morbidity. Terrorism has not

spared the continent either (Njenga *et al*, 2004). Hitting the continent with increasing ferocity, mainly directed to women and the poorest, is HIV/AIDS, with current estimates showing 40 million infected. In some countries such as Botswana, the prevalence rates are up to 40% and life expectancy in some parts of Kenya have dropped from a high of 65 years before the pandemic to 38 years, in the process decimating the workforce, including that within the health services.

Mental health, poverty and special groups

It is now well established that poverty is an independent predictor of poor mental health (Holzer *et al*, 1986; Muntaner *et al*, 2004). It is also well established that particular groups in the population have higher rates of mental disorder, especially depression – for example, abused women, people living in extreme poverty such as slum dwellers, persons traumatised by conflict and war, migrants, and children and adolescents with disrupted nurturing, as well as indigenous groups. Of great significance is the fact that many of the well established vulnerabilities occur simultaneously in the same individuals.

Post-traumatic stress disorder in Africa

In the past few decades, the people of Africa have had many wars fought in their midst (Njenga *et al*, 2003). In a study from Rwanda, Pham *et al* (2004) found prevalence rates of post-traumatic stress disorder (PTSD) of 24.8%, 8 years after the 1994 genocide. Among the survivors of torture, this rose

to 36%. In nearby Sudan, Peltzer (1999) found rates of PTSD as high as 32% among the residents of a refugee camp. In a study of internally displaced persons in Kenya, Njau (2005) found rates as high as 80.2% among heads of household.

All these reports point to the expected high prevalence rates not only of PTSD but also of comorbid disorders, including depression, substance and drug misuse, as well as other concomitants of the disintegration of social cohesion. In attempting to rebuild such communities, it will be important to understand how traumatic experiences may shape the ability of individuals and groups to respond to judicial and other reconciliation initiatives.

The challenge

Africa must respond to the seemingly insurmountable mental health challenge posed by refugees, the lack of resources notwithstanding. Importantly, the response must be home grown, culturally relevant and appropriate, as well as affordable and sustainable. It must, in addition, be evidence based and open to both monitoring and evaluation. Account should be taken of the activities of the many groups of human rights activists who are always on the ground, seeking the promotion of their own agendas. The strategy must embrace local cultural norms and belief systems, ensure full community participation and integrate fully into the existing public healthcare systems. It should in its design include elements of building the human resource base of the community. Most African cultures accommodate diversity, curiosity and dialogue in their normal states and special attention must be paid to these issues.

The success of refugee programmes will be reflected in the extent of participation of the native community. Key among these will be traditional healers, who hold custody of much health-related wisdom in these communities.

School teachers are often forgotten in the planning of services, when it should be remembered that they are often the most educated members of the community as well as 'opinion leaders' in their own right; the success or failure of programmes could therefore depend on their involvement in the planning stages.

In many parts of Africa, formal and informal community groups could be invaluable in refugee programmes. They include self-help groups (for example those involved in water supply and housing) as well as women's groups, which in some communities can be very powerful in both social and resource mobilisation. Women's groups will be of especial importance because of their knowledge and experience in child refugee programmes as well as spiritual and guidance programmes with adolescent refugees.

In the response to this challenge, particular care must be taken not to give the impression that refugee status attracts entitlement to better or superior services, as this often leads to resentment among the host community. This is often grounded in the misconception by well meaning but ignorant non-governmental organisations that the refugees are their business whereas the host population is the business of the local government authorities. School-based and community-based programmes for those with severe mental illness are often prone to some of these criticisms.

Conclusion

Refugees are often viewed as agents of environmental degradation, as well as people who arrive to share the meagre resources left after years of poverty, war and the plunder of national resources by political leaders, who are often the cause of the refugee problem in the first place.

All in all, the refugee problem is big and growing. No single strategy will be either suitable or sufficient: the approach must be multisectoral, multifaceted and multidisciplinary in nature.

The challenge is urgent, as in some countries it poses a threat to both security and national development, as tension mounts between the refugees and the host community. The world mental health community must stand together with the African people to rise to this challenge.

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College website and international issues

Readers are reminded that there is extensive coverage on the College website of international issues relevant to College members around the world (see <http://www.rcpsych.ac.uk/college/internationalaffairsunit.aspx>). Members are encouraged to send updates to Joanna Carroll by email (JCarroll@rcpsych.ac.uk).

Sudanese refugees: sufferings and suggested management

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Egypt and the Sudan have historically provided a continuum of social and cultural exchange. With the Nile valley providing the only route between the Mediterranean and sub-Saharan Africa, Egypt became the natural host for Sudanese refugees.

It is important to point out that the Sudanese refugee population is not a homogeneous group. Immigrants from Sudan have had different reasons for their move. In the south of Sudan over the past two decades, large numbers of people have sought to escape the drought as well as civil war. This is unlike the situation in western Sudan, where mass murder and the burning of villages have characterised ethnic and religious conflict. Further, Egypt's Sudanese immigrants include some who did not flee war or hunger but who sought better socio-economic standards. These include professionals employed in their host country.

Historical background

Genocide and conflict in the south of Sudan started more than 20 years ago. It is between two ethnic/religious groupings: the southern, mostly Christian ethnic group and the northern Arab-Muslim rulers. The hostility between the two is deeply rooted but flared up after the discovery of oil in the south of Sudan in the 1970s (Lesch, 1998; Johnson, 2003).

The reality of what is happening in Darfur, in the western part of Sudan, has been well documented. Many people have fled after attacks on their villages by Arab Janjaweed militias, who have burned hundreds of villages and murdered thousands of civilians. This conflict began in February 2003, with the emergence of two anti-government groups: the Sudan Liberation Army and the Justice and Equity Movement. These two groups began fighting the pro-government Janjaweed militia and units of the regular Sudanese army. The conflict resulted in the displacement of up to 200 000 Sudanese.

Magnitude and effects of the refugee problem

The problem of refugees is of alarming proportion. One out of 275 persons globally is of concern to the United Nations High Commissioner for Refugees (UNHCR, 2002). A further 21 million people are displaced within their own countries. Some 80% of refugees are women and children (Forbes, 1992). Families face the added effects of high infant mortality rates (Eisenbruch, 1998).

Many studies have shown that refugees have a wide range of psychological problems, such as psychosis, post-traumatic

stress disorder and depression (Mollica *et al*, 1993; Van Ommeren *et al*, 2001; De Jong, 2002). Adolescent refugees were found to have high levels of emotional distress related to their experience of violence. Longitudinal studies have shown that resettled adolescent refugees have significantly high levels of psychological distress, school failure, post-traumatic stress disorder and depression. Furthermore, children are less likely than adults to receive psychological care. This may be attributed to cultural differences in the expression of symptoms.

It has been estimated that about 2 million Sudanese people have died in the conflicts in the south of Sudan and that 4 million have been displaced. In addition, an unknown number of women and children have been captured and sent to the north to be sold into slavery – sexual and otherwise.

Surveys conducted in western Darfur by the World Health Organization (WHO) showed that 6000–10 000 people were dying each month from disease and the effect of malnutrition (WHO, 2004). This humanitarian crisis has political causes and the failure to recognise and address these is catastrophic.

Refugees, especially children, are exposed to malnutrition. Women are being repeatedly raped and terrorised. Refugees are also at high risk of communicable diseases, notably acute respiratory infections, diarrhoea and malaria. Outbreaks of disease are more likely to occur in refugee camps because there are limited amounts of potable water, low standards of environmental hygiene and sanitation, malnutrition and low vaccination coverage.

Women in many cases have been raped in front of their husbands, children and the entire community; unfortunately, rape is used as a weapon in this war. Girls as young as 8 years old are being raped and used as sex slaves in Darfur. Rape has a devastating impact on the health of women and girls, including medical complications and injuries, sexually transmitted diseases and HIV. Women may also become pregnant, which can have its own complications, as may delivery. Raped women may also suffer a lifetime of stigma and marginalisation from their families and communities.

The effects of violence

The experiences reported by Sudanese children include watching their villages being attacked by militia, fleeing with family and friends from the villages during attacks, watching family members being killed or mutilated, watching the death of other children, facing wild animals, getting lost during escape, being drowned in rivers and facing diseases of all kinds.

Paardekooper *et al* (1999) showed that Sudanese children, compared with Ugandan children, reported significantly more

Table 1 Comparison of the proportions of Sudanese and Ugandan children experiencing traumatising events¹

Item (Did the child ever experience...)	Sudanese (%) (n = 345)	Ugandan (%) (n = 82)
Loss of property	93.6	1.3***
Lack of food	91.3	58.2***
Loss of family member	80.0	34.6***
Witnessing death of family member	63.0	61.3
Lack of water	62.1	10.5***
Ill health, no medical care	62.1	36.4***
Near death	51.2	42.1
Torture	28.0	0.0***
Being lost or kidnapped	25.5	1.3***
Witnessing injury of family member	19.9	6.4**
Witnessing murder of family member	19.2	3.9**
Isolation from family members	17.3	5.3**
Sexual abuse	9.0	0.0***
Imprisonment	62.0	0.0
Injury	7.0	0.0

** $P < 0.01$; *** $P < 0.001$.

1. From Paardekooper *et al* (1999), with permission.

traumatic events, more daily stressors and less satisfying social support; they also had more psychological complaints, including symptoms of post-traumatic stress disorder such as trouble with sleep, nervousness, traumatic memories, depressive symptoms and psychosomatic complaints (Tables 1 and 2).

Current situation of refugees in Egypt

As a result of the war in the south of Sudan, up to 30 000 southern Sudanese refugees fled to Egypt; most are now living in Cairo. As the war is ongoing in their home country, the odds of their returning home soon are very slim.

Egypt is a low- to middle-income country with limited resources, and it is still struggling to provide sufficient services for its own population; thus, the migration of Sudanese refugees to Egypt is becoming a burden on the economy.

The refugees have different habits, skin colour, beliefs and religion, customs and language; these confirm their status as 'outsiders'. Many refugees are unable to work legally, to find housing, to obtain education for their children or even to access medical services. Thousands of Sudanese refugee families struggle to survive.

Sudanese refugees in Egypt face challenges adapting to their new situation and experience social, physical and mental problems. The collapse of their systems of social support, combined with socio-economic marginalisation, similarly lead to poor physical health, malnutrition and psychological disorder (Jablensky *et al*, 1992).

How can we help?

