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International Psychiatry publishes original and scientific articles, country profiles and points of view, dealing with the policy and promotion of mental health, the administration and management of mental health services, and training in psychiatry around the world. Correspondence as well as items for the news and notes column will also be considered for publication.

Manuscripts for publication must be submitted electronically to the Editor (hghodse@sghms.ac.uk), with a copy sent to the Secretariat (ip@rcpsych.ac.uk). The maximum length for papers is 1500 words; correspondence should not be longer than 500 words. The Harvard system of referencing should be used.

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Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style. Contributions are accepted for publication on the condition that their substance has not been published or submitted elsewhere.

The challenges faced by national psychiatric associations and societies

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Currently, national associations and societies in psychiatry are facing major problems and dilemmas concerning most of their core values and objectives. Example include (Griffith & Ruiz, 1977; Matorin & Ruiz, 1999):

- addressing ethical issues pertaining to their relationship with pharmaceutical industries
- upgrading of the educational and training models used with medical students, graduate residents in psychiatry and postgraduate trainees in the psychiatric sub-specialties (child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, etc.)
- finding a good balance with respect to research and investigation in the areas of biological psychiatry, neurosciences, psychosocial and cultural psychiatry.

Among these challenges, though, there is one that transcends the others. This is the problem related to psychiatric/mental health staff numbers (Ruiz, 1987). This challenge has existed since the end of the Second World War, but it has been accentuated during the past decade or so by globalisation. Following the war, a strong migratory process developed; this included the migration of physicians from low- and middle-income nations to richer ones. This trend was most readily observed in the immigration patterns of the United States, Canada, England and, to a certain extent, Australia. However, since the globalisation process began, migration has affected all regions of the world. In the European Union it is accentuated by the free movement of labour among member states.

As in other medical specialties, in psychiatry this migratory process has led to substantial 'brain drainage' in certain areas of the world. This phenomenon creates major problems in the educational, investigational and service aspects of all specialties, but particularly psychiatry (Garza-Trevino *et al*, 1997; Guynn & Ruiz, 1998). Take, for instance, the United States. In the United States there were approximately 646 000 physicians in the year 2000 (according to the US Bureau of the Census). Of this number, about 153 800, or 23.8%, were 'international medical graduates' (IMGs). In psychiatry, something similar is also happening. For instance, about 40% of the general psychiatric residents training in the United States (just under 2300) are IMGs. The situation is accentuated with respect to the psychiatric specialties. For example, in child and adolescent psychiatry training, 43% of the trainees are IMGs, in geriatric psychiatry the proportion is 69%, in addiction psychiatry 58% and in consultation and liaison psychiatry 48%. In the American Psychiatric Association, from a total of 26 756 fee-paying members in 2001, 25.2% were IMGs, or 6743. Of this number, 1398 were from India, 512 from the Philippines, 341 from Pakistan and 220 from Argentina. Of interest is the fact that 32% of the IMG psychiatrists are working in the public sector while only 22% of the US graduate psychiatrists do so. In other words, psychiatric care in the public sector in the United States depends to a great extent on IMGs. This situation is similar in Australia and other industrialised nations.

Another factor that needs to be taken into consideration in this regard is the fact that more than half of the total world population (about 3 billion persons) live in Asia. The Asian continent is one of the areas of the world which is most seriously affected by the migration of physicians, especially psychiatrists, to industrialised regions. Such migration has serious negative effects on the delivery of health and mental health services in the socio-economically deprived regions of the world.

The rate of serious mental illnesses, such as schizophrenia and bipolar disorders, is essentially the same all over the world. Of course, if many physicians, particularly psychiatrists, leave Asia, the number of people with serious mental disorders does not decrease in this region of the world; in fact, it remains constant or increases in accordance with the rate of increase of the population. This means that fewer of those with schizophrenia and bipolar disorders in Asia have access to specialised psychiatric care. This unfortunate situation is similarly observed in sub-Saharan Africa, where the numbers of available psychiatrists are minimal in comparison with the total population. In addition, the increase in the life span of individuals across the world makes the shortage of psychiatrists and mental health professionals yet more critical and challenging (Ruiz, 2003, 2006).

The worldwide crisis over the numbers of mental health professionals is especially striking in relation to psychiatrists in Asia, where there are today approximately 35 000 psychiatrists for a population of about 3 billion, while in the United States there are an estimated 50 000 psychiatrists for a total population of about 285 million. There are too few psychiatrists in all Asian countries. China has approximately 14 000 psychiatrists for a population of about 1.3 billion; Pakistan has about 350 psychiatrists for approximately 152 million; India about 3500 psychiatrists for a population of approximately 1 billion; and Laos has only two psychiatrists for some 5 million people. Obviously, the crisis in Asia is both acute and endemic.

In this editorial, I have described a brain drainage and a shortage of psychiatric personnel that have reached crisis proportions in many areas of the world, owing in part to

the process of globalisation seen in particular over the past decade. In addressing this situation we have to accept the fact that governments and societies in the industrialised world do not have the social interest to address and resolve this problem (Sox, 2002), while governments and societies in many other regions of the world do not have as yet the financial strength to address and resolve this situation either. Thus, it is imperative that national associations and societies in psychiatry from both high-income nations and low- and middle-income countries prioritise this issue. These associations and societies need to work together to develop a strategic plan of action to address this mental health problem. The World Psychiatric Association (WPA) has never addressed this situation in a worldwide effort. The World Health Organization (WHO) has made reference to it but has not yet made it a priority. Therefore, we need psychiatry's leaders to bring this situation to the forefront of the profession. This issue is currently the greatest challenge to the mental health system worldwide. To continue to look the other way is both inhumane and unacceptable.

References

Garza-Trevino, E. S., Ruiz, P. & Venegas-Samuel, K. (1997) A psychiatric curriculum directed to the care of the Hispanic patient. *Academic Psychiatry*, **21**, 1–10.

Griffith, E. H. & Ruiz, P. (1977) Cultural factors in the training of psychiatric residents in a Hispanic urban community. *Psychiatric Quarterly*, **49**, 29–37.

Guynn, R. W. & Ruiz, P. (1998) Aspectos didacticos relacionados con la psychiatria social. In *Anales del XIV Congreso Nacional de Psiquiatria 'Honorio Delgado'* (eds A. Perales, A. Saavedra, V. J. Acha, *et al*), pp. 137–143. Lima: Centro de Production Editorial de la UNMSM.

Matorin, A. A. & Ruiz, P. (1999) Training family practice residents in psychiatry. *International Journal of Psychiatry in Medicine*, **29**, 327–336.

Ruiz, P. (1987) A seven-year evaluation of a career-escalation training program for indigenous nonprofessionals. *Hospital and Community Psychiatry*, **27**, 253–257.

Ruiz, P. (2003) WPA strives to disseminate relevant psychiatric knowledge via scientific meetings. *World Psychiatry*, **2**, 63–64.

Ruiz, P. (2006) WPA scientific meetings: the link between sciences and quality of care. *World Psychiatry*, **5**, 126–127.

Sox, H. C. (2002) Medical professionalism in the new millennium: a physician chapter. *Annals of Internal Medicine*, **136**, 27–30.

Teaching and training in psychiatry

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One of the chief remits of the Board of International Affairs of the Royal College of Psychiatrists is to highlight, review, encourage and determine the development of psychiatric training, and to support trainees through collaboration in the development of curricula, as well as in relation to the conduct of examinations and continuing professional development. Here we present three more or less polemical articles that report on difficulties pertaining to the training of psychiatrists in Bangladesh, India and Europe. In each case, the authors turn to the College for advice, guidance and, potentially, intervention, with the aim of standardising the training of psychiatrists around the world.

Mohammad Mullick works in Bangabandhu Sheikh Mujib Medical University, in Dhaka, Bangladesh. Dhaka is situated on the banks of the Buriganga River and has a population of some 11 million. It is the largest city in Bangladesh and one of the fastest-growing cities in the world. In a country of over 120 million there are only 77 trained psychiatrists, and just two child psychiatrists for 47 million children under 15 years of age. While it would seem the quality of training is good, he asks how, given the limited resources available for aspirant psychiatrists, it is going to be possible to provide the numbers of mental health specialists required to deal with a vast and largely hidden need. He makes a number of suggestions about how the College could help, principally with a variety of schemes aimed at training the second generation of potential Bangladeshi psychiatrists. He does not discuss the substantial 'brain drain' of mental health workers from that country, a topic that has recently been reviewed by Adkoli (2006).

Professors Kulhara and Avasthi from Chandigarh, India, discuss the similar problems facing that country in its attempts to train a new generation of psychiatrists. One point they forcefully make concerns the extraordinary discrepancies between different regions of India in their provision of medical schools. The range is from just one small school in, for example, Chandigarh (with a population of 90 million) to 32 schools in Karnataka (population 56 million). Persuading medical students to consider a career in psychiatry is not easy at the best of times, and the relative lack of exposure to the specialty in curricula laid down by the Medical Council of India, together with lack of examinations in the subject, does not encourage many to select it. They review a range of problems, before turning to the College with a number of specific suggestions about how it might be able to help.

No doubt both the South Asian and European International Divisions of the College could have a role in responding to these pleas from the Indian subcontinent and to the third of our contributions, which concerns the state of psychiatric training in Europe. James Strachan draws our attention to an anomaly whereby the European Union requires mutual recognition of postgraduate specialist training schemes, but

the content of those schemes is by no means subject to the scrutiny one might expect. He raises some interesting issues that deserve exploration in a future issue of *International Psychiatry*, for example the pressure being brought to bear by insurance companies upon medically trained psychotherapists, who deliver expensive treatment in comparison with non-medical professionals. This has parallels with the 'hospital medical officer' saga in the United States over the past decade and raises the spectre of what some have called the practice of 'bottom line' medicine.

Reference

Adkoli, B. V. (2006) Migration of health workers: perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka. *Regional Health Forum*, **10**, 49–58.

Teaching and training in psychiatry and the need for a new generation of psychiatrists in Bangladesh: role of the Royal College of Psychiatrists

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Bangladesh is a small, populous South Asian nation with poor literacy, limited resources and a lack of basic healthcare. Caring for people with psychiatric disorders in such a setting is challenging. The prevalence of psychiatric disorder in Bangladesh is similar to that in other countries, yet there is a severe shortage of well trained psychiatrists and a lack of even basic mental health services. To generate large numbers of well trained psychiatrists, Bangladesh must expand its high-quality psychiatric training and education at both the postgraduate and the undergraduate levels. To achieve these ambitious goals, Bangladesh needs help and assistance from regional and international institutions. The Royal College of Psychiatrists can play a role of critical psychiatric public health importance by helping Bangladesh locally train a new generation of psychiatrists who will care for the vast number of those with ailments of mind and soul.

Bangladesh: basic facts

Bangladesh is densely populated, having a total area of 147 570 km^2 and a population of 123.85 million. About 45% of that population are under 18 years of age and 72% live in rural areas. Islam is the major religion (practised by around 88% of the population), followed by Hinduism (11%). Most Bangladeshis share a common language and sociocultural heritage. The economy, which in large part depends on agriculture, is perennially affected by flood (Asiatic Society of Bangladesh, 2003). The average per capita income is US$444 and the economic growth rate is around 6% per annum (Bangladesh Bureau of Statistics, 2004).

Extent of mental health problems in Bangladesh

The prevalence of mental health problems in Bangladesh has been variously estimated to be between 7% and 16% (Chowdhury *et al*, 1981; Mullick & Goodman, 2005). It is estimated that over 11 million adults and 8 million children and adolescents are in need of mental health services. Yet these people face both a lack of adequately trained mental health professionals and the absence of a structured mental health service.

Evolution of teaching and training in psychiatry

After Bangladesh achieved independence from Pakistan in 1971, undergraduate psychiatry training was established, with new departments of psychiatry. In 1979 a postgraduate course was started at the Bangladesh College of Physicians and Surgeons (BCPS). A course offering a Diploma in Psychological Medicine (DPM) began in 1975 at the former Institute of Postgraduate Medicine and Research (IPGM&R, now the Bangabandhu Sheikh Mujib Medical University, BSMMU). This course was replaced by an MPhil course in 1995. In 2001, an MD course in psychiatry started at the BSMMU.

Courses and curricula for psychiatry training are regulated by the Bangladesh Medical and Dental Council (BMDC).

Undergraduate training in psychiatry

About 25 government and non-government medical colleges provide undergraduate training in psychiatry. The undergraduate MBBS course consists of 5 academic years plus 1 year of internship training. Undergraduate psychiatry courses are designed to provide basic psychiatric concepts (including behavioural science) and to train doctors in the diagnosis and management of common psychiatric problems in the community setting (Bangladesh Medical and Dental Council, 2004). Courses mainly consist of didactic lectures in psychiatry for a total of 20 hours during the clinical years. This is accompanied by a 4-week clinical rotation. Knowledge of psychiatric illnesses is not evaluated in the examinations.

Postgraduate training in psychiatry

The BCPS is the pioneer organisation in postgraduate medical education in Bangladesh. It currently offers a Fellowship (FCPS) in 40 disciplines and Membership (MCPS) in 15. Annually, 8–10 candidates are accepted into the Membership and 15–20 into the Fellowship Part I programmes in psychiatry.