Many Sudanese refugees find themselves trapped in camps as refugees, without any immediate hope of moving. Meanwhile they are treated in ways that lead them to feel that they have no rights. Development programmes for refugees, to be effective, must be able to achieve the refugees' objectives, and so should help them to scrape a living and to live

Table 2 Comparison of the proportions of Sudanese and Ugandan children experiencing recent stressors¹

Item (Did the child this last week experience...)	Sudanese (%) (n = 345)	Ugandan (%) (n = 82)
Lack of clothing	88.0	47.5***
Poor sanitation	79.6	18.5***
Hunger	69.4	35.8***
Worry about family members	69.2	22.2***
Having no school fees	58.4	46.0**
Having to take care of siblings	56.3	42.0
Illness, no medical care	55.1	4.9***
Too much workload in the house	48.2	27.2***
Nightmares	45.1	30.0
Lack of parental attention	35.9	26.8
Isolation from family members	32.1	10.0***
Loneliness	31.3	26.0
Feeling insecure	28.7	14.8

** $P < 0.01$; *** $P < 0.001$.

1. From Paardekooper *et al* (1999), with permission.

in dignity; programmes should also educate children and protect families, and prepare refugees eventually to return to their home country. Programmes should protect refugees' rights and protect the refugees themselves, and should respect their cultural beliefs and customs; they should also ensure access to healthcare, including mental healthcare.

Refugees will benefit most from programmes that preserve their cultural identity (Eisenbruch, 1990; Berry, 1991). The role of traditional healers is well recognised in helping people to recover from the trauma of war and being a refugee, even in cases where HIV/AIDS emerges, such as in Uganda and Cambodia (Green, 2000).

The idea that culture plays a crucial role in the process of recovery from traumatic events arose because such events are directed by local historical experiences and are mediated by local cultural factors. Understanding local idioms of distress will unlock the local clinical symptom profile of psychological and social disorders (Eisenbruch, 1992). Combinations of local resources such as traditional healers, healthcare workers and relief workers can ameliorate the psychosocial problems of large groups, not just individuals (De Jong, 2002).

Development programmes for refugees have many obstacles to overcome, notably ongoing conflicts, but also the refugees' lack of freedom of movement, insecurity, lack of rights, poor socio-economic status and exclusion from participating in the political decision-making process.

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THEMATIC PAPER – THE MENTAL HEALTH OF REFUGEES

Post-traumatic stress disorder among Afghan refugees following war

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There was a large influx of Afghan refugees into Pakistan during the 1980s and in particular after the US invasion of Afghanistan in 2001. That refugees have high rates of mental health problems has been well established (e.g. De Jong *et al*, 2000) – causes include migration, often with painful transit experiences, difficult camp life and the experience of major trauma, including multiple losses of family members as well as the loss of property and traditional lifestyle. However, the Afghan refugees in Pakistan have been poorly studied. Although the mental health problems of Afghan refugees have been studied in the West, the numbers of participants in such research have been relatively small.

The burden of healthcare for Afghan refugees lies mainly with the Pakistani government and non-governmental organisations. The refugees place a further burden on the already poorly financed healthcare system in Pakistan. It is encouraging to note that the host population has shown great courage and patience in support of Afghan refugees.

Many studies in the West have found high rates of psychiatric disorder among refugees (Summerfield, 2001). Wide variations in the rates of these disorders can be attributed to differing cultures and experiences in the groups sampled. Although the concept of post-traumatic stress disorder (PTSD) has been questioned and it has been suggested that rates may have been exaggerated (Watters, 2001), the rates of PTSD have been estimated to be as high as 90% in psychiatric clinic populations (Silove, 1999).

In a community study of Afghan refugees in The Netherlands, the prevalence of PTSD was found to be 35% (Gernaat *et al*, 2002). Similarly, a US study examined the psychological

effects of the war in Afghanistan on two groups of young Afghan refugees currently residing in the USA. The investigators found the rates of mental health problems to be higher among the Pashto-speaking population than among the Tajik population (Mghir & Raskin, 1999). In another US study (Mghir *et al*, 1995), 38 refugees aged between 12 and 24 years were interviewed with the Structured Clinical Interview for DSM–III–R. Five of the participants met the criteria for PTSD and 11 met the criteria for major depression (13 had either PTSD or major depression or both).

Afghans living in the Western world represent a small proportion of that country's refugees. Pakistan provides a better opportunity for the study of the mental health problems of the larger Afghan refugee population. We undertook a study to measure the prevalence of psychiatric morbidity among Afghan refugees.

Method

This was a cross-sectional study. Information was collected from Afghan refugees attending a psychiatric service in Peshawar between December 2003 and March 2004. All the refugees attending who fulfilled our inclusion criteria were approached, and all those who consented were included in our study. The inclusion criteria were: being an Afghan refugee, between the ages of 15 and 65 years, attending the psychiatric service and having a diagnosis of a functional psychiatric illness. Those with a diagnosis of learning disability, dementia or organic brain disorder were excluded from the study.

Measurement of psychopathology

Psychopathology was measured using the Mini International Neuropsychiatry Interview (MINI; Sheehan *et al*, 1998). A form to record experiences of trauma was specially designed based on qualitative experiences with ten refugees.

Statistical analyses were carried out using SPSS version 10 for Windows. Both parametric and non-parametric tests were conducted.

Results

Information was available for 1540 people who attended the psychiatric service during the study period, but 40 were removed from our initial analyses as they did not meet all the inclusion criteria.

The mean age of the sample was 33 years (range 15–64). Other characteristics of the sample are shown in Table 1. A family history of mental illness was reported by 48.8% ($n = 732$) and 24.9% ($n = 373$) had a physical disability or

Table 1 Demographic and other descriptive data for the study sample of Afghan refugees ($n = 1500$)

	<i>n</i>	%
Gender		
Male	837	55.8
Female	663	44.2
Marital status of the respondent		
Single	186	12.4
Married	1251	83.4
Widowed	45	3.0
Widower	18	1.2
Level of education		
Primary	232	15.5
Matriculation	17	1.1
Uneducated	1251	83.4
Employment status		
Self-employed	462	30.8
Employed	231	15.4
Unemployed	807	53.8
Children		
Up to 2 years	396	26.4
3–5 years	302	38.1
6 years or more	267	33.4
Migration period		
1 year	249	16.6
2 years	1173	78.2
3 years	78	5.2

Table 2 Psychiatric morbidity among the study sample of Afghan refugees ($n = 1500$)

Primary diagnosis	Frequency	%
None	19	1.3
Major depressive episode: lifetime	63	4.2
Major depressive episode: current	34	2.3
Manic episode: current	3	0.2
Hypomanic episode: past	2	0.1
Panic disorder: current	27	1.8
Obsessive–compulsive disorder	5	0.3
Post-traumatic stress disorder	918	61.2
Substance dependence (non-alcohol)	163	10.9
Substance misuse (non-alcohol)	54	3.6
Psychotic disorder: lifetime	74	4.9
Psychotic disorder: current	57	3.8
Generalised anxiety disorder	81	5.4
Total	1500	100.0

Table 3 Frequency of disorders comorbid with post-traumatic stress disorder

Diagnoses	Frequency	%
None	573	38.2
Major depressive episode: current	211	14.1
Major depressive episode: lifetime	242	16.1
Manic episode: current	30	2.0
Manic episode: past	16	1.1
Panic disorder: current	47	3.1
Social phobia	6	0.4
Substance dependence	42	2.8
Substance misuse	80	5.3
Psychotic disorder: lifetime	16	1.1
Psychotic disorder: current	76	5.1
Generalised anxiety disorder	161	10.7

Table 4 Types of trauma experienced: differences between male and female respondents

	Male		Female	
	<i>n</i>	%	<i>n</i>	%
Bombardment	69	13.4	170	42.2
Watched a closed relative being killed	61	11.7	88	21.8
Watched other being killed	36	7.1	15	3.7
Shooting in combat	39	7.6	21	5.4
Witnessed dead bodies	38	7.3	39	9.7
Physical assault and torture	183	35.4	26	6.5
Lost body part owing to blast	19	3.7	9	2.3
Being held hostage	61	11.9	27	6.7
Other	10	1.9	7	1.7
Total	516	100.0	402	100.0

long-term illness. Only 13.1% ($n = 196$) had contacted health services previously to seek help with a psychiatric illness. Most of the refugees were Pashtun ($n = 1411$, 94.1%); other ethnic groups included Uzbek ($n = 29$, 1.9%), Tajik ($n = 20$, 1.3%), Hazara ($n = 12$, 0.8%), Turkman ($n = 4$, 0.3%), Baluch ($n = 8$, 0.5%) and Kizilbash ($n = 16$, 1.1%).

Table 2 shows the prevalence of psychiatric disorders and Table 3 the degree of comorbidity. Table 4 shows the frequencies of various types of trauma experienced by this sample according to gender.

Discussion

Most of the study population were unemployed, married and not formally educated; there were no significant gender differences in these respects. Most had a diagnosis of PTSD, but the rates of depression and anxiety were low. Therefore the rates of comorbid diagnoses indicated that depression and anxiety were distinct. Religious, cultural taboos could be the reason for low substance and alcohol misuse in this group.

Our patients reported a variety of traumatic events. While men reported mainly torture and assault, women were more commonly affected by the direct experience of bombardment. This is possibly because men were more likely to be directly involved in the war, while women remained at home.

The majority of our patients were Pashtuns. In a study conducted in the USA, the investigators found that the rates of psychiatric disorders and of war-related experiences among Afghans from different regions were different. Among the inhabitants of Nangarhar Province, the prevalence rates of both multiple traumatic events and PTSD were high (Scholte *et al*, 2004).

Limitations of the study

There could have been some selection bias, insofar as we studied people attending a mental health service. High rates of PTSD presentation were the core feature of this population. Also, the MINI scale was used to measure PTSD, whereas a more culturally appropriate PTSD scale might have yielded different results.

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COUNTRY PROFILE

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).

Malawi

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Malawi is a country with an approximate area of 118 000 km². Its population is estimated at 13 million and the gender ratio (men per hundred women) is 98. The proportion of the population under the age of 15 years is 47% and the proportion above the age of 60 years is 5%. The literacy rate is 75.5% for men and 48.7% for women (World Health Organization, 2005).

For administrative purposes, Malawi is divided into three regions, which are further divided into a total of 28 districts. The capital city is Lilongwe, which is situated in the central region, and the main means of travel between the capital and districts is by road.

The main languages used in Malawi are English and Chichewa. The largest ethnic group is Chewa and the other ethnic groups are Nyanja, Tumbuka, Yao, Nkhonde and Ngoni plus the Europeans, Indians and other foreign nationals. The largest religious groups are Christians followed by Muslims.

Health indicators

Malawi has high rates of infant and maternal mortality rates. The life expectancy at birth is 40 years for both males and females (National Statistical Office of Malawi).

Health services

There are very few doctors. Clinical officers, medical assistants and enrolled nurses comprise the backbone of Malawian

healthcare, but there are shortages of these health personnel, especially in the rural areas, as people prefer to practise in urban areas.

The smallest health unit in Malawi is the 'health post', which is manned by 'health surveillance assistants' (who have 10 weeks' orientation training). Each health post serves a small number of villages. Next in the referral hierarchy is the health centre, which is usually staffed by medical assistants (who have 2 years' training) and nurses. Patients who cannot be treated at the health centre are referred to the district hospitals, which are present in all but 3 of the 28 districts. There are four general tertiary referral hospitals, distributed in all three regions of Malawi, with two in the southern region, which is the biggest.

Mental health resources and services

Zomba Mental Hospital, which is situated in the southern region, is the only government tertiary psychiatric referral hospital in Malawi. It has 333 beds and on average admits 1500 patients per year. There is a smaller psychiatric unit in the central region, in Lilongwe, with about 30 beds, and this is run as part of Kamuzu Central Hospital, which is the tertiary referral hospital in the central region. Psychiatric patients from the northern region are usually referred to a missionary hospital, St John of God in the city of Mzuzu, which has 50 in-patient beds and which runs an effective

Table 1 Government mental health facilities at different healthcare levels

Level	Facilities	Staffing	Services offered
Tertiary	Zomba Mental Hospital	One psychiatrist One psychiatric clinical officer Twenty psychiatric nurses Five general clinical workers Four general nursing workers One occupational therapist	Long-stay care Forensic services Hospital day care Acute in-patient care Community services Rehabilitation services Occupational therapy Out-patient care
Secondary (district hospitals)	Only two have a psychiatric ward	From one to six psychiatric nurses ¹ Variable numbers of general clinical and nursing workers	Acute in-patient care Out-patient care Community services Medium-stay care Outreach clinics Referral to Zomba Mental Hospital
Primary (district health centres)	No psychiatric wards	General nurses (sometimes enrolled psychiatric nurses) General health workers (clinical/medical officers)	Minimal out-patient care Referral to district hospitals

¹Psychiatric nurses are often redeployed to general medical and surgical services, resulting in diminished delivery of mental health activities in the district hospitals.

community programme. In total there are therefore just over 400 psychiatric beds for the entire population.

The commonest reasons for admission to Zomba Mental Hospital are schizophrenia, bipolar disorders, intellectual disability, epilepsy, and substance-related and HIV-related conditions (according to hospital statistics for the year 2005). Nearly all patients admitted present with severe forms of these conditions.

Mental health services in all the districts fall under the office of the district health officer and the associated expenditure is included in the district's health budget. As with the other general tertiary hospitals, Zomba Mental Hospital has its own budget.

Public psychiatric services fall under clinical services (curative) within the Ministry of Health. The resources in terms of facilities and staffing at the different care levels are summarised in Table 1.

Staffing

There is only one psychiatrist for the entire population of Malawi, but since he is based in Zomba, the old capital city, the psychiatrist:population ratio is 0 for the rest of the country.

There are no professional social workers and only one occupational therapist, at Zomba Mental Hospital. There are two clinical psychologists attached to the College of Medicine in Malawi, who teach medical students; they do not do any clinical work in the psychiatric hospitals.

The district psychiatric nurses do weekly outreach clinics, visiting different health centres and health posts within their districts; the management team from Zomba Mental Hospital visits each district twice a year to monitor mental health activities throughout the country.

World Mental Health Day

World Mental Health Day is celebrated publicly every year in a selected district. Posters, T-shirts and leaflets explaining mental health issues are distributed to the public for free at the chosen venue. The public's response to this has always been very encouraging.

Mental health policy and legislation

The old 2000–04 policy is still being used while it is awaiting review. This policy includes the integration of psychiatric services into the primary healthcare system, the appointment of a national mental health coordinator at the Ministry of Health's headquarters and a human resources development plan.

The Mental Treatment Act was enacted in 1959 and amended in 1968. A Mental Health Bill is awaiting review by stakeholders and later parliamentary amendment; it is anticipated that it will be passed in 2007. It compares well with legislation in countries such as South Africa and Kenya, and includes the formation of a mental health review board, which will monitor the care and treatment of psychiatric patients in hospital. It covers areas such as admissions, the rights of in-patients and the safekeeping of patients' property.

Training

Undergraduate medical students

There is one medical school, the Malawi College of Medicine, which is part of the University of Malawi, in Blantyre. As part of their MBBS course, students in the third year have 2 weeks of psychiatry theory and in the fourth year they undergo a 5-week rotation in theory and clinical work.

Other health workers

The two main health sciences colleges offer training of para-medical staff – the clinical officers, medical assistants and enrolled nurses. Clinical officers can go for further training in specific areas and become psychiatric clinical officers, orthopaedic clinical officers and so on. Plans are being finalised to train district primary health workers in the management of common psychiatric disorders. Currently, most primary health workers lack skills in the assessment and management of psychiatric patients and end up referring all those they come across.

Postgraduate specialisation

The College of Medicine at the University of Malawi has offered postgraduate training only since 2005 in certain specialties, in conjunction with certain universities in South Africa. This does not include psychiatry, so all psychiatric training at present has to be done outside Malawi.

Psychiatric nurses

The St John of God College of Health Sciences provides a degree in psychiatric nursing for registered state nurses with a minimum of a university diploma in nursing, and the Malawi College of Health Sciences provides a certificate course in psychiatry for enrolled nurses.

Research

Mental health in Malawi has been the subject of several research projects. These have included studies in psychoactive substances, the teaching of psychiatry in the colleges and attributions for admissions to Zomba Mental Hospital (MacLachlan *et al*, 1995). More studies are under way or being developed by Zomba Mental Hospital on, for example:

- community attitudes to and knowledge of mental illness
- the prevalence of HIV and neurosyphilis among in-patients
- district mental health activities in southern Malawi, including what proportions of the district budgets are allocated to mental health
- common causes of relapse and readmission in patients with schizophrenia
- pathways to care for psychiatric patients
- neuropsychological sequelae of cerebral malaria.

At the St John of God Hospital a randomised controlled trial of carer education in schizophrenia and bipolar disorders is under way.

In general, there is not much information on mental health in the Malawian context and this provides opportunities and challenges for research.

Professional organisations

In the past there was a Mental Health Association of Malawi, but it stopped functioning, for unknown reasons, around 1999. At present, a 'core group' is being formed, comprising: the psychiatrist at Zomba Mental Hospital; the clinical psychologist at the Malawi College of Medicine; the chief nursing officer at Zomba Mental Hospital; and the psychiatric clinical officer at the St John of God Hospital. The main goal of this core group is to develop the preliminary constitution of a new professional association and to recruit members. Some of the functions of the association will be:

- to deal with challenges in mental health
- to act as an advisory body to the Medical Council of Malawi on the registration of mental health professionals
- to develop, review and conduct policy for mental health professionals.

There are at present no non-governmental organisations operating in the mental health field in Malawi.

Challenges

Notable problems include a critical shortage of trained staff and frequent shortages of drugs owing to procurement problems. The referral system is not very good; neither is follow-up care, as most district psychiatric services seem to be insufficiently well developed.

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COUNTRY PROFILE

Mental health and psychiatry in Thailand

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Thailand is located in Southeast Asia and covers an area of 513 115 km². In 2006 its population was approximately 64 million. The major nationality is Thai. About 80% of the total population live in rural areas. The country is composed of 76 provinces, divided into a total of 94 districts and 7159 sub-districts.

Prevalence of mental illnesses

The latest data concerning the prevalence of mental disorders in Thailand were obtained from a national survey conducted in 2003. The survey was a two-step cross-sectional community survey using AUDIT (Alcohol Use Disorders

Identification Test) and MINI (Mini-International Neuropsychiatric Interview). There were 11 700 participants, aged 15–59 years, selected by stratified two-stage cluster sampling. The top three problems found (1-month prevalence) were alcohol use disorders (28.5%), major depressive disorder (3.2%) and generalised anxiety disorder (1.9%) (Siriwanarangsang *et al*, 2004).

Mental health policy and legislation

The current mental health policy was formulated in 1995. Its main components are advocacy, promotion, treatment and rehabilitation, but it also includes sections on administration and technical development. The policy plan is to promote mental health and prevent mental health problems, to expand and develop treatment and rehabilitation services, to develop a management system to reform all aspects of mental health services, and to develop modern psychosocial and other technical knowledge in order to apply them fruitfully to Thailand's mental health situation (World Health Organization, 2001).

There is at present no mental health legislation, although a Mental Health Bill, which was drafted by the Department of Mental Health and then revised according to suggestions from service providers, carers and ex-patients during a public hearing process, has been submitted to parliament. However, parliament was dissolved in February 2006 following an army coup and we must now wait until we get a new parliament to approve the Bill. The Mental Health Bill is, in essence, similar to the legislation enacted in other countries, in that all persons in need of psychiatric treatment either will be able to access it voluntarily or will be compulsorily brought to a hospital for evaluation and to receive treatment.

The healthcare system

The system was originally set up (before 2001) so that those with a medical problem were expected to consult first in the primary care setting; then, if necessary, they would be referred to secondary and if necessary tertiary care. (These services are described below.) However, in reality, patients could go directly to any level they chose. Many were first seen at secondary or tertiary settings, including university hospitals. Except for those with a psychosis, referral of patients from primary to secondary care seldom happened – patients were referred directly to a tertiary service or a psychiatric hospital.

Since the last government introduced the policy of universal coverage under its '30 baht healthcare scheme' in 2001 (30 baht is approximately 0.60 euros), referral systems have been strengthened. Under this scheme, people who have no health insurance must register with a nearby hospital. If they are ill, they can go to that hospital and pay the hospital only 30 baht per visit. This covers all kinds of treatment, from medication to open-heart surgery. If doctors at the registered hospital cannot treat that patient for any reason, they will refer the patient to a larger hospital, which will in turn send the bill for reimbursement back to the first hospital.

The government allocates a yearly budget to each hospital according to its number of registered patients. The hospitals received 1202 baht per registered patient per year in 2003, which increased to 1308 baht in 2004, 1396 baht in 2005 and to 1659 baht for 2006. This budget is meant to cover all expenses, including salaries, equipment and materials. Under this scheme, patients now are unable to visit a doctor in a secondary or tertiary care setting without a referral letter from the registered hospital, unless they are prepared to pay all of the expenses out of their own pocket (Udomratn, 2006). In October 2006, the new interim government scrapped payment of 30 baht per visit but the system remains the same.

Primary care services

These cover all areas of the country and fall under the administration of the Ministry of Public Health, except in Bangkok, which is under the Bangkok Metropolitan Administration. The services located nearest the local communities are the sub-district health centres, each of which is run by three or four health workers. Their main function is the prevention of illness, although they also provide treatment for simple illnesses or problems. If the problem is beyond their ability they refer the patient to the district (community) hospital. There are about 8800 sub-district health centres covering the whole country.

The second level of primary care service is the district hospital, which typically has one or two physicians, between five and seven nurses and 10–30 beds. The largest district hospital has 120 beds. Out-patient services are the main provision. Currently there are approximately 695 district hospitals in Thailand.