A 3.5-year course leads to the Fellowship of the College of Physicians and Surgeons in Psychiatry (FCPS-Psych). It starts in July of each year. Candidates are required to have the MBBS or an equivalent medical qualification recognised by the BMDC and 1-year internship after passing the MBBS. Modelled on the MRCPsych, the FCPS-Psych comprises Part I, basic science, and Part II, clinical psychiatry. After completing Part I, candidates must complete 3 years of clinical training in psychiatry in a recognised institution and submit a dissertation before they become eligible for Part II.

The BSMMU is the premier postgraduate medical institution in Bangladesh and sets the gold standard for medical education and practice in the country (Bangabandhu Sheikh Mujib Medical University, 2005*a*). It offers a Master of Philosophy in Psychiatry (MPhil-Psych) course and Doctor of Medicine in Psychiatry (MD-Psych) programme, which both accept 20–22 candidates each year. Trainees receive training in general adult psychiatry as well as sub-specialties in psychiatry from qualified faculty members. MPhil-Psych is a 2-year course and MD-Psych is a 3-year course; they begin every January and July respectively. The basic requirements for acceptance into the MD programme are similar to those of the FCPS-Psych. Unlike the FCPS-Psych, however, it consists of three parts; Part II is a transitional one, involving both basic and clinical science (Bangabandhu Sheikh Mujib Medical University, 2005*b*).

MAG Osmani Medical College, Sylhet, is the only medical college with a postgraduate course in psychiatry: it has offered a Master of Philosophy in Psychiatry degree since 2003. On average 4–6 seats are available in each academic year. This MPhil-Psych has similar eligibility criteria to the FCPS and MD programmes. The course consists of three parts and is similar to the MD-Psych programme.

Quality *v*. quantity

The above courses and examinations set a high standard, which helps produce high-quality psychiatrists, but is also perceived as problematic in relation to overcoming the acute shortage of trained psychiatrists in the country. The shortage is likely due to lack of adequate exposure to psychiatry during undergraduate medical education and a lack of enthusiasm on the part of clinicians for psychiatry as a career.

Current initiatives

Current initiatives include increasing postgraduate training in psychiatry to 4 years and opening a child and adolescent psychiatry sub-specialty course at the BCPS. The National Institute of Mental Health (NIMH) in Dhaka is planning to offer an MD (Psychiatry) course from July 2007. The World Health Organization (WHO) envisions having at least one doctor in each rural health centre in psychiatry within the next 20 years.

Future directions

To meet the acute shortage of trained psychiatrists in Bangladesh, there is a need for both short- and long-term programmes. In the short term, postgraduate training programmes should be opened in all medical colleges. The quality of training and examination of the programmes should be supervised by either the regional public universities or, preferably, a central body, such as the BSMMU. Long-term plans should focus on reforming undergraduate medical education to incorporate expanded, structured training in psychiatry so that MBBS doctors are well prepared for the high standards of postgraduate training and examinations. In addition, psychiatry sub-specialty training programmes need to be started at the BSMMU and the NIMH. However, to accomplish these ambitious goals, Bangladesh needs assistance from regional and international agencies.

Role of the Royal College of Psychiatrists

The Royal College of Psychiatrists has played a key role in training Bangladeshi psychiatrists in the UK; many have since assumed leadership roles in improving psychiatric care in Bangladesh. However, to meet the acute shortage of well trained psychiatrists, Bangladesh now must train its own psychiatrists. The College Board of International Affairs, in particular the South Asia International Division, can play a vital role in improving the quality of psychiatric teaching and training in Bangladesh by facilitating collaboration among Fellows and Members in the South Asian Region. In particular, a short exchange training programme for mid-level psychiatrists would prepare them to assume leadership positions in developing new psychiatry training programmes. At its national meetings the College could recognise the substantial contribution its Members and Fellows make in developing psychiatry training programmes in Bangladesh.

The College could also send experts to give lectures and to deliver short courses, as well as unannounced examiners to the

new postgraduate programmes, at random. The College could have delegates at the national annual meeting of psychiatrists. By recognising local training and degrees, the College could promote the development of a strong programme that would attract the best and the brightest to psychiatry. In addition, the College could consider waiving its own Part I examination for those with FCPS-Psych or MD-Psych degrees from Bangladesh, so that they could directly take the MRCPsych Part II examination. The College could also offer opportunities for sub-specialty training in psychiatry to psychiatrists with strong roots in Bangladesh, who would then lead the development of various domestic sub-specialty programmes.

Conclusions

Teaching and training in psychiatry in Bangladesh are in an advanced state of development. However, to meet the acute shortage of trained psychiatrists and to provide quality psychiatric care to large numbers of patients, Bangladesh must adopt short- and long-term strategies: expanding supervised high-quality postgraduate training to existing medical colleges; and incorporating expanded, structured psychiatric training at undergraduate level. To accomplish these ambitious goals with limited resources, it needs regional and international help. The Royal College of Psychiatrists played a historic role in training the first generations of Bangladeshi psychiatrists. The College can now play a pivotal role in improving psychiatric care in Bangladesh by helping to establish local training programmes for a new generation of psychiatrists, who will be well qualified and dedicated to improving the mental health of Bangladesh.

References

Asiatic Society of Bangladesh (2003) *Banglapedia: National Encyclopaedia of Bangladesh*. Asiatic Society of Bangladesh.

Bangabandhu Sheikh Mujib Medical University (2005*a*) *Guide to Academic Programmes*. BSMMU.

Bangabandhu Sheikh Mujib Medical University (2005*b*) *Examination Manual*. BSMMU.

Bangladesh Bureau of Statistics (2004) *National Accounts Statistics (Provisional Estimates of GDP, 2003–04 and Final Estimates of GDP, 2002–03).* Bangladesh Bureau of Statistics.

Bangladesh Medical and Dental Council (2004) *Undergraduate Course Curriculum 2003–2004*. BMDC.

Chowdhury, A. K. M. N., Alam, M. N. & Ali, S. M. K. (1981) Dasherkandi project studies: demography, morbidity and mortality in a rural community of Bangladesh. *Bangladesh Medical Research Council Bulletin*, **7**, 22–39.

Mullick, M. S. I. & Goodman, R. (2005) The prevalence of psychiatric disorders among 5–10 year olds in rural, urban and slum areas in Bangladesh: an exploratory study. *Social Psychiatry and Psychiatric Epidemiology*, **40**, 663–671.

Teaching and training in psychiatry in India: potential benefits of links with the Royal College of Psychiatrists

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Education in modern medicine in India began in 1835 with the establishment of the Madras Medical College, in what is now Chennai. Initially the growth of new medical schools was slow but it gathered pace after independence in 1947. In the past decade or so, the growth in terms of the creation of new medical schools has been phenomenal.

Undergraduate medical education

The Medical Council of India (MCI) is a statutory body charged with the responsibility for regulating the establishment of medical schools in India. It lays down standards for undergraduate and postgraduate medical education and prescribes curricula for both. It has the power to accredit, recognise or de-recognise medical schools. According to a recent release from the MCI, India has 233 recognised medical schools, to which 25374 students are admitted every year at the undergraduate level (see Table 1).

The undergraduate curriculum of the MCI gives meagre representation to psychiatry. Undergraduate medical students are exposed to psychiatry for only 15–20 hours by way of didactic lectures during the entire course of their medical education, which spans 4.5 years! The clerkship in psychiatry lasts only 2 weeks. During the 1-year compulsory internship, the psychiatric rotation is optional, and in any case that, too, lasts only 2 weeks. Furthermore, psychiatry has no prominence in the final examinations.

At organisational level, many medical schools even today do not have independent departments of psychiatry but rather psychiatry is catered for within the department of medicine; for those schools that do have a psychiatry department the staffing situation is generally poor. Moreover, training in psychiatry is perfunctory and tends to address the cognitive aspects rather than the psychomotor or affective aspects of mental disorder.

Table 1 Undergraduate medical schools in India, as listed by the Medical Council of India

State	Number of recognised medical schools	Yearly intake of students
Andhra Pradesh	31	3825
Assam	3	391
Bihar	8	510
Chandigarh	1	50
Chhattisgarh	2	100
Delhi	5	560
Goa	1	100
Gujarat	13	1425
Haryana	3	350
Himachal Pradesh	2	115
Jammu and Kashmir	4	350
Jharkhand	3	190
Karnataka	32	3585
Kerala	15	1650
Madhya Pradesh	8	830
Maharashtra	39	4995
Manipur	1	100
Orissa	4	421
Pondicherry	4	375
Punjab	6	520
Sikkim	1	50
Tamil Nadu	22	2315
Tripura	1	100
Uttar Pradesh	13	1262
Uttaranchal	2	100
West Bengal	9	1105
Total	233	25374

Undergraduate students do not gain the clinical competence they need to deal with common mental disorders. There is no quality assurance in the training given. Since psychiatry has no significant place in the final examinations, most students pay only lip service to a posting in psychiatry and absenteeism during postings in psychiatry is high.

Postgraduate training

MD in psychiatry

There are only 49 medical schools in the whole country that are recognised by the MCI for training at postgraduate level for the award of an MD in psychiatry. These medical schools admit about 240 medical graduates every year for the 3-year degree course.

The MCI is the regulatory authority for postgraduate courses. It prescribes the curriculum in a broad sense. The universities to which medical schools are affiliated are the examining authorities. There is no uniformity in teaching, and training varies from university to university. Even the examination system is not uniform. This leads to wide variation in standards.

Diploma in Psychological Medicine

There are 29 medical institutions in the country that provide training that leads to the award of the Diploma in Psychological Medicine (DPM). Their combined yearly intake is 89 students.

The MCI is the regulatory authority and the university to which the medical institution is affiliated is the examining authority. The duration of the DPM course is 2 years. Again, the standards of teaching for the DPM across the country are variable and there is no uniformity in the conduct of examinations.

Training in psychiatry for general practitioners

Little information is available about the needs of general practitioners (GPs) vis-à-vis psychiatry. It is felt that they need more psychiatric expertise and that they should be thoroughly conversant with psychological medicine.

Felt need: the national perspective

For the huge population of India and its needs for mental health infrastructure and professional resources, the current training base is not sufficient. At the present rate, it will take a long time to establish a healthy ratio between the population and the number of psychiatrists serving it. Looking at this dismal scene, it is obvious that undergraduate training in psychiatry needs to be strengthened, postgraduate psychiatric training needs to be improved and GP training programmes in psychiatry need to be expanded.

Stumbling blocks

All levels of training in psychiatry – undergraduate, postgraduate and GP – lack a competence-based curriculum. This can be rectified only if policy and decision-makers recognise the importance of psychiatry, not only in medical education but in all healthcare. Unfortunately, the representation of psychiatrists at the higher levels (the MCI, university senates and university syndicates) is marginal. Furthermore, psychiatry has a very thin slice of the medical curriculum 'cake'. Therefore, the profession as a whole will have to exert pressure on others to give psychiatry its due recognition.

The Royal College of Psychiatrists

The Royal College of Psychiatrists is known for its integrity, high standards and professionalism. Its training programmes, system of accreditation and examinations are highly regarded. For these reasons, the College could make substantial contributions to psychiatric education in low- and middle-income countries such as India. However, while the College has the professional base to do so, it does not necessarily have the resources to undertake such a mammoth task. None the less, what can be achieved is suggested as follows.

Psychiatric education in India and links with the College

India has a shortage of teachers and trainers in psychiatry. Links with the College at undergraduate, postgraduate and GP levels could be of great benefit in this respect. In relation to the teaching and training of GPs, the College could develop links with the Indian Psychiatric Society and the Indian Medical Association. At the undergraduate and postgraduate levels, links could be fostered with the existing

medical schools, the universities and the Indian Academy of Medical Sciences, and so on.

What could be developed?

To overcome the shortage of teachers in psychiatry in India, a system of visiting teachers could be initiated. A large number of eminent College Members and Fellows are of Indian origin. They could be asked to provide some teaching and training in India. The logistics of operating such a system – by whom, for how long and how much – needs to be worked out through the good offices of the institutions mentioned above, as would the financial support required. Material support to the visiting faculty (costs of travel within India, board and lodging) could be provided with relative ease at institutional level. A pool of visiting professors and teachers from the membership of the College could be established and a group from this pool could visit India for variable lengths of time to provide the requisite teaching and training. With the help of the visiting faculty from the College, special programmes in continuing medical education could be developed for both psychiatrists and GPs. Links could be fostered by developing 'memoranda of understanding', initially between the Indian Psychiatric Society and the College, and later with the medical schools.

Is this feasible or is this a figment of our imagination? We believe that, given the will, this can be achieved.

Further reading

Agarwal, A. K. & Katiyar, M. (2004) Postgraduate psychiatric training in India. II: Status of psychiatric education at postgraduate level. In *Mental Health: An Indian Perspective, 1946–2003* (ed. S. P. Agarwal). Directorate General of Health Services, Ministry of Health and Family Welfare.