Secondary care services

These are the responsibility of the general hospitals, which typically have 100–120 beds and are located in each of the 76 provinces. A few provinces have two general hospitals. Typically, five specialised services (medicine, paediatrics, surgery, obstetrics and gynaecology, and orthopaedics) are provided by the general hospitals. There may be a psychiatric unit in the general hospital, but this will usually be supervised by a non-psychiatrist physician and a psychiatric nurse: only about a third of the general hospitals have a psychiatrist as the head of the psychiatric unit.

Tertiary care services

There are about 20 tertiary care hospitals, with 150–200 beds or more, located in the larger provinces. Patients with complications are referred from primary and secondary care. More specialists are available in these hospitals and some have psychiatric staff.

Medical school hospitals also provide tertiary care. There are eight medical schools in seven universities in Thailand. One is under the control of the Ministry of Defence and one is run by a private organisation.

Mental health services

Before 1964, all mental health activities were located in mental health or psychiatric hospitals. Psychiatrists and their colleagues acted as the sole providers of services. During the First to Third Five-Year National Health Plans (1962–76),

Table 1 Mental health personnel and proportion to the whole population, by region¹

Region	Psychiatrists		Psychiatric nurses		Psychologists		Social workers	
	<i>n</i>	Ratio ²	<i>n</i>	Ratio ²	<i>n</i>	Ratio ²	<i>n</i>	Ratio ²
Bangkok	218	1:26267	173	1:33099	42	1:136338	117	1:48942
Central	75	1:195374	481	1:30464	44	1:333023	78	1:187859
North	31	1:391111	308	1:39365	45	1:269432	84	1:144338
North-East	39	1:551120	551	1:39009	48	1:447785	61	1:352356
South	24	1:346315	222	1:37439	17	1:488916	33	1:251866
Total	387	1:161005	1735	1:35913	196	1:317902	373	1:167048

1. Data from the Department of Mental Health, Ministry of Public Health, 2003.

2. Ratio: ratio of staff to regional/national population.

mental health activities were extended to community health services.

Nowadays psychiatric care is provided in the government, private and non-governmental sectors. The public sector, mainly supported by the government budget, includes the Ministry of Public Health, the Ministry of Education, the Interior Ministry, the Ministry of Defence and the Office of the National Police. The Ministry of Public Health includes the Department of Mental Health, the Office of the Permanent Secretary and the Medical Department, which oversees many psychiatric units and psychiatrists.

All government hospitals face the problems of too many patients, lack of staff and under-financing. Most hospitals have additional income from fees and donations, but even so their total expenses are almost always higher than their total income.

At the moment there are about 400 psychiatrists working in Thailand. Most are public sector employees who also have a private practice outside their official hours. Not only is the number of psychiatrists insufficient but there is also a lack of other mental health personnel (Table 1), especially occupational therapists, of whom there are only 49 nationally (ratio 1:1271610). Moreover, the distribution is also skewed, with more than half the total number of psychiatrists working in Bangkok (Table 1) and most of the rest working in the other big cities.

Most specialised care is offered by the psychiatric hospitals. In 2001, there were nine of these, with a total capacity of 8893 beds (Boonyawongvirot, 2003). They provide in-patient services, out-patient clinics, emergency services, rehabilitation services, education and training, and mental health promotion and prevention services. There are also two mental health centres, which provide out-patient services and which emphasise mental health promotion and prevention. There are also two sub-specialty psychiatric hospitals, the Forensic Psychiatric Hospital and the Institute of Mental Health for Children and Family.

Problems of the mental healthcare system

The main problems to be found in the mental healthcare system in Thailand can be summarised as follows:

- The number of mental health workers is insufficient (see Table 1).
- General physicians and general practitioners are not confident in the assessment and management of psychiatric patients. Some psychiatric disorders, especially depression, are under-diagnosed, whereas other diagnoses are made too often, such as anxiety disorders. Many patients receive anxiolytic or antidepressant medication in sub-therapeutic

doses. (Patients with a psychosis are an exception, as most are directly referred to psychiatric hospital.)

- The primary and secondary care services have little opportunity to care for psychiatric patients during the continuation and maintenance phases of their illness because of limited supplies of medications. District hospitals usually have only haloperidol for schizophrenia and amitriptyline or imipramine for depression. Although the Ministry of Public Health added fluoxetine (generic) to the list of essential hospital drugs a few years ago, only the central hospital and a few general hospitals are able to supply this. Atypical antipsychotics have only just been supplied to psychiatric hospitals, university hospitals and some central hospitals, but they are not covered by health insurance unless the medical committee of the hospital decides, on a case-by-case basis, that they are necessary. The shortage of psychiatric drugs at local hospitals, the long distances that patients have to travel to get treatment, and the high cost of travel (because of increasing fuel prices) are also problems for continuation of treatment.
- Patients and their families have a poor understanding of psychiatric disorders. In the case of psychoses, most have some knowledge about the symptoms but tend to believe that they were caused by stress, worry or supernatural influences. This may result in patients discontinuing their treatment early.
- During the continuation and maintenance phases of treatment, even though some mental health teams in general hospitals can monitor symptoms, adjust the doses of drugs and provide psychosocial intervention, often the patients and their families still prefer to see a psychiatrist, and this overloads many psychiatrists in tertiary care.

Role of carers

In January 1995, the PRELAPSE (Preventing Relapse in Schizophrenia) programme was introduced in Thailand. This was implemented in five psychiatric hospitals under the Department of Mental Health. Preliminary results showed that for patients with schizophrenia whose families joined this programme, the readmission rate decreased by 44% and the length of hospital stay decreased for 50% of patients (Udomratn, 1999). After evaluating these preliminary results, the Department transformed this programme into the 'Technology for Caring Relatives of Schizophrenic Patients' programme and some hospitals integrated it into their routine services. Many relatives who joined in the educational activities later agreed to meet regularly and formed clubs at various psychiatric hospitals

throughout the country. These clubs went on to form the Association for the Mentally Ill (AMI), in 2003. The AMI now receives funding from the Thai Health Promotion Foundation, the Health Systems Research Institute of Thailand and other agencies. The AMI has contributed to many activities related to mental health promotion and prevention, and to increasing awareness of mental health problems in Thailand.

Conclusions

Psychiatric services in Thailand, as in many low- and middle-income countries, still face shortages of mental health workers. Mental health problems are not well recognised by general practitioners. Patients' poor understanding of psychiatric disorders causes a delay in seeking help and frequently early discontinuation of drug treatment.

Many strategic plans have been initiated by the Thai Department of Mental Health, with the aim of increasing

human resources and providing a better quality of care in both general and psychiatric hospitals. Destigmatisation campaigns have been run. We expect a brighter future for Thai psychiatric patients and their families within the next decade.

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COUNTRY PROFILE

Lebanon

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Lebanon is a western Asian country with an area of 10452 km² and a population of around 4 million (excluding the 10 million Lebanese immigrants worldwide). It has approximately 60 psychiatrists, mostly concentrated in the capital, Beirut, although a trend for decentralisation is currently observed. The number of psychiatrists is steadily increasing as postgraduate training centres have been established during the past decade. There are, however, few sub-specialists, owing to a lack of adequate training programmes.

Training

Undergraduate training

Six schools of medicine offer medical undergraduate education. The 7-year curriculum includes courses on psychology, psychopathology, psychotherapies and general psychiatry. A typical example would be the undergraduate training programme at the American University of Beirut Medical School, where the Department of Psychiatry offers an undergraduate course to 'Med II' students and a clinical clerkship to 'Med III' students, as well as clinical electives to interns and residents. It also provides training and supervision for psychologists. The course covers:

- *Psychopathology*. A DSM-IV-based course introduces Med II students to normal and abnormal psychological

mechanisms as well as the classification and pathophysiology of psychiatric illnesses.

- *Clinical clerkship in psychiatry*. Third-year medical students spend 1 month working on psychiatric cases and attending morning rounds on a psychiatric service. They are supervised by an attending psychiatrist. Students also attend the psychiatry clinic in the out-patient department, where they see new cases and prepare seminars.

The rotation also includes seminars on psychopathology, case presentation and discussions, interview techniques and basic psychotherapy, as well as psychopharmacology. Seminars are held daily and are supervised by the faculty members.

Postgraduate training

Psychiatrists go through a 4-year postgraduate training programme provided by two universities. This includes a 1-year rotation on medical wards (with a specific focus on neurology) as well as exposure to child, adult and geriatric psychiatry through in-patient psychiatric wards and out-patient facilities. One of these universities (Saint Joseph University, which, since the 1980s, has been affiliated to the Saint Anne Psychiatric University Centre in Paris, France) requires six research subjects, a university diploma in cognitive-behavioural therapy (CBT) and passing a neuropsychiatry examination in order to grant the specialty certificate; the other requires passing the Arab Board of Psychiatry examination (in its three parts).

Professional bodies and legislation

The Lebanese Psychiatry Association (LPA), founded in the mid-1980s, has a membership of 65 psychiatrists. It holds regular meetings, sponsors psychiatric seminars and closely follows – with the Lebanese Order of Physicians (LOP) – the drafting of legislation. In the absence of national programmes aimed at raising public awareness of psychiatry and mental health, the LPA works with the appropriate authorities to establish a new state strategy that incorporates psychiatry within the core of public health. Such efforts were rewarded in 2000, when, following a study on benzodiazepine use in the Lebanese population (after the war), which found a usage rate of 9.6% and a dependence rate of 50.2% among users (Naja *et al*, 2000), a state law was passed that prohibited selling these drugs without a medical prescription.

The mental health model in Lebanon

The mental health model in Lebanon has always combined the private and government sectors. Psychiatrists in private practice depend on private general hospitals to admit their patients, some of whom have these costs met by the public sector. Private insurance does not cover mental health, but the cover provided by public sector agencies does (e.g. that provided by social security, the armed forces and civil service unions). There are no governmental mental health institutions as such, and the public sector contracts for beds in private general hospitals.

There are two mental hospitals in Beirut: one that is run by the Order of the Cross, which has a capacity of around 1000 beds, including beds for acute, chronic, child and geriatric patients, as well as facilities for rehabilitation, drug misuse and day care; and the Islamic Mental Hospital, which has a similar capacity, layout and facilities. There is a third such institution in the south of the country – the Fanar Hospital, which is run by a private board. All three hospitals have a relatively high degree of stigmatisation and therefore cater mainly for psychiatric patients with a low degree of social integration.

Recently there has been a vast improvement in public general health services and therefore there is a campaign for a training programme for general practitioners, contracted by the government, in primary care mental health. With this in mind, steps were taken by the Ministry of Health to aid such a programme, taking into consideration the following:

- Research projects are to be funded by agencies and not by the Ministry of Health.
- The majority of health services (including mental health) are private and the government contracts with the private sector for services.
- All 60 or so psychiatrists are in private practice and the majority work with private institutions.
- The mental institutions (which are all private) carry the burden of maintaining a database, of quality assurance and consequently of conducting statistical and epidemiological surveys. They are funded to do so, however, through the Ministry of Health's contracts for in- and out-patient care,

and so the data should be available to the Ministry.

- Non-governmental organisations are doing an adequate job in the south but should be further encouraged, since Ministry funds should be reserved for services needed in the whole country.
- Psychologists do not have a professional association, and there are no licensing laws for their practice.
- Awareness and anti-stigma programmes are available through international organisations. Already, anti-stigma programmes for schizophrenia and Alzheimer's disease are under way, with the support of two drug companies.
- Legislation is a very delicate issue as there is no updated Mental Health Act. So far, there have been no problems in consequence, but mental health should have a separate section or department at the Ministry, to handle all policies regarding mental health.
- As part of an ongoing evaluation of services provided by the Ministry, the cost-effectiveness of mental healthcare is being assessed.
- Mental health programmes proposed within the eastern Mediterranean region have been only partially implemented in some countries because of their 'over-ambitious' scope. All eastern Mediterranean countries have a centralised health delivery system except for Lebanon (as it is mostly in private hands). A mental health programme as such would be likely to have a similar fate; instead, improvements to services at different levels and at different times would be much more applicable and beneficial. These considerations led to a strategy for a primary care mental health programme, with partial incorporation of mental health services into primary care, featuring education programmes in mental health for general practitioners, along the following lines:
 - A part-time psychiatrist will be appointed to each primary care centre. The psychiatrist will be paid per weekly visit made. The object of such visits will be consultation on psychiatric patients presented by the general practitioners. Visits can be adjusted according to the needs of each centre. The visits will also feature a form of clinical seminar, where cases are discussed with the general practitioners.
 - Psychiatrists will be appointed to the government general hospitals. Their role will be to provide a consultation-liaison service to the hospital and to provide in-patient psychiatric care (the number of beds allocated for the purpose will need to be five to ten or more, depending on the catchment areas of the hospital).
 - Therapeutic teams will be created, comprising a psychiatrist, social worker and nurse, and psychologists can be available on demand.
 - Ongoing monthly seminars will be given on various mental health topics relevant to general practice.

Psychogeriatric services

The age profile of the Lebanese population is shifting, as a higher proportion of its population reaches older ages. The existing services will not meet future needs. Although there are private homes that cater for the elderly, there are insufficient beds. A community-based system is needed, spearheaded by the Ministry of Health. This would be more cost-effective than the provision of in-patient beds for the elderly. This programme will be part of the primary care out-patient system, with the addition of a geriatrician and nurses

to make domiciliary visits to monitor, and sometimes administer, home care, and also to help families to care for their elderly relatives. Greater public awareness and destigmatisation programmes will also be necessary. In-patient acute care will be in geriatric units in general hospitals. Such a system will minimise the back-log of admissions to homes for the elderly, which will be reserved for advanced cases.

Research and publications

In the absence of state financial support and because of the multiple wars that have devastated Lebanon, research work is still in its infancy. Nevertheless, some studies have, for example, found similar epidemiological characteristics in the Lebanese psychiatric population to those described in the literature for other countries. Other studies have examined the consequences of the war on psychiatric health, including

post-traumatic stress disorder, benzodiazepine misuse and alcoholism. New publications have even appeared in the field of biological psychiatry.

Conclusion

Psychiatry in Lebanon is moving towards an increase in resources and capacities. The process of health sector reform will undoubtedly give psychiatry its place in the medical community.

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SPECIAL PAPER

Reform of the mental healthcare system in Greece, 1984–2006

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Greece joined the European Community in 1981 and, 3 years later, the Commission of the European Communities provided financial and technical assistance under EEC Regulation 815/84 for the modernisation of the Greek mental healthcare system, with an emphasis on decentralisation and the development of community-based services, as well as the deinstitutionalisation of long-stay patients and improvement of conditions in public mental hospitals.

Over the past 20 years, public sector psychiatry in Greece has shown notable progress in deinstitutionalisation and the development of rehabilitation services. The role of the large mental hospitals has gradually diminished. In the area of primary care, however, progress has been rather slow. Utilisation and training of primary care physicians have not been given the priority they deserve and much remains to be done in the areas of primary psychiatric prevention and sensitisation of the public to mental health issues, in spite of notable exceptions (e.g. the Athens Mental Health Promotion Project, 2003).

In the early 1980s, psychiatric care in Greece was largely based on nine overcrowded, inadequately staffed public mental hospitals, and on a number of private mental hospitals (Christodoulou, 1970; Madianos, 1983; Stefanis *et al*, 1986). Community-based mental health services were underdeveloped and there were no psychiatric units in

general hospitals. Thus, mental health services could not meet the needs of the population (Madianos *et al*, 1993).

The urgent need to establish psychiatric units in general hospitals and to improve psychiatric education, as well as for more specialised training, full utilisation of other mental health professionals and revision of mental health legislation, had been stressed since at least 1970 (Christodoulou, 1970).

Reform

Reform of mental healthcare became imperative in 1983 within the context of planning for the new National Health System in Greece. Law 1397/83, especially article 21, provided the basis for the decentralisation of psychiatric services (Sarantidis *et al*, 1992; Madianos *et al*, 1999a).

The Greek government undertook revision of the psychiatric care system by developing a 5-year plan. As part of the response to a request from the Greek government for financial support, EEC Regulation 815/84, Programme B, was adopted in 1984 and provided a grant of 120 million ECU. The strategic objectives of the 5-year plan (1984–89) in fact extended beyond 1989, up to 1995, and emphasised decentralisation of mental health services and the development of community-based services, deinstitutionalisation of

Table 1 Numbers of patients in public mental hospitals, 1984–2006

	1984	1987	1990	1993	1996	2000	2004	2006	% change, 1984–2006
Total number of patients (1-day census)	7487	7370	6504	5770	4765	3315	2564	2022	–73.0
Number of long-stay patients (stay > 36 months)	5677	4925	4408	3747	3062	2922	1898	1091	–80.8
Proportion of patients who were long stay, %	75.8	66.8	67.8	64.9	64.3	88.1	74.0	54.0	

long-stay patients and improvement of conditions in the public mental hospitals, with special attention to the Leros Mental Hospital (Bouras *et al*, 1992; Christodoulou *et al*, 1994, 1999; Zissi & Barry, 1997). In 1989, the Hellenic Psychiatric Association, following an evaluation by a task force, prepared a comprehensive report on the Leros asylum (Hellenic Psychiatric Association, 1989) and made a number of recommendations to the Greek Ministry of Health. One of these was the placement of a substantial number of patients, after appropriate preparation, in sheltered housing on the mainland. This was implemented by the Ministry with the financial and technical assistance of the European Union (EU) in 1990 and heralded the deinstitutionalisation of a great number of the then 1150 chronic patients at the asylum (Christodoulou *et al*, 1999).

In 1997 a new multidimensional programme for the completion of the psychiatric reform, named Psychargos, was submitted to the EU and approved in 1998. This programme is divided into three phases: A, 1998–2001; B, 2002–06; and C, 2006–15. The main goal of the programme is the deinstitutionalisation of the remaining 3000 long-stay patients, with a parallel development of a total of 616 mental health services, residential alternatives and rehabilitation units.

This paper examines the first strategic objective of the 20-year psychiatric reform programme: the deinstitutionalisation of the long-stay patients in the nine public mental hospitals and the shift to extramural care and rehabilitation.

The setting

Greece has a total area of 132 000 km². In the 2001 census the total population was found to be 10 939 605, of whom 3 756 607 lived in the Athens metropolitan area. The majority of the population (60%) live in urban areas and the rest (40%) in semi-urban and rural areas. In this census, some 800 000 persons were identified as foreign immigrants, mainly from Albania, Bulgaria, Poland, other Balkan countries and the Middle East. The age distribution of the population was as follows: 0–14 years, 16%; 15–64 years, 68%; and 65 years and over, 18%. In that census, 48% of the population were classified as dependent persons.

Administratively, the country has 54 prefectures (*Nomos*) and 13 regions (each region consists of several prefectures). It should be noted that, in the majority of regions, the main towns of the prefectures are not far from the capitals of each region.

The social security system covers 100% of the population for illness and 95% for disability and old age pensions. In 1995 the employment make-up by the main sectors of economic activity was found to be agriculture 21%, industry 29%, services 46% and administration 5%. The unemployment rate in 2003 was 10.8% of the labour force.

The study

To explore the effect of the psychiatric reform programme on patterns of psychiatric care, the following two groups of indicators were selected:

- quantitative trends (1984–2006) in the development of decentralised services and their regionalisation
- mental hospital in-patient population censuses.

Data that cover the period 1984–2006 concerning the establishment of new decentralised mental health services were obtained from DATAPSY, a database constructed by the Monitoring and Evaluation of Mental Health Services Unit (MEMHSU) on behalf of the Department of Mental Health of the Ministry of Health and Welfare. These data relate to: psychiatric bed numbers in general hospitals; various types of extramural services; the numbers of places in day hospital/care facilities and psychosocial rehabilitation services; and the numbers of beds in residential alternatives. Population-based ratios were computed on the basis of the 1971, 1981, 1991 and 2001 population censuses.

Findings

The number of long-stay patients in public mental hospitals between 1984 and 2006 decreased by 80.8% and the total number of patients was reduced by 73.0% (Table 1).

In Table 2, the trends in the numbers of patients in eight of the remaining public mental hospitals over the period 1984–2006, and projected to 2012, are shown. In 1984 and 2006, the numbers of patients in a day's census in all public mental hospitals were 7487 and 2022 respectively. Three mental hospitals were closed in 2006 and by the end of the same year another hospital was due to have been closed. By 2012, three more mental hospitals are due to be closed. By then there will be only 130 long-stay (geriatric) patients, at the Leros Mental Hospital, living in small pavilions.

Table 2 Trends in the public mental hospital population and planning for mental hospital closure, 1984–2012

Mental hospital	1984	2000	2004	2006	2012
Attica	1950	831	640	728	To be closed
Dromokaition	880	555	419	493	To be closed
Thessalonica	1000	581	526	254	To be closed
Petra Olympou	500	260	51	Closed	–
Chania (Crete)	416	250	167	Closed	–
Corfu	416	280	120	Closed	–
Leros	1905	538	495	469	130
Tripolis ¹	420	220	124	78	–
Total	7487	3515	2542	2022	130

Note: Eginition University Hospital beds (60) are not included.