Kulhara, P. (2004) Postgraduate psychiatric training in India. I: Current status and future directions. In *Mental Health: An Indian Perspective, 1946–2003* (ed. S. P. Agarwal). Directorate General of Health Services, Ministry of Health and Family Welfare.

Srinivasan, K. (2004) Undergraduate psychiatric education reforms and training of general practitioners in primary level mental health care. In *Mental Health: An Indian Perspective, 1946–2003* (ed. S. P. Agarwal). Directorate General of Health Services, Ministry of Health and Family Welfare.

Training in Europe in perspective

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In psychiatric medicine, as in other fields, Europe offers a diversity of history and academic tradition that belies its limited geographical area. There are numerous centres of excellence – in psychiatric research, service innovation and practice – and many countries have internationally recognised and excellent training schemes in psychiatry. But uniformity of practice is seldom in evidence.

An increasing number of states now belong to the European Union (EU) and, as with other groupings, the profession of medicine has found itself drawn into a need for greater unity by the Treaty of Rome (1957). This is reflected in European law. For example, in Council of Europe Directive 93/16/EEC some important principles are outlined:

- The legal expectations of member states are clarified in respect of such matters as the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.
- Psychiatry is recorded as a medical specialty with a training duration of a minimum of 4 years following basic medical training.
- The recognised titles of European training qualifications in medical specialties are listed. For the UK, for example, it is the Certificate of Completion of Training; for Germany, it is the Fachärztliche Anerkennung.
- These qualifications must be mutually recognised across national boundaries. Member states are not entitled to require medical practitioners who have such certification to complete any additional training in order to practise within its social security scheme, even when such training is required of holders of diplomas of medicine obtained in its own territory.

The Directive also recognises the need for some coordination over the requirements of training in specialised areas of medicine but leaves it to representatives of the specialties themselves to provide the details – the minimum training period, the method by which such training is given, the place where it is carried out, as well as the supervision required. These, therefore, are the focus of committees referenced for each of the European medical specialties. In psychiatry, this is the Union Européenne des Médecins Spécialistes (UEMS) Section and Board of Psychiatry, on which each EU national medical association is entitled to have two delegates.

Training in practice

With the requirement of mutual recognition of training already in place, one would expect there to be not only unity of content in training but also unity of conduct and audit. This is not the case. Surveys of UEMS national organisations of specialist training in psychiatry in Europe reveal continued variation in all aspects of training. The UEMS has sought

broadly to outline training requirements, advocating a multi-dimensional approach. But the differences in the content of training reported in surveys of specialist training are striking and significant. A miscellaneous range of issues appear to lie outside the orbit of unity or receive limited attention within it. Among these are the psychiatry of old age, community psychiatry, research methodology, epidemiology, forensic psychiatry, learning disability, transcultural issues, management and medical informatics. The settings in which psychiatry is taught within the EU are split between university psychiatry hospitals, general hospitals and general psychiatric hospitals. Although the majority of these have out-patient functions, the community aspects of care generally receive less attention and do not feature at all in many training programmes, despite a recognition that this is the likely future direction of the specialty in general.

Audit of training schemes

The recognition of training centres falls to the national authorities. The UEMS has neither the staff nor the legal authority to certificate or accredit training institutions. None the less, there are relatively few countries which engage in independent audit of training. That is, most engage in internal systems of review, and external visits are rare (Strachan & Schudel, 2004). This seems a serious omission, as those national associations which do engage external audit processes regularly identify discrepancies between what is described as happening in respect of training and what occurs in actual practice. In particular, the perceptions of those providing training and of trainees is often at variance. Recently, however, European psychiatric associations have become increasingly interested in audit as a means of enhancing training quality assurance (Prinz, 2005).

Procedures for the assessment of trainees are likewise widely varied in form; many centres rely solely on the internal assessment completed by local university staff. Competency-based examination programmes have mainly still to be developed. Few countries have an independent national system of examinations that assess both knowledge and clinical skills.

Psychotherapy

A significant area of discrepancy concerns the place of psychotherapy in psychiatric training. Some countries require trainees to undertake personal experience of psychotherapy, often at their own cost, while others provide training in psychotherapy which is partially funded.

There is as yet no consensus as to what forms of psychotherapy should be taught. Despite the current support for evidence-based intervention, psychoanalytic psychotherapy still dominates, although cognitive–behavioural and other systematic psychotherapies are gaining increasing recognition. Most centres provide both a theoretical and a practical training experience, although the time allocation for these varies widely. There is likewise variation in the training experience expected of those working with individual patients, families and groups.

Teaching in psychotherapy is seen as an area of particular interest to psychiatrists in Europe. Such treatments can be, and often are, delivered by professions other than medical in several countries and in many there is a challenge to the view that psychotherapy is of necessity a medical act. Particular challenge comes from those insurance and other agencies expected to meet the financial costs. Improvement in training in psychotherapies for psychiatrists is therefore a particular focus for many training schemes.

Clinical and educational supervision

There is similar variation in the experience trainees get in their supervision. A distinction between clinical and educational supervision has been highlighted by the UEMS. In brief, the former relates to the process of routine clinical practice, the latter to a dedicated period which each trainee has with a senior trainer in order to explore academic, theoretical and career aspects of training on a regular (usually weekly) basis. The demands of the service determine the agenda in clinical supervision; the needs of the individual trainee determine it in educational supervision. The available evidence from international surveys and from the outcome of audit processes suggests that educational supervision is not consistently provided. This has inevitable adverse consequences for a training which incorporates apprenticeship as well as theoretical elements.

Conclusion

It comes as a surprise, therefore, that both trainers and trainees report general satisfaction with their national training programmes. One suspects this reflects in part a persistent insular perspective in respect of expectations of both the content and the process of training. But it presents a real challenge for pan-European agencies trying to implement a more unified approach.

Psychiatry is not alone in its complex perspective on training in Europe – many other specialties report similar variation. Some, most notably in the surgical field, have been more successful in establishing European standards in their approach to training, the assessment of trainees and the audit of schemes.

In psychiatry at present there is a process of exploration of mutual strengths and challenges. This reveals very different political and social arrangements and attitudes in different member states. It will require change not only from psychiatric professionals but also from allied social and medical services if unification of psychiatry training in Europe is to proceed. But now that the differences and similarities are becoming clearer, further progress seems much more attainable.

References

Prinz, R. (2005) Erste deutsche Klinikvisitation durch die UEMS. *Nervenarzt*, **76**, 371–372.

Strachan, J. G. & Schudel, W. J. (2004) Accreditation of European training schemes in psychiatry. *Psychiatric Bulletin*, **28**, 19–20.

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).

Profile of psychiatry in Japan

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During the Edo period in Japan (1603–1867), people with mental illness were not excluded from society. Upon the introduction of European psychiatry around the 1870s, Japanese society became more discriminatory, however. In 1900 a primary law was introduced to regulate the custody of patients. In 1919 another law was approved to facilitate the establishment of public psychiatric hospitals. In 1950 the Mental Hygiene Law was enacted to prohibit home custody. However, these regulations did not assure quality of care or protect service users' rights. Also, after the Second World War, many private psychiatric hospitals were built, but this expansion of the sector was not well thought out or well coordinated. In Japan, the government regulates the private health sector only insofar as it sets standardised fees for treatments and carries out basic quality assurance.

In 1984 a scandal involving the murder of in-patients by nursing staff was reported at a psychiatric hospital. This prompted huge international pressure and the Japanese government passed the Mental Health Law in 1988. In 1995 this law was further revised to include welfare support.

Service provision

Japan operates a unique medical system in which payment for treatment is met via nationally standardised insurance; service users enjoy free access to the treatment facility of their choice. This financial assurance has sustained high accessibility to care, especially for those who fall under the Services and Supports for Persons with Disabilities Act. In consequence, numerous psychiatric clinics have emerged and in-patient treatment, including an emergency service, is available throughout the country. There are also many mental health and welfare centres, as well as rehabilitative facilities (including day treatment centres, work factories, group homes and community centres). With some variations these services are standardised and available throughout the country.

There has been a steady shift from in-patient to out-patient treatment in psychiatry in Japan. According to the World Health Organization (2005) there are 28.4 psychiatric beds per 10 000 population in Japan. There remains a huge population of elderly patients who have been in hospital for many years, but for newly admitted in-patients the average length of stay is around 2–3 months.

The private sector plays an important role. In 2004, of the total of 1667 psychiatric hospitals, 1370 were private. There has been some discussion regarding the discrepancy between academic psychiatry at universities and practice within private psychiatric hospitals.

The Japanese government has recently undertaken a structural reform of psychiatric services to reduce its expenditure in this area. The Services and Supports for Persons with Disabilities Act seems to be actually causing difficulties in some respects.

Collaboration between psychiatric and medical staff needs to be developed further in Japan. The standard of education of psychiatric nurses is not high. There is not yet a national professional qualification in clinical psychology.

Service users and stigma

The rights of service users are well protected. The Community Office and the Legal Advisory Board receive complaints from the users of psychiatric facilities and work to support them.

The stigma associated with mental health problems has been lessened through the media and the internet. The media frequently report on the importance of depression, suicide prevention and post-traumatic stress disorder (PTSD), for example. Also, many people are exchanging information and experience through internet 'chat' and 'blogs'. The internet is thereby facilitating a spontaneous anti-stigma movement in the general population.

The royal family in Japan has always been supportive of people with mental health problems. The honorary president of the national Epileptic Society is a member of the royal family and the prince and princess attended the World Congress of Psychiatry in Yokohama. Recently members have spoken rather openly about mental health problems within the royal family.

Current legislation

Only designated psychiatrists can authorise the involuntary detention or treatment of people with mental health disorders. Under the Mental Health and Welfare Law, the Ministry of Health and Labor designates for such work psychiatrists with more than 5 years' experience and knowledge of the legislative procedures; those who wish to be designated must submit eight case reports, which a board examines to ascertain whether appropriate reference is made to legal procedures and clinical treatment.

According to the law, there are three main types of admission. Voluntary admission is based on consent of the patient. Medical protection admission requires the consent of a responsible relative and the assessment of one designated psychiatrist that the patient needs in-patient treatment.

Compulsory admission requires that two independent assessments by designated psychiatrists agree the patient is exhibiting explicit danger of self-harm or harm to others.

A written report should be submitted for medical protection and compulsory admission; regular reports are also required thereafter. The law also regulates the conditions under which seclusion and restraint can be implemented.

The law gives patients the right to meet with a lawyer and to make a claim to the Community Office about treatment under any condition. An officer will visit the facility in response to a claim. Also, there is an annual inspection of psychiatric in-patient facilities.

Recent developments

Terminology

The most important recent development has been the substitution of the Japanese term for 'schizophrenia'. The term was previously translated as 'split-of-mind disease'. In 1993 the Japanese Society of Psychiatry and Neurology (JSPN) received a request from a family group to change the translation. After comprehensive discussion, in 2002 the JSPN adopted 'integration dysfunction syndrome' as the official term. This change, which coincided with the World Congress of Psychiatry in Yokohama, launched an active anti-stigma movement (Sato, 2006).

Specialist qualification

The second significant recent development has been the introduction of a specialist qualification by the JSPN. The project was approved in August 2002 and the first examination was implemented in 2006. For the specialist qualification, candidates are required to attend lectures in a wide range of areas. This system is expected to improve the quality of care provided by Japanese psychiatrists.

Law on Treatment and Surveillance

The Law on Treatment and Surveillance was implemented in July 2005. It applies to those who are mentally incapacitated and who commit a grave offence. Although there were many disputes in its passing, this law aims to provide a specialised, high-standard, rehabilitative treatment for this population. Under the law, a team composed of a judge, a psychiatrist and a psychiatric social worker decides the need for compulsory out-patient or in-patient treatment.

Treatment guidelines for schizophrenia and depression

Evidence-based guidelines for the treatment of schizophrenia and depression were developed in Japan in 2004. The American Psychiatric Association's *Practice Guidelines for the Treatment of Psychiatric Disorders (Compendium 2004)* was translated into Japanese and published in 2006. Psychopharmacology algorithms for schizophrenia and depression have been available since 1998.

Other developments

Other notable recent developments include the introduction of strategic planning to reduce suicides and a project of assertive community treatment.

Numbers of professionals

Japan has a population of about 128 million, for whom there are around 13 000 psychiatrists, 13 000 clinical psychologists, 3600 psychiatric occupational therapists and 22 000 psychiatric social workers. The number of specialised psychiatric nurses is only 25 (2005 figures).

Education

Psychiatric training is included in the core undergraduate medical curriculum. The focus is on tutorial teaching and less on lectures. Bedside learning and clinical clerkship are emphasised.

For postgraduate training, there are good psychiatric textbooks available in Japanese. In the past there was no explicit standard for postgraduate training programmes; however, the JSPN now sets a clear standard for the areas to be included in the postgraduate curriculum for specialist qualification.

Child psychiatry

Relatively few facilities provide effective treatment for children and adolescents. However, several issues affect this population in particular, such as domestic violence, child abuse, withdrawal at home and a lack of motivation to participate in study or work. The government and psychiatrists are trying to develop specialists in this area.