1. To be closed by the end of 2006.

Table 3 Alternative mental health services: numbers of psychiatric beds in general hospitals, extramural facilities and psychosocial rehabilitation places and residential beds, 1984–2006

	1984	1987	1990	1993	1996	1999	2006	% change, 1984–2006
Number of beds in general hospitals	36	99	281	306	327	407	646	+1694.5
Number per 1000 population ¹	0.004	0.01	0.03	0.03	0.03	0.03	0.06	
Number of community mental health centres ²	7	15	19	23	33	41	45 ³	+542.8
Number of child guidance clinics	8	12	22	24	24	28	30	+275.0
Number of out-patient departments in general hospitals	20	38	43	51	56	56	70	+250.0
Total number of extramural services	35	65	84	98	113	125	145	+314.3
Number per 100000 population	0.34	0.63	0.81	0.95	1.10	1.20	1.32	
Number of places in day hospitals/care centres	55	295	258	381	369	390	941	+1610.9
Number per 1000 population	0.005	0.02	0.02	0.04	0.04	0.04	0.08	
Number of places in psychosocial rehabilitation services	195	315	779	1603	1643	1780	3080	+1479.5
Number per 1000 population	0.01	0.02	0.06	0.1	0.2	0.2	0.3	
Number of beds in residential alternative facilities	15	25	359	540	1052	1962	4026	+2674.0
Number per 1000 population	0.001	0.002	0.03	0.05	0.1	0.2	0.3	

¹Psychiatric beds in general hospitals, extramural facilities, and psychosocial rehabilitation places and residential beds (per 1000 population).

²Fifteen community mental health centres also provide services for children and adolescents by multiprofessional teams.

³Thirty-four in operation.

It should be noted that the number of beds in the private mental hospitals decreased from 4817 in 1984 to 4007 in 2006. There is no provision for their future increase.

With regard to the length of stay in mental hospital, there was a significant reduction (78.5%) in the average number of in-patient days between 1984 and 2003. During the same period, a gradual development of community-based mental health services of all types took place (Table 3). The number of psychiatric beds in general hospitals reached 646 in 2006, whereas there had been only 36 in 1984. However, the corresponding population-based ratio is still low, at 0.06 beds per 1000 inhabitants.

Extramural facilities, including community mental health centres, child guidance clinics and out-patient departments, showed an enormous increase in number. In 1984 there were only 7 community mental health centres, but there were 19 in 1990 and 45 by 2006. Similarly, the number of child guidance clinics increased by 275% between 1984 and 2006 (Table 3). There was also a marked increase in the number of mental health personnel working in the extramural services.

The increase in the total numbers of extramural facilities is also reflected in their increased ratios per 100 000 inhabitants: from 0.34 in 1984 to 1.32 in 2006. Places in day hospitals, psychosocial rehabilitation services and residential alternatives were also dramatically increased, or even created where previously there were none. However, the number of places in day hospitals per 1000 inhabitants still appears to be low compared with the population-based ratios in other rehabilitation facilities.

With respect to the regional variations in the establishment of alternative mental health services, although the majority of facilities were established in Athens and other big cities, significant numbers of mental health services of various types have been established throughout Greece.

Comment

It appears that between 1984 and 2006 profound changes took place in the mental health scene, especially in the public mental hospital sector. The data presented above provide quantitative evidence of progress in the following areas:

- transformation of the public mental hospitals, with the parallel deinstitutionalisation of long-stay patients (Madianos *et al*, 1999b)
- decentralisation of the mental health services by provision of community-based structures, especially alternatives for community placement of discharged long-stay patients (Zissi & Barry, 1997; Madianos, 2002).

In fact, the implementation of EEC Regulation 815/84, Programme B, within the period 1984–95, and the new Psychoargos programme have contributed to the gradual discharge of thousands of psychiatric patients. Nationwide, the programme provided the possibility of immediate deinstitutionalisation of 889 patients through placement in 68 hostels and sheltered apartments, between 1999 and 2001. It is of note that the programme contributed to a significant shift towards extramural care and rehabilitation, with a total of 264 services in 1995.

The reduction in the number of beds in public mental hospitals has not been accompanied by an increase in the number of beds in private psychiatric hospitals, where a reduction has also been recorded. A similar finding was reported by Tansella *et al* (1987) in Italy.

By 2006 the number of long-stay patients was found have fallen to 1091, from 5677 in 1984; obviously, these hundreds of patients will require further rehabilitation and community integration. It is true, for example, that few of the patients who receive occupational rehabilitation training eventually find a job consistent with the training they have received. In fact, most patients do not find a job at all, for a variety of reasons, including the high unemployment rate, particularly in the 25- to 30-year age-group.

Finally, the closure of the public mental health hospitals within 10 years, a policy already practised in other European countries (Thorncroft & Bebbington, 1989; Hall & Brockington, 1991), seems to be realistic. In addition, legislation (Law 2716/99) on the sectorisation of mental health services has introduced the basic legal and managerial framework for the completion of the psychiatric reform.

In conclusion, it is evident that public health psychiatry in Greece has made significant progress in the areas of deinstitutionalisation, decentralisation and rehabilitation. It is widely accepted that implementation of the psychiatric reform programme (1984–2006), despite some inadequacies and

constraints, has had a significant, positive impact on mental health. On the other hand, much remains to be done in the areas of primary care, prevention, integration of psychiatric and medical services, evaluation of the quality of extramural services and the quality of life of the patients in these services.

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SPECIAL PAPER

Attitudes towards mental illness in Uganda: a survey in 18 districts

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Uganda, in common with many countries in sub-Saharan Africa, has many population risk factors predictive of high levels of mental disorder but poor coverage of mental healthcare (Kigozi, 2005). Recent population studies conducted in Uganda have shown rates of disorder in excess of 20% (Kasoro et al, 2002; Bolton et al, 2004; Ovuga et al, 2005) and the survey by Kasoro et al (2002) showed a high prevalence of patients with severe mental illness and poor access to services. There are 19 psychiatrists for 24.8 million people in Uganda, all but one of whom is based in the capital city, Kampala (Kigozi, 2005). The provision of mental health services relies on the use of psychiatric clinical officers (a cadre of trained mental health workers, similar to community psychiatric nurses, who currently cover 18 of the 56 districts in Uganda), primary care personnel, non-governmental organisations and members of the community. Liaison with traditional healers is encouraged (Ovuga et al, 1999).

In addition to poor access to services, it is possible that ignorance and stigma prevent people with mental illness

from seeking appropriate help, and that community attitudes and beliefs play a role in determining help-seeking behaviour, as well as the success of treatment (Hugo et al, 2003). A strong element in the culture of Uganda is the collective nature of the people and this can be utilised in enhancing services. In order to develop mental health policy and services in Uganda, there is a need to establish a series of estimates of the extent of psychiatric disorder and knowledge of local idioms, beliefs and management (Boardman & Ovuga, 1997). The aim of this study was to examine community attitudes toward mental illness in urban and rural Uganda.

Methods

The study was carried out in 2002–03, when one of the authors (V.W.) was working as a visiting psychology lecturer at Mbarara University of Science and Technology. The study was a cross-sectional survey exploring attitudes towards

mental illness in 18 districts of Uganda: Kabale, Ntungamo, Bushenyi, Mbarara, Kasese, Kabarole, Masaka, Mpigi, Mubende, Wakiso, Kampala, Jinja, Tororo, Bugiri, Soroti, Masindi, Lira and Gulu.

Interviews were undertaken with 60 rural and 60 urban participants. The sample was collected by first-year medical students, who conducted a survey in their home districts during their half-term holiday. Each student interviewed four people using a structured interview schedule that gave opportunity for open-ended answers. Participants were allowed to give more than one answer to each question and there were no prompts in the interviews. The questions and answers were translated by the interviewing students, who all spoke fluent English and the local language in question.

The interview protocol included demographic questions such as age and educational level. The other questions explored people's attitude to mental illness, using five main questions (see Results, below). The interview schedule had good face validity but content validity and reliability were not established.

From an initial content analysis of the 120 transcribed interviews, recurring themes were identified and coded. The data were analysed using descriptive statistics and cross-tabulation. The five items describing participants' attitudes to mental illness were compared on the basis of location (rural v. urban), age-group (20–39 v. 40–60 years) and educational level (no formal or only primary education v. senior or higher-level education).

Results

Can you get better from mental illness?

Most participants believed that mental illness is treatable (73.3%) or sometimes treatable (23.3%). Only a small number of participants (3.3%) thought that it was not treatable. Although most people therefore had positive attitudes regarding the treatability of mental illness, this was significantly more common among people with higher levels of education (77.3%) than among those who had obtained no or little education (66.7%; $P < 0.001$). Similarly, those with less education were more likely to endorse negative attitudes than their more educated counterparts (9% v. 0%; $P = 0.009$).

What people can you go to see in case of mental illness?

Most participants expressed a clear preference for one form of treatment, although 26 participants mentioned both traditional and Western forms of treatments. Less than half of all participants (45%) believed that mental illness can be treated by traditional medicine, whereas over two-thirds (67.5%) believed that mental illness is treatable by Western medicine. A few participants (9.2%) believed that mental illness is treatable by other means, such as counselling by a priest or a church leader. People from an urban setting and those who had obtained a higher level of education more often regarded Western medicine as the most appropriate treatment for mental illness than did their rural counterparts and those with less education, who more commonly mentioned traditional medicine as a treatment choice for mental illness (Table 1). Younger people were more likely to believe

Table 1 Percentages of people from different demographic groups who mentioned Western and/or traditional medicine as a possible treatment choice for mental illness

Variables	Western medicine %	Traditional medicine %
Rural location	43.3	70.0
Urban location	91.7***	20.0***
Lower education	35.6	71.1
Higher education	86.7***	29.3***
Younger age (< 40 years)	73.5	43.4
Older age (> 40 years)	54.1*	48.6

Totals add to greater than 100% as multiple preferences were allowed.

* $P = 0.036$; *** $P < 0.001$, v. comparison demographic group

Table 2 Participants' views on how people who are mentally ill should be dealt with and actual practices mentioned by participants

	Percentage of sample (n = 120)
<i>Participants' views (with statements beginning 'People who are mentally ill should be...')</i>	
Helped and looked after like any other person	42.5
Taken to hospital	37.5
Treated or given medication	25.8
Isolated from the society	25.0
Given advice or counselling	16.7
Taken to traditional healers	6.7
<i>Actual practices reported ('People who are mentally ill have been...')</i>	
Ignored, isolated, neglected, left to move freely	45.8
Beaten up, tied up, locked up, chased away or stoned	38.3
Taken to hospital	32.5
Helped by giving food, clothes	11.7
Taken to traditional healers	7.5
Looked after by relatives	5.0
Other	1.7

Totals add to greater than 100% as multiple preferences were allowed.

that mental illness was treatable by Western medicine than were older people (Table 1).

What do you think and feel about people with mental illness?

Most of the participants (82.5%) expressed a sympathetic attitude to or concern for people with a mental illness. Although 15.8% feared such people, only 5% expressed a negative attitude.

How do you think people with mental illness should be dealt with?

Over 40% of participants believed that people with a mental illness should be helped and looked after 'like any other person' (Table 2). Almost as many believed that they should be taken to hospital, whereas just over a quarter believed that they should be treated or given medication. Whereas 16.7% believed that people who are mentally ill should be given advice or counselling, only 6.7% advocated a traditional healer. A quarter of all participants believed that they should be isolated from society (Table 2). There were no significant correlations between these attitudes to treatment and socio-demographic factors.

How are people with mental illness dealt with in this community?

Participants' attitudes did not correspond well with how people who are mentally ill are managed in the community (Table 2). Regardless of most participants' sympathetic attitude, only 11.7% reported that people with a mental illness are helped in their communities by giving them food and clothes and so on. Almost half of all participants reported that people with a mental illness are isolated, ignored or neglected, and over 38% reported violent behaviour towards such people (violence included being beaten up, tied up, locked up, chased away or stoned). However, almost a third reported that people with a mental illness are taken to a hospital and 7.5% reported that they are taken to traditional healers (Table 2).

Discussion

The study utilised a cost-effective means of carrying out valuable data collection in a setting where research grants are in short supply. We acknowledge that using medical students as research workers may compromise the reliability of the study but believe that the benefits of this approach may override the limitations. Student research workers from different parts of Uganda with relevant language fluency, in a country with over 50 languages, offered a great opportunity for accessing areas that otherwise would have not been accessed in a research project without funding.

Attitudes of the population towards mental illness were mainly positive, but did not always match the community practices reported, which included unsympathetic acts and which corresponded with those reported by Kasoro *et al*

(2002). The differences between urban and rural populations indicate that social change and greater education have an impact on beliefs and attitudes. Education about mental illness and people who are suffering from it can lead to change, and one area where this is urgently required is in the continuing dehumanising management practices described in this study.

Acknowledgements

We would like to thank the first-year medical students (year 2002–03) at Mbarara University of Science and Technology for their help in collecting and translating the data and conducting the community survey.

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POINT OF VIEW

Doctors' values, resilience and professionalism

Richard Williams

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In 2001, Richard Smith, then editor of the *BMJ*, asked why doctors were so unhappy. He provoked a huge international response. The suggested reasons included: changes in the social structures of work; the demographic shift and difficulties in the recruitment and retention of staff; the replacement of trust with accountability; changes in relationships with people and bodies that are responsible for policy and practice; and negative media reporting.

Edwards *et al* (2002) concluded that 'this is an international and widespread problem' and ascribed the cause to 'a breakdown in the implicit compact between doctors and society'. At much the same time, Salter (2001) presented his analysis of the tensions in the triangle of relationships between the medical profession, society and the state in the UK.

In her Reith lectures, O'Neill (2002) provided a commentary on the impact on trust of interacting societal changes and governments' policies in the Western world. In my opinion,

the latter have responded to, but also amplified, the real change in the nature of the public's trust of professionals. Salter (2001) pointed to the very rapid growth of a regulatory industry in the UK, such that all aspects of knowledge creation (research), knowledge and skill transmission (education) and application (practice) are now covered by organisations that set standards and monitor and/or evaluate their implementation. This has led to beliefs that, although there are similar developments across the world, healthcare is now more regulated in the UK than it is anywhere else.

Openness, transparency and accountability have been developed in place of reduced trust. Openness relates to processes for decision-making being open to scrutiny. Transparency refers to the basis of decision-making being overt. Accountability concerns the allocation of responsibility for decision-making, so that everyone is clear about their role and the scope of their capacity to make decisions. Although

I welcome, these developing notions, it is noticeable that they are gaining the status of ethics principles (University of Toronto, 2005). However, Stein (2001) has written authoritatively about the limitations of accountability and critically about what lies behind the 'cult of efficiency' as a means of improving services. Trust is still required!

But has trust at the clinical level actually been eroded? Mike Shooter, past President of the Royal College of Psychiatrists, identifies a paradox. Often I hear him say that, although there is evidence in governance policy of reducing trust in professionals and the expectations of patients and the public are rising, the majority of patients continue to have good, trusting relationships with their doctors. My experiences are similar. Generally, psychiatrists are viewed very positively by their patients.

Similar findings have been presented in reports from the Picker Institute, which stands for 'patient-centred professionalism'. Its work provides a window on to the perceptions and wishes of the public about their healthcare. In one report (Hasman *et al*, 2006), the Institute found that most patients want to trust the clinicians they consult, and most still do. But, importantly, trust does not equate with blind faith: nowadays, people expect to see evidence that their trust is justified. Although I quote selectively, the Institute's view is that the barriers to change include a medical culture that prioritises the 'hard' sciences over what is seen as 'soft' evidence, curricular and service pressures, insufficient knowledge of how best to teach the relevant skills, and lack of effective mechanisms to spread good practice (Hasman *et al*, 2006).

Science has blossomed in the past 60 years, although there is much more that could be achieved with greater investment in academia and a greater focus on translational research. Now, healthcare has the potential to be increasingly effective and the promises for the future are enormous. This poses a huge challenge to the public purse that we cannot fail to face, as the Wanless reports identified (Wanless, 2002; Welsh Assembly Government, 2003). But will science eventually answer all questions and result in less need for professional judgement? In my view, and that of many others, the answer can only be 'no'.

Fulford (2004) has argued that more science brings more choices and, therefore, more decisions. It is clear from clinical experience that much of patients' and professionals' decision-making turns on values as well as facts. Thus, more science results in more decisions and an increasing need for the ability to work from a strong humanitarian base with a diversity of values. Fulford and I might dispute the Picker Institute's wording because we do not see 'hard' and 'soft' evidence as alternatives but as better used in synergy. Fulford has advocated that practitioners base their work on drawing together evidence-informed and values-based practice. Together, these approaches create appropriate opportunities: for openness and transparency in our work; for the responsive application of guidelines; and for patients to benefit from good relationships with doctors and individualised healthcare.

In this modern context, is professionalism a stuffy, out-of-date notion based on elitism, in which people in certain occupations are seen as enjoying particular privileges? Or is professionalism essential to assuring the public and ensuring high-quality practice? Might the public suffer if it were displaced?

I see professionalism as vitally important in sustaining effective, trusting relationships between patients and practitioners and between them and representatives of the state. The essence of professionalism is exercising good judgement in sensitively advising our patients in the face of incomplete knowledge, uncertainty, complex problems and diversity of values (Williams, 2002). Clarity about how our values and ethics guide action is essential in that context. My own reviews, and those of the College's Scoping Group on Roles and Values, found that core professional values, including altruism and integrity, remain as important as ever, although the context in which they are applied has changed dramatically and will change further. The Scoping Group will be publishing its findings and thinking in a book in 2007.

I am attracted by the work of Van De Camp *et al* (2004). They found 'considerable inconsistency in the use of the term' *professionalism* and advised building the concept afresh from their thematic analysis of the literature and qualitative research. They concluded from their research that professionalism is a multidimensional concept that encompasses:

- interpersonal professionalism (prerequisite qualities for effective work with and respect for patients and other professionals)
- public professionalism (qualities relating to the demands that society makes, including ethics, knowledge and skill, which constitute expertise, and commitment to best-practice guidelines, continuity of patient care and acceptance of greater accountability)
- intrapersonal professionalism (qualities and skills of judgement, flexibility, critical analysis, knowing one's limits, self-awareness and humanistic values that enable us to function well, within bodies of similar people).

Evidently, there is now a much more challenging edge to our relationships with patients, which I welcome. So, I conclude that trust is secure in those relationships, provided we work to develop our notions of what is good practice and are explicit about doing so. The Picker Institute recommends creative educational initiatives for professionals that include greater use of patients as teachers.

Over the past several years, our College has actively revisited its engagement with service users and carers, and now requires their involvement in educating trainees. It has produced a creative system for continuing professional development and 'ACP 360', a multi-source appraisal service for consultants (see <http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement/acp360.aspx>). Together, these and other measures are likely to go a long way to helping psychiatrists in the UK to meet the more exacting rigours of relicensing proposed by the General Medical Council (GMC).

But are these sufficient responses to the increasing concerns about how best to ensure the continuing quality and capability of doctors, including psychiatrists, or sustaining trust at political, societal and organisational levels? Sir Liam Donaldson, Chief Medical Officer for England, thinks not. In his 2006 report following the investigation into Shipman's gross crimes, he recommended a much more demanding process for revalidation, one that is split into two processes: relicensing by the GMC and recertification, probably conducted through the medical Royal Colleges.

In this circumstance of change and challenge, I was reminded by a colleague that resilience is 'the physical property of a material that can return to its original shape or position

after deformation that does not exceed its elastic limits'. Psychological resilience can be defined as a person's capacity for adapting psychologically, emotionally and physically reasonably well and without lasting detriment to self- or personal development in the face of adversity, threat or challenge. It is not about avoiding short-term distress or deleterious responses, but about adapting to and realistic recovery from them.

I think the professions must give thought to their resilience in responding effectively, adaptively and well to the challenges that face us. I believe that psychiatrists and other doctors should afford particular priority to sustaining and developing their relationships with their patients and the public. We should also pay greater attention to maintaining our corporate resilience. I believe that rebuilding professionalism so that it remains an appropriate guide in the modern context and creating synergy between evidence-informed and values-based practice are important contributions.

I am optimistic about the future of psychiatry and mental healthcare, although, in the short and medium term, I am concerned about how we cope with the rising profile and demands of regulation. Regulation is essential but costly and, on its own, is unlikely to reassure the public. Its price must not be the erosion of relationships with patients or of creativity. It is difficult to resist the reasoned calls for relicensing and re-certification but, in my opinion, both must be tempered with encouragements to practitioners to enable them to sustain and develop their relationships with the public and with patients. In this context, the new version of *Good Medical Practice*, the GMC's code of practice that has been effective from 13 November 2006, strikes an appropriate balance (GMC, 2006).

Of course, I write from a UK perspective. However, the evidence from Smith's enquiry (2001) is that expectations of doctors are changing across the world. So, I am keen to hear your opinions and experiences.

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NEWS AND NOTES

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

Middle East War

The College President and the Director of International Affairs wrote to all College members in the Middle East Division to pledge support and offer help with the effects of the recent violence on the civilian population. Professors Hollins and Ghodse also wrote to the Presidents of the Lebanese, Israeli and Palestinian Psychiatric Associations and the World Psychiatric Association calling on the governments involved, on the United Nations and on the international community for the immediate cessation of fighting and a lasting resolution to this conflict.

WHO national mental health counterparts

The ninth annual meeting of the World Health Organization (WHO) European national counterparts took place on 30 March to 1 April 2006, hosted by Greece, in Chania. The aim

of the meeting was to offer a forum for the WHO to report back on progress achieved after the January 2005 meeting of ministers in Helsinki and for national counterparts to discuss the mental health priorities in their countries and reach an agreement on future activities in partnership with the WHO.

Participants identified common challenges across countries and challenges specific to different stages of development of national mental health systems.