Psychotherapy

The training for psychotherapy is not yet systematically established. Typically, senior psychiatrists will teach the basics of psychotherapy and the rest will depend on the interest of residents. The JSPN plans to provide standardised psychotherapy training opportunities.

Research

Numerous high-quality research projects in the mental health field are being conducted in Japan. Especially noteworthy for international colleagues may be studies in neuroimaging, neuropharmacology, neurophysiology and genetics. On the clinical side, social skills training has been rigorously researched. Other clinical projects are investigating cognitive therapy for various populations, the 'Rework Assist Programme' (which seeks to facilitate the rehabilitation of company employees who experience mental health problems), the introduction of electronic patient record systems and clinical paths to improve the quality of care. An active interest in anthropological psychopathology from the German and French traditions has been maintained.

Professional associations

There are around 85 associations which deal with psychiatric issues. Each usually has an annual meeting, and there are

numerous seminars and lectures provided by these associations for both professionals and the general public.

Conclusion

Access to psychiatric treatments and services is available throughout Japan. Current priorities are the development of community care and the standardisation of professional education and training, as well as treatment. We look forward to exchanging our experiences with international colleagues.

References

Sato, M. (2006) Renaming schizophrenia: a Japanese perspective. *World Psychiatry*, **5**, 54–56.
World Health Organization (2005) *Mental Health Atlas 2005*. WHO.

COUNTRY PROFILE

Psychiatry in Cambodia: the phoenix rises from the ashes

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Cambodia is a low-income country in south-east Asia. It covers an area of 181 035 km^2 and has a population of 14.5 million, of whom 42% are less than 15 years old. Life expectancy is 56.8 years and 36% of the population live on less than US$0.50 per day. Cambodia experienced a brutal civil war and genocide in the 1970s under the Khmer Rouge regime, during which approximately 1.7 million Cambodians were killed (Chandler, 1999) and the social and medical infrastructure was almost completely destroyed. No mental health services existed throughout the conflict and subsequent Vietnamese occupation, despite the incalculable impact of the Khmer Rouge regime on Cambodians' mental health. The current political situation is more stable, although there remain concerns about human rights abuses (Khan, 2005).

Historical perspective

From 1935 to 1975, all psychiatric care was provided by a single psychiatric hospital located about 9 km to the south of Phnom Penh. By 1975, the patient population of the 800-bed hospital had grown to around 2000. Under the Khmer Rouge, the psychiatric hospital was destroyed and it is likely that all the patients were murdered. Across the country most professionals of all types were also killed – only 43 doctors survived, none of whom were psychiatrists (Savin, 2000). Between 1975 and 1994, there were no statutory psychiatric services and no mental health training in Cambodia.

Revitalisation of psychiatry in Cambodia

In 1994, a cohort of 10 junior doctors joined the Norwegian-funded Cambodian Mental Health Training Programme; they graduated in 1998. A second cohort of 10 completed training in 2001 and, in addition, 40 psychiatric nurses have now been trained in Cambodia. The first out-patient department was opened in Phnom Penh in May 1994. The present mental health service situation in Cambodia is summarised in Box 1.

Paradoxically, the complete destruction of the former mental healthcare system presented a unique opportunity to introduce community-based mental health services, as the often difficult tasks of reintegrating institutionalised patients into community settings and retraining staff who are accustomed to a custodial model of care were obviated in Cambodia.

Box 1 Current public sector mental health services in Cambodia

Staffing
- 26 psychiatrists
- 40 psychiatric nurses
- About 150 medical doctors have been trained in basic mental healthcare
- About 170 registered nurses have been trained in basic mental healthcare

Services
- 3 in-patient units for emergency assessment
- 18 psychiatric out-patient departments at provincial level (in general hospitals)
- 13 psychiatric units at health-centre level
- 1 child psychiatric out-patient department at national level
- 1 day-care centre at national level

Cambodian beliefs about mental health

Considerable stigma and fear surround mental illness. The majority of Cambodians with mental health problems are cared for by their families, neighbours, friends or traditional healers. Common complaints include tiredness, 'thinking too much', 'feeling very insecure' and flashbacks or disturbing dreams of traumatic events.

Under traditional belief systems, psychiatric disorders are typically attributed to witchcraft, possession by spirits or curses that pass from one generation to the next within a family. Some syndromes recognised by traditional healers approximate Western conceptions of mental illness, including alcohol dependence, postnatal depression and psychosis. Referral rates from traditional healers to mainstream services were thought to be low, but there is some evidence that they may be increasing.

Mental health policy and services

The Mental Health Subcommittee of the Cambodian Ministry of Health, now known as the National Programme for Mental Health (NPMH), was given responsibility for developing mental health services in Cambodia in 1992. It is helped by the World Health Organization and collaborates closely with foreign aid organisations. Considering the paucity of central government funding, the NPMH has had considerable success in developing community psychiatric services in Cambodia.

Government mental health clinics are now operating in 23 of the 24 provinces and cities of Cambodia, although, because of the poor transport infrastructure, patients commonly have to travel for several days to reach help. Consultation and initial medical treatment are subsidised by the government, but patients are expected to pay for ongoing treatment themselves and this is frequently beyond their means. In some settings, brief psychological interventions are offered, usually in groups. Home visits by psychiatric nurses are occasionally available in some areas. There are small in-patient units at the main psychiatric clinic in Phnom Penh and in two provinces; these are used exclusively for brief assessments, usually for 24 hours or less.

Under a pilot scheme in the province of Battambang, mental health services have been integrated into the existing system of 13 community health centres, which operate at the village level. The NPMH hopes to extend this model into other provinces.

There is no legislation relating to the involuntary detention of patients in hospital.

Voluntary and charitable organisations

In addition to the statutory services, a number of non-governmental organisations (NGOs) are working in mental health in Cambodia. Probably the largest is the Trans-cultural Psychosocial Organisation (TPO Cambodia), which was set up in 1995 by its parent organisation, TPO Amsterdam. TPO focuses on raising awareness of mental health issues and the training of local health professionals, volunteers, religious leaders and traditional healers in the detection and treatment of psychiatric disorders. It now employs over 60 staff, including two psychiatrists, six psychologists and six social workers. Another NGO, the Centre for Child Mental Health, established Cambodia's only child mental health service. The Social Services of Cambodia, another NGO, has been working on community mental health projects since 1994.

Patient mix and referral patterns

A survey undertaken by K.S. and P.B. of clinic attenders at the main psychiatric out-patient department in Phnom Penh in 1996 found that around two-thirds were female. Nineteen per cent were diagnosed with psychotic disorders, 40% with mood disorders and 33% with anxiety disorders. Around a third had initially sought advice from traditional healers, a third had consulted general medical services and the remaining third had not consulted previously for their presenting problem.

Training and research

Psychiatry is now part of the undergraduate curriculum for both doctors and nurses, and is taught in all regional training centres. There are plans for a basic 3-month training programme to be made available to doctors and nurses, as well as plans for a 2-week mental health course for general practitioners and registered nurses working at health-centre level.

In order to attract investment in mental health, there is a need for research into the health needs and illness behaviour of Cambodians with mental health problems. In addition, the tragic recent history of Cambodia and the post-conflict situation make the country a potentially important resource for research into the individual and collective psychiatric sequelae of genocide and other traumatic events. Some foreign universities are collaborating in research and training in Cambodia, including the Institute of Psychiatry in London, but there is little research infrastructure within Cambodia itself.

Conclusion

Mental health services in Cambodia have progressed at an impressive rate in the past 10 years, but there is much that remains to be done. So long as the political situation remains relatively stable, and foreign aid continues at current or increased levels, the hard work of the mental health professionals in Cambodia should continue to reduce the gap between the need for and the provision of mental health services.

References

Chandler, D. (1999) *Voices From S21: Terror and History in Pol Pot's Secret Prison*. University of California Press.

Khan, I. (2005) Open letter on the occasion of International Human Rights Day 2005 raising concern about the state of freedom of expression in the Kingdom of Cambodia. Amnesty International. Public statement ASA 23/006/2005. See http://www.amnestyusa.org/countries/cambodia/document.do?id=ENGASA230062005. Last accessed 8 February 2007.

Savin, D. (2000) Developing psychiatric training and services in Cambodia. *Psychiatric Services*, **51**, 935.

Mental health in The Netherlands

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The Netherlands borders the North Sea and is located between Belgium and Germany. Its total area is about 41 500 km², nearly 34 000 km² of which is land area. The country consists mostly of coastal lowland and land reclaimed from the sea (polders). An extensive system of dykes and dams protects nearly one-half of the total area from being flooded.

The Netherlands is one of the most densely populated countries in the world, at around 480 persons per km² of land area (total population of 16 299 000 as of 1 January 2005). About 20% of the population have a foreign background. Of the total number of jobs available, about one-sixth are in trade, one-sixth in industry, one-eighth in business and one-eighth in health and social care. Agriculture and fisheries account for only 1.5% of the workforce, so it is fair to call The Netherlands an advanced post-industrial society (Metz & Poorter, 1998).

According to the Healthcare Budgetary Framework (Ministry of Health, Welfare and Sport), the cost of healthcare was €45 billion in 2004, representing 9.2% of gross domestic product (GDP). Healthcare expenditure as a percentage of GDP in The Netherlands is on a level with the middle group of European countries.

The annual prevalence rate of mental conditions (excluding alcohol and substance misuse) in the Dutch population is 16%. Over 40% of the Dutch population have at one time had a mental condition (including alcohol and substance misuse). In the period 2000–4 one in every three Dutch adults with a mental condition sought help.

Mental health policy

Mental healthcare is part of the portfolio of the Minister of Health. Since the late 1990s, government policy has been based on principles such as continuity of care. Collaboration between clinical and ambulatory care resulted in the establishment of integrated institutes for mental healthcare.

Mental healthcare is mainly financed through the Exceptional Health Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ), but this mechanism is due to change over the next few years. A substantial part of mental healthcare will be transferred to the health insurance system and be financed in a manner similar to physical healthcare. Payments will be based on 'diagnosis treatment combinations' (*diagnose behandel combinaties*, DBCs). Only hospitalisation exceeding 12 months will be paid through the Exceptional Health Expenses Act.

Government policy on mental healthcare is also changing. Mental healthcare is now integrated into general healthcare. The introduction of evidence-based programmes and guidelines will improve the diagnosis and treatment of psychiatric disorders, both in primary care and in specialist care; a system of 'stepped care' will also be introduced. Competition between care providers will be promoted and new mental healthcare organisations are being persuaded to enter the (mental) health market. The purpose of this competition is to keep costs down and to improve the quality of care.

Mental health service delivery

Mental healthcare is delivered by some 40 integrated institutions (hospital, day hospital, out-patient and community care) for children, adults and elderly people, of which ten are for children and adolescents, nine for people with addictions and seven for forensic psychiatric care. The total number of beds is 29 000. Mental healthcare uses 8% of the total healthcare budget of €45 billion and employs about 40 000 people.

Psychiatric training

Undergraduate medical training takes 6 years and ends with the final licensing examination, after which the student obtains the formal qualification to practise medicine. Nearly all graduates continue their studies with specialty training. Dutch specialist training is elaborately regulated and closely monitored; there is no final examination. Regulations for specialist training specify the requirements for the specialists in charge of the training, the teaching institutions and the duration, content and conditions of training.

Candidates for training in psychiatry apply for a place on an acknowledged specialist training programme. If accepted by the trainer, they are required to notify the Committee for the Registration of Medical Specialists (MSRC) and to submit a training schedule for approval. This schedule must accord with the regulations for psychiatry. The trainee works as a resident under the supervision of a specialist trainer within the framework of specific teaching rules. Residents are evaluated annually and feedback is sent to the MSRC. In case of concerns about the resident's progress, the MSRC is empowered to prolong, or even terminate, the training. Once the resident has completed training, the MSRC may, on receipt of the trainer's final statement, enter them as a psychiatrist on the Dutch register of specialists. The resident must provide the MSRC with detailed information on the training, in the form of a logbook. As one of the requirements for registration, doctors must publish a paper in a peer-reviewed journal or present a lecture at a peer-reviewed scientific meeting.

In 2006, 664 (266 male, 398 female) doctors were trained to become psychiatrists. The 2616 (1649 male, 967 female) registered psychiatrists constitute around 15% of the total number of medical specialists in The Netherlands (17 030).

Training for psychiatrists in The Netherlands complies with most requirements of the Board of Psychiatry of the Union Européenne des Médecins Spécialistes (UEMS; see http://www.uemspsychiatry.org/board/reports/Chapter6-11.10.03.pdf). The only departure from this guidance provided by the UEMS is in the duration of training, which in The Netherlands is 4.5 years instead of the recommended 5.

Training in community psychiatry and psychotherapy is an integral part of the programme. Also, 50 sessions of psychotherapy undergone by the trainee (i.e. as a client) is a mandatory part of training.

Most training in psychiatry is carried out in the integrated mental health institutes (27 of these offer training), but it is also done in seven of the university clinics and in one psychiatric department at a general hospital.

Assessment visits to every training scheme are mandatory at least every 5 years. The assessment team includes a trainee who speaks independently to the trainees on that scheme.

There are no formal sub-specialties in psychiatry in The Netherlands, although there is a register of child and adolescent psychiatrists.

Re-registration

Every medical specialist has to be re-registered every 5 years. To meet the revalidation criteria, psychiatrists are required to work at least 16 hours a week in psychiatry for 5 years and to accumulate 40 hours of continuing medical education (CME) a year. In addition, psychiatrists should take part every 5 years in the assessment visit scheme of the Dutch Psychiatric Association (Nederlandse Vereniging voor Psychiatrie, NVvP).

Allied professions

All healthcare professionals providing direct patient care must, by law, be registered under the Individual Healthcare Professions Act – that is, on the wet Beroepen Individuele Gezondheidszorg (BIG) register. The legislation covers both general medical doctors and specialists.

An estimated 16 000 nurses work in mental healthcare, 30% of whom are graduates and 2% of whom have achieved a professional qualification at a masters or specialist level. About 5500 generalist psychologists and an estimated 1100 specialist psychologists (clinical psychologists, *klinisch psycholoog*) work in mental healthcare. As in psychiatry, psychotherapy is an integral part of the professional training of specialist psychologists. Furthermore, there are about 1400 psychotherapists and an estimated 600 medical doctors working in mental healthcare.

Main areas of research

Research in psychiatry in The Netherlands is concentrated around the seven university clinics, although the efforts of the integrated mental health institutes are growing. An important impetus to mental health research in general has been given by the ZonMw (the national health council appointed by the Ministry of Health; http://www.zonmw.nl/programmas/geestkracht) and The Netherlands Organisation for Scientific Research (NOW) to promote quality and innovation in the field of health research and care. An ambitious long-term programme, with a budget of €24 billion, under the name 'Geestkracht' (Mental Power), has three specific objectives:

- to promote application-oriented research, knowledge transfer and implementation
- to facilitate PhD research and to promote the availability and uptake of adequate educational opportunities for mental health researchers
- to strengthen research and knowledge infrastructure through cooperation between different scientific institutes and institutions providing healthcare.

GROUP (http://www.groupproject.nl) is a national consortium of 39 university and non-university institutes that concentrates its research on psychotic disorders. 'Generation R and Trails' and NESDA (Netherlands Study on Depression and Anxiety, http://www.nesda.nl) are both engaged in research concerning children and young adults, and anxiety and depression respectively.

Human rights issues

Although there are no exact data available, the general view is that seclusion rooms are used more frequently in The Netherlands than in neighbouring countries. One of the reasons for this is that treatment against the patient's will is restricted by law. Only when there is acute danger to the patient or others is carefully monitored forced medication allowed. Fortunately, the growing feeling of discomfort among professionals, psychiatrists and nurses is slowly contributing to the re-evaluation of the use of seclusion rooms. Furthermore, there are initiatives to change mental health legislation in The Netherlands which would lead to (involuntary) treatment being sometimes used as an alternative to seclusion and restraint.

Challenges

Further implementation of multidisciplinary guidelines is one of the challenges for the healthcare professions. Psychiatrists, supported by their scientific association, will play an important part in this implementation process.

Although prevention is not neglected at the moment, primary and secondary prevention, in cooperation with public healthcare, should receive more emphasis in the near future.

As mentioned above, a reduction in the use of restraint, supported by scientific research, will be one of the major challenges for psychiatrists in the coming decade.

It is not unlikely that psychiatric patients with chronic illness will fall victim to greater competition in the healthcare market. It is reasonable to expect that the attention of the insurance companies, healthcare organisations and professionals will be focused on the less complicated cases

(typically patients with Axis I disorders). The challenge for psychiatrists and other professions will be to ensure that patients with chronic illness receive adequate (community) mental healthcare in the future.

Reference

Metz, J.& Poorter, J. (1998) The Netherlands. In *Medicine and Medical Education in Europe* (ed. G. Eysenbach). Thieme.

The teaching and training of psychiatry in Thailand

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In Thailand, we have only two programmes for residency training in psychiatry: one is general or adult psychiatry, which takes 3 years to complete; the other is child and adolescent psychiatry, which takes 4 years. There are nine institutes that offer residency training but only three medical schools have the capacity to offer training in both general and child psychiatry (Table 1).

The curriculum for training in adult psychiatry is similar to that in many other Asian countries. It is outlined in Table 2. Most residents learn psychiatry in both in- and out-patient settings simultaneously, although some institutes prefer to have their trainees initially learn in a psychiatric ward, during their first 3–6 months of training.

It is compulsory that all accredited training institutes arrange at least 2 hours of supervision per week. Trainees will meet one or two supervisors during the 3-month rotation. Most of them will have one supervisor who is in charge of the ward staff and another who supervises care of out-patients. The second- and third-year residents will have an extra supervisor specifically to supervise psychotherapy cases.

Outline of the curriculum

Most institutes emphasise interviewing techniques and mental status examination during the first 3 months. The techniques are taught through lectures and observation. Thereafter they are practised throughout the programme, both individually with feedback by supervisors and in group sessions – 'interviewing seminars' – with feedback from peers and staff.

Trainees learn the concepts of psychological treatment largely from lectures, but also in book clubs and topic discussion sessions.

They have to manage at least two psychotherapy cases during the 3 years of training, including one of short-term therapy and another of long-term treatment. They normally review cases with their supervisor once a week and bring cases for discussion in a psychotherapy seminar once a month. Apart from psychotherapy, trainees must also study another psychological treatment method, such as behaviour therapy, cognitive therapy or family therapy. They are not required to practise these methods, however, as there are too few skilled and certified therapists in those areas to supervise them.

For electroconvulsive therapy (ECT), trainees will listen to a lecture first. Then they will observe staff and/or senior

Table 1 Institutes that provide psychiatric residency training in Thailand

Medical school/institute	Province	General psychiatry	Child psychiatry
Siriraj Medical School	Bangkok	Yes	Yes
Ramathibodi Medical School	Bangkok	Yes	Yes
Phramongkutklao Hospital	Bangkok	Yes	No
Chulalongkorn Medical School	Bangkok	Yes	Yes
Chiang Mai Medical School	Chiang Mai	Yes	No
Prince of Songkla Medical School	Songkhla	Yes	No
Khon Kaen Medical School	Khon Kaen	Yes	No
Somdet Choapraya Institute of Psychiatry	Bangkok	Yes	No
Yuwaprasart Waithayopathum Psychiatric Hospital	Samut Prakan	No	Yes

Table 2 General psychiatry curriculum in Thailand

Year of training	Topic	Duration
First year	General adult psychiatry	6 months
	Mental health hospital psychiatry	3 months
	Neurology	3 months
Second year	General adult psychiatry	6 months
	Child and adolescent psychiatry	3 months
	Consultation–liaison psychiatry	3 months
Third year	General adult psychiatry	6 months
	Addiction psychiatry	1 months
	Community psychiatry	1 months
	Forensic psychiatry	0.5 months
	Day hospital, juvenile court	0.5 months
	Electives	3 months

residents performing ECT and will eventually practise ECT by themselves.

In terms of management skills, they must take the role of chief resident at least for some period in the last year of training. They will also be involved in ongoing quality-improvement activities which are related to the hospital accreditation process.

Research

In 1999 the National Board of Examiners requested that all residents submit research reports with their application for the national examination.

Examinations

At the end of each year (in some institutes twice a year, mid-year as well as end of year), each institute sets examinations. There are three sections: a written paper, a case interview and an oral examination. The written paper consists of three parts: 150 multiple-choice questions, sat in 3.5 hours; six modified essay questions (MEQs), sat in 3 hours; and six short essays, sat in 3 hours (five of these relate to psychiatry and one to neurology). The pass mark is 50%.

For the case examination, trainees have to interview two psychiatric patients and evaluate one neurological case. They have 30 minutes to interview each patient and 45 minutes to summarise and answer questions. The pass mark is 60% for each case; marks are awarded by two independent examiners.

For their oral examination, trainees are assessed in 1 hour by three examiners in the following areas: knowledge, attitude towards the profession, cultural considerations, ethics, judgement and emergency decision-making skills. The examiners grade each area A, B, C or F. Examinees will pass if they do not receive any Fs.

If trainees fail a case examination only, they will have a chance to resit within the following 6 months, but if they fail in written and case examinations they will have to resit the next year. After the examination, trainees are asked to provide feedback on the examination process to the National Board of Examiners.

Trainees who pass the National Board examination are qualified to apply to be Fellows of the Royal College of Psychiatrists of Thailand (RCPsychT). When their application has been approved by the executive committee of the College, they can use the letters FRCPsychT after their family names. As of 8 February 2007 there were only 407 Fellows.

Conclusion

Psychiatric residency training in Thailand is at present offered for only general and child and adolescent psychiatry. Training in other sub-specialties, such as geriatric psychiatry or forensic psychiatry, is not yet available. The number of doctors who apply for training in psychiatry is increasing, which means a bright future for teaching and training in Thailand can be expected.

Further reading

Udomratn, P. (2003) Psychiatric education in Thailand. *ASEAN Journal of Psychiatry*, **6**, 102–106.

SPECIAL PAPER

Self-harm by poisoning in Mauritius

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Suicide rates and rates of self-harm are high in Mauritius. This report concerns a comprehensive analysis of the incidence of self-poisoning on the island. The incidence of self-poisoning could be minimised if all the causative factors contributing to the practice were identified. Since this form of self-harm is influenced by demographic patterns, the social and economic environment, legal provisions and the healthcare system, a study specific to Mauritius will be of great relevance.

Self-harm is defined as a non-fatal act in which an individual deliberately caused self-injury or ingested a substance in excess of any prescribed or generally recognised dosage (Kreitman, 1977). The term self-poisoning is used when the self-harm results from drug overdose or ingestion of other noxious agents and where there is no intention to die.

Background

The Republic of Mauritius is a group of islands in the south-west of the Indian Ocean, east of Madagascar, with a population of about 1.2 million. The population is multi-racial and multi-ethnic, with origins from the continents of Asia, Africa and Europe: 68% of the population are Indo-Mauritians, 27% are Creoles, 3% are Sino-Mauritians and 2% are Franco-Mauritians. Around 24% of the population are

under the age of 14 years, 70% between the ages of 15 and 64 and 7% over 65 years. Forty-eight per cent of the population is Hindu, 32% Christian and 17% Muslim.

Mauritius is classified as an upper-middle-income country in sub-Saharan Africa by the World Bank. Its per capita gross domestic product is US$13 200. Mauritian society has undergone a process of rapid economic and social change and modernisation over the past three decades. With the advent of tourism as an industry, better air services and the electronic media, Mauritius has opened up to the rest of the world. The birth rate has dropped to 15.3 per 1000 population and a typical family has two or three children. Life expectancy is 68.6 years for males and 76.6 years for females. The literacy rate is 86%. Primary education has been compulsory for many years and secondary education is so now. There is gender equality as far as education is concerned. The increasing numbers of school-leavers have led to an imbalance between opportunities and aspirations, which has caused some frustration and maladjustment. With the establishment of an 'export processing zone', many literate women in the country have found employment. This has also contributed to a change in the fabric of society.

The Ministry of Health is the governing body responsible for providing health services. Mental health services have been decentralised; units in all regional hospitals provide outpatient care as well as liaison psychiatric services.

Self-poisoning: a survey

Self-harm is the strongest risk factor for suicide (Owens *et al*, 2002). According to government (in-patient) statistics there was a sudden rise in attempted suicide in 1998, to 118 per 100 000, followed by a gradual decline, to 78 per 100 000 in 2004 (Fig. 1).

For the present study, 147 patients admitted as a result of self-poisoning to a regional general hospital in an urban area between August 2004 and July 2005 and referred to the psychiatric unit were reviewed. They constituted about 30% of the total in-patient referrals. During the same period 28 patients claimed to have ingested poisonous substances accidentally.

There are no rules or regulations regarding referral of such patients – the physicians refer at their own discretion; however, the majority of such patients are referred to the psychiatrist.

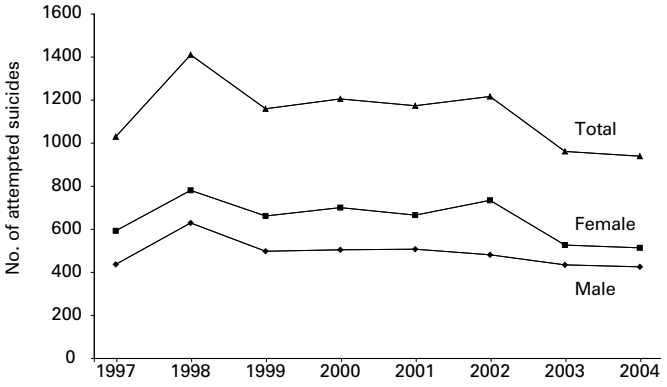

Figure 1 Number of suicide attempts in Mauritius (public sector in-patients statistics), 1997–2004.