Future work in partnership between countries and the WHO will include cross-country projects and country-specific projects focused on a set of agreed priority areas for future collaboration with the WHO, as follows:

- service development
- workforce
- financing
- knowledge dissemination
- strategy development and legislation.

Information supplied by Dr Matt Muijen, Regional Adviser for Mental Health at the European Regional Office of the WHO

UEMS child and adolescent psychiatry psychotherapy training guidelines

The Section and Board of Child and Adolescent Psychiatry (CAP) of the European Union of Medical Specialists (UEMS) has a working group that has produced psychotherapy guidelines in response to the substantial need for psychological treatments for the psychiatric disorders and disturbances of children and adolescents and the consequent need for specialist training. These guidelines outline different levels of training and competence. They are now available on the UEMS website (http://www.escap-net.org/web/images/stories/document/guidelines_on_pschotherapy_training.pdf) and comments are invited.

In brief, the working group recommended that all psychotherapy training should consist of: familiarity with theoretical models; personal skills and knowledge of techniques; and awareness of the effect of one's own life experiences. The duration of training should be 3–4 years and consist of a minimum of 400 hours in any model and competence must be demonstrated.

- *Familiarity with theoretical models.* Psychoanalytic/psychodynamic psychotherapy requires knowledge of theories of both child and family development and of techniques. Cognitive-behavioural psychotherapy requires knowledge of learning theory, focused on human behavioural, cognitive, emotional and social development and functioning as well as of the brain-behaviour relationship and the dynamics of social networks. Family psychotherapy requires proficient knowledge of family development and functioning in normal and disordered families, and how specific family features affect the development of children.
- *Personal skills and knowledge of techniques.* All modes of therapy require the capacity to develop a therapeutic relationship with the child and significant others. Psychoanalytic/psychodynamic psychotherapy requires the ability to recognise that meaningful communication involves emotional contact and participation (empathy), and the ability to differentiate the limits and objectives in case management, environmental interventions, counselling, support and psychotherapy. An optional recommendation is skilled training in infant or child observation. Cognitive-behavioural psychotherapy requires the therapist to be

able to reflect on the aspects just described and to apply various techniques and protocols for specific psychiatric disorders. In family psychotherapy the therapist must be able to attend fully to the verbal and non-verbal contributions of each family member.

- Part of psychotherapy training involves heightening awareness of the fact that the therapist's own emotional reactions and life history experiences are an essential and inevitable part of the psychotherapy process.

The national status and criteria for psychotherapy differ across European countries, and as a consequence the training resources and curricula will vary. The trainers responsible for CAP psychotherapy training must be trained therapists themselves.

J. Tsiantis, Professor of Child Psychiatry, University of Athens, and President of the UEMS Section of Child and Adolescent Psychiatry; J. Piha, Professor of Child Psychiatry, University of Turku; D. Deboutte, Professor of Child Psychiatry, University of Antwerp

UEMS response to the EU green paper

The UEMS/CAP Section and Board, while fully supporting the intentions of the Green Paper from the European Commission, *Promoting the Mental Health of the Population: Towards a Strategy on Mental health for the European Union*, have produced a response that raises concerns that the topic of mental health for children and adolescents is not sufficiently addressed. The view is that these important initiatives should be framed according to a life-cycle approach, with a specific focus on children, adolescents and their social context. The full text of the response can be found at <http://www.escap-net.org> and correspondence can be conducted with J. Tsiantis, President of the CAP section, via email (itsianti@med.uoa.gr).

Early intervention in psychiatry

Reflecting a new and important trend in psychiatry, Blackwell has announced a new international journal for 2007, *Early Intervention in Psychiatry*. There is a call for papers at <http://mc.manuscriptcentral.com/eip>. The Editor-in-Chief is Professor Patrick McGorry.

Correspondence

Psychiatric care in south-west Stockholm: the SHO perspective

Sir: Academic overseas visits are usually the undertaking of senior psychiatrists. Recent articles have tended to focus on service provision (Kennedy, 2005) or to have reported on the struggles of mental health services in low- and middle-income countries (Feinstein, 2002).

In May 2005, a group of six senior house officers on the St George's Hospital Scheme in London visited the Karolinska

Psychiatric Institute in Huddinge, Stockholm. The inspiration came after a group of Swedish doctors visited our trust at the invitation of Dr Najmeddine Al-Falahe, a Stockholm-trained local consultant. Our self-funded visit was planned to coincide with a bank holiday. Whereas Friday and Monday were academically oriented, we used the weekend to discover Stockholm by day and night.

On arrival, the educational coordinator, Dr Maria Starsjö, our excellent host for our stay, escorted us to the faculty's breakfast meeting. We were allocated residents to shadow on various in-patient units and community facilities. The wards,

run by dedicated doctors with no community commitments, were in pristine condition. They consisted of individual rooms and a communal area that featured a large aquarium, reading lounge, small library and table tennis table. The doctors wore white coats over casual clothes and the atmosphere was generally relaxed. Despite a policy of separating patients who were severely psychotic from those who were less disturbed, in-patient units faced familiar pressures of bed shortages and social problems delaying discharge. While general, forensic and child and adolescent psychiatry had equivalents in Sweden, the management of organic illnesses such as dementias was left to medical teams. Separate drugs and alcohol services were based in central Stockholm. As might be expected, we found similarities with the bio-psychosocial and multidisciplinary approach adopted in the UK, but were impressed with the quality of administrative and logistical support. Trainees had access to individual computers, modern on-call facilities and trendy quarters. A tour of the laboratories revealed common monitoring of psychotropic blood levels and the availability of metabolic profiling.

Recruitment into psychiatry had traditionally been difficult. The number had peaked from the late 1990s and stood at 1400 in 2002 (Silfverhielm & Stefansson, 2006). After 5 years of medical school and 18 months as house officers, doctors enrol on a 5-year training programme that leads to recognition as specialists. Many trainees we met had recently joined following a successful recruitment campaign based on financial and academic incentives. These included encouragement and funding to train in a range of psychotherapy modalities, a flexible on-call system and research opportunities. In contrast to their British counterparts, residents became actively involved in research early on and were given appropriate time and resources.

We found our visit extremely informative, enjoyable and productive. It highlighted some of the positive aspects of our own clinical practice and provided valuable lessons for the future. We strongly recommend that international visits be incorporated into training at an early stage. They broaden horizons and encourage reflection. They also further links between institutions and professionals that can only benefit service users and the National Health Service.

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Tremors within the health system

Sir: I read with great interest M. M. Khan's paper 'Earthquake 2005: challenges for Pakistani psychiatry', in the July 2006 issue of *International Psychiatry* (vol. 3, no. 3, pp. 21–23). It was heartbreaking to read

of the state of mental health in Pakistan, but hope still remains as long as there are people putting in effort to rectify this. I agree that the Pakistan Psychiatric Society should play a more prominent role than it has up to now.

At the same time, one should not underestimate the difficulties and obstacles in improving standards of mental health in a country where almost a third of the population live below the poverty line. We are also observing an increase in the incidence and prevalence of mental illness in that region, owing to growing insecurity, terrorism, economic problems, political uncertainty, unemployment and disruption of the social fabric. A feudal mind-set exists not only in the rural areas of the country but also in institutions of learning, where established psychiatrists do not promote or help junior doctors, for fear of either increased competition or of being replaced by the younger generation, but this puts patient care at stake. Not enough effort is being directed towards psychiatric research either, and there is no dedicated psychiatry journal in the country. According to Gadit (2006), the *Journal of Clinical Psychiatry*, which was once published regularly from Lahore, has ceased to exist and the first issue of the journal of Pakistan Psychiatric Society, called *JPPS*, was published in the year 2003 but was blocked politically and not reproduced again.

Prejudice and nepotism are the major factors contributing to decline. The system, which is already fragile, is further destabilised when locally trained psychiatrists in Pakistan are recruited internationally as consultants, leaving behind an increasing doctor:patient ratio.

In principle, I also agree with Dr Khan that one-off programmes should be discouraged and solutions which help in the longer run should take priority. After graduating in Karachi, I was involved in a community mental health initiative with our head of department in 2001–02, at Manora, an island near Karachi in the Arabian Sea with a population of 25000. The Manora Health Project was launched in 2000 and was working under the aegis of Department of Psychiatry, Hamdard University Hospital, with the objective of improving the general health of the population, but with a special emphasis on improvement of their mental health status. It was a centre which provided consultations with health professionals and medication free of charge. It also worked at training local mental health social workers. Referral to its parent private teaching hospital provided patients with further treatments at a discount. This greatly helped in identifying and managing numerous mental illnesses in that community which were either misunderstood or ignored owing to a lack of knowledge, stigma or financial incapability.

Last but not least, I think it is high time that in Pakistan there was a separate postgraduate college for each medical specialty.

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Forthcoming international events

23–24 January 2007

WPA Regional Meeting
Budapest, Hungary
Hungarian Psychiatric Association
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
London, UK
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 Neuropsychopharmacology
WPA Section on Interdisciplinary Collaboration
Marakkosh, Morocco
Contact: Dr Uriel M. Halbreich
Email: urielh@acsu.buffalo.edu

26–27 April 2007

Risk Factors in Psychiatry. XIV International Symposium about Current Issues and Controversies in Psychiatry
Barcelona, Spain
Website: http://www.grupogeyseco.com/controversias07/Controversias_Ing.htm

6 May 2007

Play and Power. Sixth '3-section' Conference of the European Federation of Psychoanalytic Psychotherapy in the Public Sector
Copenhagen, Denmark
Email: psyklich@post1.tele.dk
Website: <http://www.efpp.dk>

11–12 May 2007

Conference on Conflict, Mental Health and Making the Peace
Lymassol, Cyprus
Organised by the Royal College of Psychiatrists' European Division in collaboration with the London Institute of Psychiatry
Contact: Dr Nathaniel Minton
Email: nd.minton@btinternet.com

16–19 May 2007

New Treatment Methods in Psychiatry in a Challenging World
15th World Congress for Dynamic Psychiatry
St Petersburg, Russia
Contact: Dr Monika Dworschak
Email: wadpcongress2007@dynpsych.de

4–6 June 2007

X Pan Arab Congress
Organised by the Arab Federation of Psychiatrists and the Algerian Psychiatric Society
Algiers, Algeria
Contact: Dr Saida Douki; Dr. Farid Kacha
Email: Saida.Douki@gnet.tn; F.Kacha@caramail.com

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

21–23 September 2007

First Congress of the Psychiatric Association for Eastern Europe and the Balkans
Thessaloniki, Greece
Organised by the Psychiatric Association for Eastern Europe and the Balkans
Contact: Dr George Christodoulou
Email: gchristodoulou@ath.forthnet.gr
Website: <http://www.paeeb.com>

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>

25–30 August 2008

13th World Congress of the International Association for the Scientific Study of Intellectual Disabilities (IASSID)
Cape Town, South Africa
Website: <http://www.iassid.org>

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