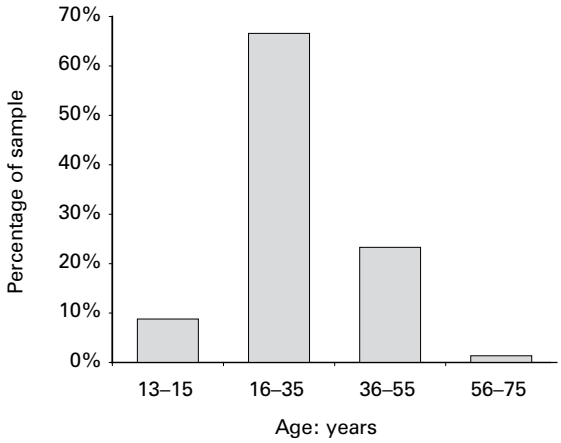

Figure 2 Age distribution of study sample (all cases of self-poisoning admitted to a regional general hospital in an urban area between August 2004 and July 2005, n = 147).

A slight majority of the 147 patients reviewed were female (58.5%; male:female ratio of 1:1.4). More males (64%) than females (55%) were single. Although single, most of them were living with family.

Figure 2 shows the age distribution of the sample. The majority (67%) of patients were between the ages of 16 and 35 years; 23% were between 36 and 55 years. That 9% were in the age group 13–15 years is of some concern. Only 1% of the sample was over the age of 55.

The difference between religious groups was striking: 57% of the sample were Hindu and 13% Muslim, with Christians (Catholics) comprising the other 30%. However, if the absolute percentages are normalised to the religious make-up of the general population then the difference is less marked.

Forty-five per cent of the patients had education up to upper secondary level, similar to the findings of another study of attempted suicide carried out in Mauritius (Dewkurrun, 2002). Eighteen per cent had been educated up to lower secondary level and 35% had had only primary-school education. The level of education was higher for females than for males.

The incidence of past psychiatric illness was higher than reported by Dewkurrun (2002). Ten per cent of the sample had made a previous attempt at self-poisoning, females more than males.

Twenty per cent had imbibed alcohol before the act of self-poisoning; most of these were male (71%). In these instances alcohol was found to be the disinhibiting factor or they had had disputes because of the drinking. Ten per cent of the patients were diagnosed with alcohol dependence syndrome. Chronic alcohol and drug problems have been cited as a risk factor for self-harm and eventual suicide (Beck & Steer, 1989). The incidence of past medical illness was not significant (5%).

Figure 3 shows the agents used by the sample. Self-poisoning took the form of an overdose of a medicine in 60%. In 22% psychotropic drugs were used. Paracetamol, either prescribed or bought over the counter, was used in

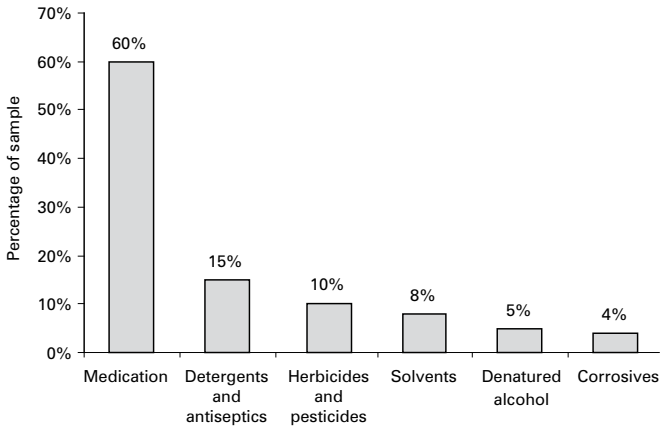

Figure 3 Agents used for self-poisoning (n = 147).

14%. Other prescribed drugs were commonly used (24%); these included chlorphenamine, ibuprofen and antibiotics. In some instances a mixture of alcohol and paracetamol or other tablets was used. Detergents and antiseptics (which are readily available) were used by 15%. Herbicides or pesticides were used by only 10%. Solvents were used in 8% and corrosives in 4% of cases, with serious consequences. Denatured alcohol (commonly for cleaning purposes) was used in 5% of cases.

Most of the acts were impulsive, in response to social problems. The reasons for self-poisoning varied. Interpersonal difficulties were common, and often involved a spouse (26%) or another family member (24%). Alcohol misuse was an important factor. Other reasons cited were disputes with a boyfriend or girlfriend, problems with parents (especially among the young), unsatisfactory academic results and financial problems.

Major medical complications were mostly seen in cases of corrosive poisoning. Minor complications like gastric irritation were common.

Discussion

According to government statistics, the number of people attempting suicide seems to be diminishing. It is worth mentioning that these statistics are wholly based on in-patient admissions to government hospitals; those admitted to private clinics are not included. Further, many people who do not become seriously ill as a consequence of self-poisoning do not come forward for treatment, but instead resort to home remedies. Attempted suicide is not an offence in Mauritius, but social prejudice following self-harm is so strong that many people try to conceal it.

The large number of young people seen is in keeping with studies carried out locally and worldwide. The transition from a traditional to a modern society typically generates conflicts between the younger generation and their parents. In this group a large percentage had received secondary education and might have been frustrated by unsatisfied aspirations. The stress associated with work and family responsibilities for literate married women who had entered the labour force was also noted, as were the difficulties faced by the spouse.

In the married group social problems resulting from alcohol misuse were common. The difference in incidence among the three principal religious groups was significant; a similar finding was reported from Fiji, which has an immigrant population similar to that of Mauritius (Haynes, 1984).

The means used for self-poisoning has changed over the years. Prescribed psychotropic and other drugs have become more readily available. The free sale of highly toxic herbicides and pesticides has been curtailed and this has had a positive effect.

Although the numbers of patients with psychiatric illnesses were relatively high, these were impulsive acts without suicidal intent. However, proper assessment of this group is of great importance. Social factors were contributory, most probably having led to the illness in the first place.

Conclusion

These findings have implications for suicide prevention strategies:

- The young population has to be targeted. The introduction of education on mental health in secondary schools will be of prime importance and will not be too difficult to implement. Regular counselling and education sessions on suicide and self-harm and related topics will have to be organised at youth centres (these are present in all regions of the island).
- A protocol for assessing patients attending casualty after an act of self-harm has to be established, so that they are seen by trained personal and further assistance and follow-up are given. These patients are more likely to die by suicide. As many fail to attend follow-up clinics, support and counselling services away from hospital would probably be more effective.
- In addition to the National Strategic Action Plan for Suicide Prevention which was implemented in 2006, the introduction of a national policy to deal with alcohol dependence and related problems will be of great preventive value.
- Community psychiatric services and social workers can also aid the prevention of suicide.
- Non-governmental organisations are active in this sector and their contribution should be recognised and encouraged.
- Enlisting the services of sociocultural organisations to educate the vulnerable population will also have to be considered.

References

Beck, A. T. & Steer, R. A. (1989) Clinical predictors of eventual suicide: a 5- to 10-year prospective study of suicide attempters. *Journal of Affective Disorders*, **17**, 203–209.

Dewkurrun, G. (2002) *Attempted Suicide in Mauritius: A Sociological Study*. Dissertation thesis, University of Mauritius.

Haynes, R. H. (1984) Suicide in Fiji: a preliminary study. *British Journal of Psychiatry*, **145**, 433–438.

Kreitman, N. (ed.) (1977) *Parasuicide*. Wiley.

Owens, D., Horrocks, J. & House, A. (2002) Fatal and non-fatal repetition of self-harm. Systematic review. *British Journal of Psychiatry*, **181**, 193–199.

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

Psychological therapy organisations

Introduction

Brian Martindale

This article informs readers of four organisations that have undergone substantial development in recent years. All four aim to be European or even wider vehicles for the exchange of clinical knowledge and expertise in particular psychological therapies relevant to psychiatry and allied professions.

Psychodynamic, cognitive–behavioural and systemic models are the three core theoretical modalities on which much practice is based in public services, although technical applications of these take many creative forms. Three of the European organisations described below bring the particular practitioners of these modalities from different countries together and the fourth organisation focuses more on a specific clinical field – psychosis – where psychological therapies still tend to be somewhat neglected.

Training in psychotherapy for psychiatrists as well as the regulation of the practice of psychotherapy varies considerably, even in Europe, from one country to another and readers may find considerable food for thought and debate in reading the 2004 report on psychotherapy from the Section of Psychiatry of the European Union of Medical Specialists at http://www.uemspsychiatry.org/section/sectionReports.htm.

The European Federation for Psychoanalytic Psychotherapy

Siv Boalt Boëthius, Chair, EFPP

The European Federation for Psychoanalytic Psychotherapy (EFPP) was inaugurated in 1991. It was founded by the British psychoanalyst and psychiatrist Brian Martindale in collaboration with some colleagues from different countries in Europe. Its overall aim is to contribute to the mental health of people living in Europe and to facilitate communication between psychoanalytic psychotherapists in Europe. The EFPP is concerned with extending the availability of psychoanalytic psychotherapy, and is especially concerned with psychoanalytic psychotherapy within mental and physical health and related public services.

The EFPP promotes networks of psychoanalytic psychotherapists through annual conferences, publication of the EFPP book series, support of training programmes and research, and its website. The EFPP supports its member networks in their discussions and the setting of national training standards for psychoanalytic psychotherapists. The EFPP's training standards are agreed upon as the benchmark for national networks and the general principle is that the EFPP is an inclusive organisation.

Membership of the EFPP is open to all European countries; at present 26 are members. The EFPP consists of three sections, which work with psychoanalytic psychotherapy for adults, children and adolescents, and groups. A fourth section, for psychoanalytic couple and family psychotherapy, is being developed. The membership of the EFPP is built on national networks. Each country with full membership can have at most two delegates on each of the three sections. Delegates are appointed by the organisation or network of organisations from the member countries.

The executive committee consists of three delegates from each section. Members of the executive serve a maximum of two 4-year periods. The executive seeks to keep up to date with the development of psychotherapeutic work in the member countries, especially in relation to conditions for work with patients, facilities for training in psychoanalytic psychotherapy, and research. A major task has been to agree standards of training that are desirable and functional.

Another main area of work is the EFPP conferences. Each section arranges its own conferences in turn: the group section's conference was held in Lisbon in 2004, the adult section's conference in Dresden in 2005, and the child and adolescent section's conference in Berlin in 2006. A three-section conference will be held in Copenhagen in 2007. Besides the section conferences there are the Francophone conferences, the latest of which took place in 2006 in Ibiza in Spain. Until 2005, special conferences were also arranged for Central and Eastern Europe, but these countries have now joined the regular EFPP conferences.

Special features of the EFPP conferences are the discussion groups after each plenary session and a number of ongoing workshops on, for example, infant observations, trauma and state violence, research, training, psychoanalytic couple and family psychotherapy and peer-review sessions in collaboration with the editorial board of the *International Journal of Psychoanalysis*.

An area where much remains to be done is in relation to clinically based research, where the clinicians themselves can contribute in a more integrated way by systematic documentation of their own clinical work. This type of research is often done in cooperation with a university and has to have the support of the clinical centre.

How to develop the publication of the EFPP book series and other publications is another area of concern, as we need good publications.

We are also working with different types of summer school, focusing on, for instance, supervision of psychotherapeutic work and other ways of supporting such work in Eastern and Central European countries.

For further information see http://www.efpp.org.

The European Family Therapy Association

Arlene Vetere, President, EFTA

The European Family Therapy Association (EFTA) was inaugurated in 2001 in Budapest. Its statutes set out its seven aims, two of which are:

- to link and coordinate European-wide national family therapy organisations, family therapy training institutes and practitioners in the field of family therapy and systemic practice, and family mediation
- to spread information about family therapy and systemic approaches throughout Europe to individuals, institutions and organisations concerned with the health and development of families and human systems.

I have highlighted these two of the seven because they capture the essence of our mission – to promote systemic thinking and practice through communication, liaison and cooperation, both within and outwith our organisation. Such a mission carries with it special responsibilities for overseeing and monitoring standards of practice, for training, qualified practice and supervision within our own field at a European level, and assisting other mental health disciplines that include systemic training as part of their own professional training and practice.

The EFTA was originally founded in the early 1990s by a group of committed trainers who wished to promote systemic training and practice across Europe. It was their vision, under the then presidency of Mony Elkaim, to invite the national family therapy associations to meet and discuss how they might all work in cooperation. It posed an interesting systemic problem: how to develop a structure that would support the autonomy of all the interest groups that operate at different levels of systemic influence and responsibility, while retaining the coherence and cooperative potential of the whole.

The EFTA is a vibrant and complex organisation. Our new statutes were designed to support our organisational structure. We host three autonomous 'chambers', each represented by an autonomous board:

- the Chamber of National Family Therapy Organisations (which has 25 participating countries)
- the Chamber of Family Therapy Training Institutes (120 training institutes)
- the Chamber of Individual Practitioners and Trainers (1500 members).

Each board comes together to form the General Board of the EFTA, which is chaired by the President. The Coordinating Body comprises the President, the three board chairpersons, the General Secretary and the General Treasurer; it oversees and supports the cooperative activity of the three chambers. Each chamber hosts separate activities for its members and participates in EFTA-wide organisational activities. The EFTA has always mounted an international conference every 3 years. Our last conference, held in Berlin, attracted over 3500 participants.

Nearly all EFTA members are dual-trained; the disciplines of clinical psychology and psychiatry are the most commonly represented. In practice this means we have strong informal links with national professional associations of psychology and psychiatry, at European and international level. For example, Tamas Kurimay, a member of our General Board, is also a member of the board of the World Psychiatric Association.

Our vision for the future includes consolidating our achievements and developing our ambassadorial roles. We intend to help regional and national associations develop their influence on social policy, with an emphasis on preventive work and, at the very least, to help social policy makers bear in mind the wider systemic consequences of a more narrow, individualised approach to mental health in our communities.

We welcome contact from other European-level psychotherapy and mental health organisations. We believe we should be working together at European level to promote well-being in our communities, and in helping to think about and resolve community-based inequalities and conflicts.

Please contact us if you would like to know more about us, or visit http://www.efta-europeanfamilytherapy.com.

The European Association for Behavioural and Cognitive Therapy

Rod Holland, Communications Officer, EABCT

The European Association for Behavioural and Cognitive Therapy (EABCT) was established in 1976. It is an organisation of national cognitive and behavioural therapy associations and brings together 41 individual associations from 28 different European countries plus Israel; it has a combined membership of over 25 000 clinicians and researchers. Membership continues to rise: three new associations have already applied for membership in 2007.

Associations vary widely in size and structure: they range from associations of over 5000 members in the UK (the British Association for Behavioural and Cognitive Psychotherapies – see http://www.BABCP.com), Germany and The Netherlands to smaller associations in Iceland, Estonia and in Lithuania (one of the most recent member associations). Most countries have one association representing cognitive–behavioural therapy (CBT) but some (Austria, Germany, Belgium, Switzerland, Italy, Finland and Romania) have two or more, reflecting regional and sometimes language differences. Associations may also have a different focus, with some being more cognitive or behavioural than CBT in orientation. This highlights the fact that cognitive and behaviour therapy is more than just one approach but rather represents a family of approaches. This family will no doubt continue to grow as new CBT approaches develop, such as schema-focused therapy, 'mindfulness', acceptance and commitment therapy (ACT) and so on.

The professional background of members reflects the broad mix of professionals who are trained in the approach. The UK group has the broadest membership, with practitioners from psychiatry, clinical and other applied psychology, nursing, counselling, social work, occupational therapy, special needs teaching and so on. Other associations have a narrower range of professionals in their membership, which is often the result of the regulations or traditions that govern who can or cannot practise psychotherapy in their country.

The EABCT and each of its member associations is committed to empirically based principles and the practice of behavioural and cognitive therapy approaches in the

health, social, education and related fields. They have a common goal – to develop the highest standards of clinical practice – and the EABCT is committed to ensuring the training of competent therapists in each of its member associations. The EABCT has developed a set of core training standards that apply to all member associations that accredit their members as cognitive–behavioural therapists.

One of the EABCT's main activities as an international forum in Europe has been to host an annual congress and workshop programme; this is open not just to members but also to non-members who are interested in the development of cognitive and behavioural therapies. This congress is organised by a different member association each year, which ensures that it moves around Europe and is made accessible to as wide a membership as possible. Each year the congress will draw in over 1000 clinicians and researchers from across Europe and the rest of the world.

The EABCT works closely with the other CBT associations around the world and in July 2007 it will be hosting what is likely to be the largest meeting on CBT, the Fifth World Congress of Behavioural and Cognitive Therapies, in Barcelona, Spain (http://www.wcbct2007.com). In 2008 the EABCT congress will be held in Helsinki, Finland, followed in 2009 in the city of Dubrovnik in Croatia.

The EABCT does not publish its own journal but many of its member associations have developed their own well respected journals and details of these can be found on their respective websites. The Association does publish its own newsletter, *European Behaviour and Cognitive Therapist*, which can be downloaded from the website (http://www.eabct.eu). The website also provides information on each of the member associations, activities of the EABCT that support them, the constitution, board of directors, congress details and other information relevant to cognitive and behavioural therapies.

The International Society for the Psychological Treatments of Schizophrenia and other Psychoses

Brian Martindale and Yrjo Alanen, former members of the ISPS executive committee

As its name implies, the International Society for the Psychological Treatments of Schizophrenia and other Psychoses (ISPS) is an international organisation that focuses on the development of psychological knowledge and practice relevant to persons with psychotic disorders.

Since its foundation, more than 50 years ago, by two Swiss psychiatrists, Christian Müller and Gaetano Benedetti, it has been organising regular conferences in Europe, the USA and recently Australia, at which clinicians, theoreticians and researchers can exchange ideas, information and experiences of clinical work and service development relevant to the focus of the ISPS.

In the past decade – beginning with the innovations executed at the London conference in 1997 – the ISPS has taken substantial organisational steps to achieve its range of constitutionally stated objectives. It has promoted local networks of practitioners with the aim of offering local support and education in (and promotion of) psychological therapies. It has developed active international and national email discussion and information groups, and has a rapidly developing book series covering a range of contemporary topics; it further aims to bring to the English-speaking world the works of some master clinicians and theoreticians, such as Gaetano Benedetti and the Swedish psychoanalyst Johan Cullberg. It also has a regular newsletter and a website (http://www.isps.org). For 50 years it has been organising a triennial international conference, each of which attracts some 1000 participants. With the development of national networks, national and local conferences are now occurring in places stretching from Auckland in New Zealand, Stavropol in Russia, Split in Croatia, Hamar in Norway to different regions of the USA. The last and very successful triennial conference, in Madrid, was associated with a celebration of the 50th anniversary of the ISPS; many of its leading figures from over the decades were able to attend. In connection with the Madrid congress, a book in honour of the history of the ISPS, *Fifty Years of Humanistic Treatment of Psychoses* (Alanen *et al*, 2006) was published and distributed to participants.

The ISPS had its routes in psychoanalysis. From the 1980s, with the growth of a range of approaches involving the family members of those with a psychosis, the ISPS became 'multi-modal' and now includes practitioners interested in a range of psychological models of understanding aspects of psychosis and the resulting practices that have evolved.

A particular strength of its membership has been the degree of involvement from practitioners from the Scandinavian countries. Senior clinicians such as Alanen of Finland, Cullberg of Sweden, Ugelstad and Johannessen of Norway and Rosenbaum of Denmark have been national leaders in the development of clinical services. There the psychological individual, therapeutic group, community and family approaches to psychosis with an applied psychodynamic emphasis are far more the norm than in many other Western countries, where the power of the pharmaceutical companies and perhaps a lack of a more balanced training of psychiatrists has tended to marginalise psychological approaches. However, the rapidly growing local ISPS activities in the USA and Britain – as well as in some other English-speaking countries – indicate a growing interest at such integrated direction also in other parts of the world.

Although the ISPS promotes psychological therapies and would support the development of these to a high standard, it has an open membership and besides mental health professionals it encourages the involvement of users, carers and other family members, as well as persons such as administrators of mental health services. The ISPS is an affiliate organisation with the World Psychiatric Association, organises symposia within other bodies, such as the Royal College of Psychiatrists, and is keen to form bridges and dialogue with pharmaceutical approaches and those developing biological knowledge, fully aware that we know all our disciplines know both a lot about psychosis and very little!

Reference

Alanen, Y. O., Silver, A.-L. S. & González de Chávez, M. (eds) (2006) *Fifty Years of Humanistic Treatment of Psychoses*. Fundación para la Investigación y Tratamiento de la Esquizofrenia y otras Psicosis (available from Karnac Books and via http://www.paradox.es).

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Progress in the development of the International Divisions

The end of 2006 showed tangible signs that the International Divisions of the College are making significant developmental strides. This follows on from the filling of the places on their executive committees and perhaps also is a result of the discussions and networking that take place at the College's annual meetings (with their increasing international participation), witnessed by the good attendance at all the Divisions' presentations in Glasgow in June last year.

The informative annual reports for 2006 outlined the Divisions' programmes for the forthcoming year. Educational and local training events and meetings are being planned, all suggesting that the rejuvenation of College international activity through the Board of International Affairs is starting to have an effect 'on the ground' and that local College members of International Divisions are increasingly taking initiatives.

The first newsletter of an International Division

The African International Division is the first to produce a newsletter, thanks to the editorship and enthusiasm of the Division's Secretary, Femi Olubile. Electronic copies of the newsletter can be obtained from femi_olugbile@yahoo.com. The newsletter outlines the current contextual issues of the Division, leading to the development plans that follow on from that context. College meetings in the UK have been a unifying and important rallying point but now the newsletter will also have that function, as well as the meeting of the Division within the much awaited Regional Conference of the World Psychiatric Association (WPA) in Nairobi in March 2007. College Division members are playing a leading part in the conference as they did in their editorship of the two major new textbooks on psychiatry in Africa, as reported in the October issue of *International Psychiatry* (vol. 3, no. 4, p. 18).

Middle East news

The long-held plans for a Middle East International Division conference in Beirut have had to be postponed because of the outbreak of hostilities and ongoing insecurity. Alternative plans are being made. There will be a symposium on Iraq's mental health services during the College's June Edinburgh meeting and the Iraq sub-committee of the Board of International Affairs is developing plans to support mental health initiatives in the Kurdistan part of Iraq.

The MRCPsych and Hong Kong

Hong Kong, which is in the Western Pacific International Division, is currently the only site outside the UK and the Republic of Ireland where it is possible to sit the MRCPsych examination. About 80 candidates take the exam each year and a high pass rate is achieved. Recent discussions at the Board of International Affairs have led to the recommendation that International Divisions have a trainee representative, and perhaps the Western Pacific is best placed to initiate this.

Resilience and recovery from the psychosocial consequences of disasters: a training module

Professor David Alexander, Director of the Aberdeen Trauma Research Centre at the Robert Gordon University, and Professor Richard Williams, Professor of Mental Health Strategy at the University of Glamorgan, will run a pilot workshop on this training module at the College annual meeting on Friday 22 June (9.45–17.30).

The growth of communications technology enables us to 'experience' catastrophic natural disasters, conflict and war from the safety of our own homes. It also provides a flexible infrastructure for implementing the virtual organisations that are favoured by terrorists. But several recent large-scale natural disasters and terrorist attacks stand out in our recent experience and few of us are not now sensitised to potential risks around us.

Unsurprisingly, in this context, attention has turned increasingly to the psychological impacts of natural and human-created disasters in the short span of the 21st century. Although mental health practitioners have, for a very long time, contributed to promoting the resilience of populations to disasters of all kinds and to promoting recovery after catastrophic events, interest in the knowledge and skills that are required to be effective practitioners has risen dramatically in the past decade.

In this context, the College has formed a group to recommend a curriculum for developing the skills and knowledge of mental health practitioners so that they may better understand what is required during and after disasters to aid the resilience and recovery of those affected, by enabling practitioners to make effective psychosocial interventions. As a part of this work, the group has designed a modular approach to the delivery of training and the workshop will offer a trial run of the basic module. It will provide those attending the annual meeting with the opportunity to sample the course, with a view to learning from it and also critiquing it to help the College improve the contents.

The College at the American Psychiatric Association's annual meeting

The annual meeting of the American Psychiatric Association will take place in San Diego in May 2007. The College

is expected to be very strongly represented at this meeting, with many joint activities.

College reception
The Pan-American International Division will host the Royal College of Psychiatrists' reception at the meeting. This will be on Monday 21 May 2007, 18.30–20.30, at the Omni Hotel, 657 L Street (one block from the Convention Center) on the Palm and Sail Terrace – Level 6. All Members, Fellows, International Associates and friends of the College are invited and encouraged to come.

International symposium
The College's International Symposium, organised by the Pan-American International Division, entitled 'Women and psychiatry around the world: the importance of gender and culture', will be on Tuesday 22 May, 14.00–17.00, in Room 28 D/E, Upper Level, San Diego Convention Center. Speakers will be from Pakistan, Egypt, Kenya, Mexico, Trinidad and Australia.

Joint Presidential Symposium
There will be a Joint Presidential Symposium of the College and the American Psychiatric Association (co-chairs Sheila Hollins and Pedro Ruiz) entitled 'Health inequalities for persons with mental health problems and developmental disabilities', which will have speakers from each organisation, on Wednesday 23 May, 14.00–17.00, in Ballroom 6D, Upper Level, San Diego Convention Center.

Nigel Bark, Chair, Pan-American International Division

Fountain House

Fountain House is one of the best-known public mental health institutions in Pakistan, if not in Asia. Situated in Lahore, it has just had its 35th anniversary celebrations. A number of distinguished guest speakers will be visiting Fountain House this year and a number of presentations have been made at College meetings. It is funded from charitable sources and is located close enough to the earthquake disaster to have developed worrying cracks in its buildings. Staff have been very active in giving assistance to earthquake victims. UK fundraisers recently gave a cheque for a substantial sum to assist the rehabilitation of earthquake victims with mental health problems.

Fountain House has an agricultural therapeutic community 1 hour away from the city centre, which takes patients with psychosis, learning difficulties and heroin addiction; the community achieves excellent results, akin to those found in other low- and middle-income countries, and superior to those achieved with Western biology-oriented approaches.

Fountain House has an active educational programme and welcomes lecturers and visitors. The current director (and son of the founder) is Professor Haroon Rashid Chaudry. Fountain House can be contacted by email (fountain_house1971@yahoo.com).

News from the WPA

All members of the College are automatically members of the World Psychiatric Association (WPA) as a result of the College's institutional membership. Up-to-date information about WPA activities is available on http://www.wpanet.org.

The WPA's high-quality journal, *World Psychiatry*, reaches 32 000 psychiatrists and has recently been accepted by PubMed, Current Contents and the Science Citation Index. It is sent free to those psychiatrists whose names and addresses are supplied by WPA member societies and sections, and is also available free on the WPA website.

The WPA is currently going through a period of considerable activity. Two new task forces, Brain Drain and Psychiatric Manpower, and Mass Violence and Mental Health, have been set up in addition to a host of existing projects.

Efforts are being directed at adapting the WPA's own institutional procedures so that they will correspond more appropriately to the extensive development of WPA activities in the past decade, including procedures for nominations and elections. The Permanent Secretariat in Geneva continues to develop and the WPA is achieving greater financial security through corporate supporters and other sources of income.

News from the UEMS

On 1 January 2007, Bulgaria and Romania joined the European Union (EU). As a consequence, these two countries endorsed EU legislation, including the provisions regulating the free movement of health professionals. Holders of qualifications from these member states must hence be recognised in other EU countries. A specific Directive was adopted in December 2006 (2006/100/EC) to set out the basic requirements for different medical specialties. This enlargement naturally also applies within the structure of the Union Européenne des Médecins Spécialistes (UEMS), and Bulgaria and Romania were upgraded to the status of full members at the Council meeting in March this year.

The contribution of the UEMS to the European Commission's consultation on patient mobility and cross-border care was the main focus in December and January. A particular tribute must be paid to the UEMS sections and boards for their constructive comments and enthusiastic support. The Commission is now expected to release a formal initiative later this year after having examined all the stakeholders' responses. The entry into force of the Professional Qualifications Directive in October 2007 will undoubtedly be the other major European project on which the UEMS will be very active.

The UEMS will celebrate its 50th anniversary next year. The Executive has set up a new working group to find ways of improving the Union's overall functioning. The UEMS general strategy for the next few years is being developed in an effort to streamline its action in the fields of interest to European specialists.

Further details of UEMS activities and publications are available on the website http://www.uems.net/.

Correspondence

The College – inside and out

Sir: Having just read Matt Muijen's vivid interview in the *Guardian* (25 October 2006) in which he extolled the new-found virtues of the English mental health services from his viewpoint at the World Health Organization's Regional Office for Europe, I was prompted to make a similar inside/outside comment about the College from the perspective of the World Psychiatric Association (WPA). I, too, was immersed in the leadership of British psychiatry for almost 10 years, as Dean and President of the College, before being transported to an elected international post as Secretary General of the WPA.

What do I, and perhaps other voyeurs, see?

Interestingly, Matt Muijen overlooked an additional reason why what he called 'English psychiatry' has prospered in comparison with the discipline in many other European countries, and that is the crucial role of the College over the years as a strengthener of British psychiatrists.

This is perhaps easier to see from the outside than from the inside. The College is, for example, a sole national professional association that can speak directly to government, has retained an accountable, delegated mandate for standard setting and examining, exerts a scientific influence through four journals that resound throughout Europe and across the world, has over 150 paid staff and financial resources unparalleled elsewhere and, above all, has recently rediscovered an international collegiality.

The College is indeed therefore a massive resource for international psychiatry. But how to realise this potential fully on the world stage is a key question for the new College structures. How can it be one of the 'first among equals'? How can collaboration be facilitated? How should it use its resources (human and financial) to strengthen the WPA and its networks in low-income and isolated regions? How could it strengthen the ethical and educational roles of the WPA and support its disaster fund?

It is in the best interests of the College and the world community for these questions to be asked and answered. Going it alone is neither desirable nor practical.

The updated international programme planning for the annual meeting in Edinburgh is a real step forward, as is the greater participation of College members in sustaining the institutional vibrancy of the WPA.

Holding together national and international obligations, I can recall, is never easy. Yet it was right for the College at its annual meeting to celebrate the millennium with the world community in London and to celebrate the sociocultural diversity of mental health expertise.

Seeing the College inside out (and even at times upside down) is therefore a reason for optimism that other professional associations will become, over time, similarly empowered.

It is much to be hoped that this nettle will continue to be grasped by our College officers and that this new internationalism will flourish. This in turn will ensure that the WPA structures, which can at times creak and audibly groan, will increasingly become more fit for purpose. It is also, I believe, in the best long-term interests of the College.

John Cox

Honorary Fellow, Royal College of Psychiatrists; and Secretary General, World Psychiatric Association

Natural disasters and their aftermath

Sir: I am writing in response to the two papers published about Sri Lanka in the July 2006 issue of *International Psychiatry* (vol. 3, no. 3, pp. 5–11). Danvers *et al* and Samarasinghe have contributed to our understanding of population responses to natural disasters; in the case of Sri Lanka, this was superimposed on a manmade disaster, in the form of 20 years of conflict. Any population exposed to either type of disaster, natural or manmade, may develop post-traumatic stress disorder in significant numbers. I am not surprised by the experience of Danvers *et al* of volunteers wanting to carry out psychosocial activities, including 'counselling', despite not having any psychosocial skills or training. But Sri Lankans have been treating trauma for millennia. My experience of working in Sri Lanka was that, at times, one did not need specific skills to deal with trauma-related problems, especially soon after the traumatic incident. I found that people wanted practical help or somebody to listen to their problems and experiences. I found that clergy had taken on the role of sympathetic/empathetic listeners and were doing an excellent job. Proper skills and training were, of course, needed for more complex problems, but these were not that common. However, the recent development of offers of counselling simply due to promotion of Western-style delivery of mental health services might not be appropriate.

I spent 1 year volunteering in northern Sri Lanka, from March 2005 to March 2006. I found it a wonderful and enriching experience, particularly as I am lucky enough to speak and understand Tamil reasonably fluently and understand basic Sinhalese. My work involved organising training in mental health problems following trauma, for example identification, referral pathways and basic counselling skills. The training sessions were given to staff working in relief and reconstruction (development work). Danvers *et al* worked in Jaffna, which incidentally had a history of good mental health services, with a team of experienced workers. However, in other north-eastern districts, such as Mullaitivu, Batticaloa and Trincomalee, this did not seem to be the case. Therefore, many affected people did not get the help that they might have benefited from. In my experience, raising awareness of mental health issues following trauma and providing information about what help is available and where,

seemed the best way forward. Interestingly, getting people to attend the awareness-raising sessions was extremely difficult, because people are more interested in getting help for housing, livelihood, hospitals and schools for their children than in mental health issues. My observation was that the idea of integrating a psychosocial component into development work did not seem to be very effective. One of the main reasons might be that most of the staff working in development were men, who, despite the training, might not have felt comfortable talking about mental health issues. Also, some of the staff had themselves suffered trauma and therefore might not have wanted to talk about it.

The other issue that I think was important was the understanding that a majority of the people in the north and the east were war-displaced, and some might have been suffering from the traumatic effects of the 20 years of conflict. It might have been useful to have some data on the mental health problems following the tsunami of the people who were already suffering from the psychological aftermath of the war. Again, we do not seem to have any data comparing the coping strategies of tsunami-affected people of the north, the east and the south (Galle).

There was concern that the services provided by the non-governmental organisations (NGOs) and the international NGOs might have let local services off the hook by sorting out problems for them, a view shared by Rose (2006).

To conclude, Western-style mental health services would do well by assisting disaster-affected communities through collaboration.

Shobha Singh

Consultant Clinical Psychologist, Department of Psychiatry, Pilgrim Hospital, Boston, Linconshire, UK, email shobha_singh@hotmail.co.uk

Rose, N. (2006) Diary from Sri Lanka's east coast: departure. *Psychiatric Bulletin*, **30**, 387–388.

Meeting with Hong Kong trainees

Sir: I thought your readers might be interested to know of my recent experience in Hong Kong. Castle Peak Hospital was celebrating its 45th anniversary by holding an international conference entitled 'Hospital to community – psychiatry in the new era', in November 2006. I was delighted when my paper, 'An integrated acute psychiatric service – extending the ward into the community', was accepted.

Castle Peak was the first psychiatric hospital in Hong Kong. It has a large sprawling campus and impressive buildings that house 1445 beds. It is set in the mountains, far from the city, on the border with mainland China. 'This,' the chief executive of the hospital pointed out, 'was an indication of the stigma attached to mental health'. I had the opportunity to hear and interact with psychiatrists from east and south-east Asia. I learned that psychiatrists were in short supply in Hong Kong and that trainees typically had about 30 patients in their half-day clinics and the reliance was on in-patient and out-patient services. They have 0.8 beds/100 000 population, compared with under 0.6 in the UK. More services were being developed in the community and Castle Peak itself has been able to reduce its bed strength, from over 2000 in the past.

Hong Kong psychiatrists have had long-term formal as well as informal links with the College. A good number have trained in the UK and even more have passed the MRCPsych and are Members of the College. Trainees from Hong Kong and neighbouring countries comprise one of the highest numbers of overseas candidates taking the MRCPsych examination. It was this connection with the UK that made me feel quite at home. I knew Hong Kong trainees whom I had trained with or met during the MRCPsych Part II. I got in touch with the Hong Kong Trainees Committee.

As a member of the Psychiatric Trainees' Committee (PTC) of the Royal College of Psychiatrists and a trainee representative on the Board of International Affairs, I used this opportunity to meet with trainee representatives of the Hong Kong College of Psychiatrists. I wanted to explore possibilities for representation of Hong Kong trainees to the PTC and the Western Pacific International Division. The PTC supported this.

Until 2004, Hong Kong trainees did not need to sit the Professional and Linguistic Assessments Board (PLAB) Test. Now, with the Modernising Medical Careers programme and visa rule changes, the MRCPsych is appearing less relevant. The form of the MRCPsych examination is likely to change and the Hong Kong trainees committee felt that our meeting was timely as they had many concerns regarding these changes. They were grateful that their interests were acknowledged and that there was a possibility for representation in the PTC and the Western Pacific International Division. The Board of International Affairs has decided to recommend Hong Kong trainee representation to the Division and this would enable them to sit on the PTC.

This was a unique experience for me and reminded me that training changes in the UK have far-reaching consequences in other parts of the world. It would be useful to hear of similar experiences.

Allen Kharbteng

Specialist Registrar, Cambridge, UK,

Forthcoming international events

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

27–29 April 2007
The New Era of Transcultural Psychiatry: Advancing Collaboration of East and West
Organised by the WPA Transcultural Psychiatry Section
Kamakura, Japan
Contact: Dr Shuishi Katsuragawa
Email: ktsrgw-1@b-star.jp; wpa@shonan-village.co.jp
Website: http://www.shonan-village.co.jp/wpatcp.htm

1–3 May 2007
Third International Conference on Psychiatric: Future of Psychiatry as a Neuroscience
Organised by the Saudi German Hospitals Group in collaboration with the Saudi Psychiatric Association and the Egyptian Psychiatric Association
Jeddah, Saudi Arabia
Contact: Dr Mohamed Khaled
Email: moh.khaled99@gmail.com

3–6 May 2007
Reflections and Ideas for an Innovation Psychiatry Conference
Organised by the WPA Section on Ecology, Psychiatry and Mental Health
Fiuggi, France
Contact: Dr Giuseppe Spinetti
Email: gspinetti@libero.it

6 May 2007
Play and Power. Sixth '3-section' Conference of the European Federation of Psychoanalytic Psychotherapy in the Public Sector
Copenhagen, Denmark
Email: psykliah@post1.tele.dk
Website: http://www.efpp.dk

11–12 May 2007
Conference on Conflict, Mental Health and Making the Peace
Organised by the Royal College of Psychiatrists' European International Division in collaboration with the London Institute of Psychiatry
Limassol, Cyprus
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

26–30 August 2007
Hypothesis, Neuroscience and Real People
Organised by the International Network for Philosophy and Psychiatry in collaboration with the WPA Section on Philosophy and Humanities
Sun City, South Africa
Contact: Dr Kenneth W. M. Fulford
Email: pwwf@norcam.demon.co.uk

20–23 September 2007
WPA Regional Meeting
Shangai 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
Organised by the Psychiatric Association for Eastern Europe and the Balkans
Thessaloniki, Greece
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 the 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

5–8 February 2008
WPA European Congress and Regional Meeting
Organised by the Association of the French Societies Members of WPA
Paris, France
Contact: Dr Michel Botbol
Email: mbotbol@wanadoo.fr

14–17 March 2008
IV Biennial Conference: Integrative Approaches to Affective Disorders
Organised by the International Society for Affective Disorders in collaboration with the WPA Section on Affective Disorders
Cape Town, South Africa
Contact: Caroline Holebrook
Email: caroline.holebrook@iop.klc.ac.uk
Website: http://www.isad.org.uk

16–20 March 2008
Third World Congress on Women's Mental Health
Organised by the WPA Section on Women's Mental Health
Melbourne, Australia
Contact: Dr Donna Stewart
Email: Donna.Stewart@uhn.on.ca
Website: http://www.IAWMHCongress2008.com.au