Volume 4 Number 4 October 2007
ISSN 1749-3676

International Psychiatry

Affiliated journal: *African Journal of Psychiatry*

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Subscriptions

International Psychiatry is published four times a year. Non-members of the College should contact: Publications Subscriptions Department, Maney Publishing, Suite 1C, Joseph's Well, Hanover Walk, Leeds LS3 1AB, UK tel. +44 (0)113 243 2800; fax +44 (0)113 386 8178; email subscriptions@maney.co.uk

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Annual subscription rates for 2007 (four issues, post free) are £25.00 (US$45.00).

Single issues are £8.00 (US$14.40), post free.

International Psychiatry was originally published as (and subtitled) the *Bulletin of the Board of International Affairs* of the Royal College of Psychiatrists.

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

US mailing information
International Psychiatry is published quarterly by the Royal College of Psychiatrists. Subscription price is $45. Periodicals postage paid at Rahway, NJ. Postmaster send address corrections to *International Psychiatry*, c/o Mercury International, 365 Blair Road, Avenel, New Jersey 07001.

™The paper used in this publication meets the minimum requirements for the American National Standard for Information Sciences – Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

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The journal is intended primarily as a platform for authors from low- and middle-income countries, sometimes writing in partnership with colleagues elsewhere. Submissions from authors from International Divisions of the Royal College of Psychiatrists are particularly encouraged.

International medical graduates in the National Health Service

Amit Malik[1] and Greg Lydall[2]

[1]Consultant Psychiatrist, Hampshire Partnership NHS Trust; Correspondence Editor, *International Psychiatry*, email ip@rcpsych.ac.uk

[2]Specialty Registrar (ST4) in General Adult Psychiatry, Highgate Mental Health Centre, Dartmouth Park Hill, London, UK

The UK's National Health Service (NHS) has benefited from the skills of foreign qualified doctors for many years. International medical graduates (IMGs) – that is, those doctors with primary medical qualifications outside the European Economic Area (EEA) – have come to the UK despite the significant personal and financial costs, alongside the burden of taking the Professional and Linguistic Assessment Board (PLAB) examination. Despite the costs and increasing indications that the UK job market was becoming saturated with the increased indigenous medical school output and expansion of the EEA, doctors still migrate to the UK in their thousands (McGinn, 2005). The government's active international recruitment policy, which continued until very recently despite the significant increase in places in UK medical schools, was partially responsible for this trend. Until last year, once registered to practise in the UK, access to specialty training was facilitated by the permit-free training visa (PFTV) system, which allowed IMGs to work and train simultaneously, without the need for a work permit. This meant that they could compete on an equal footing with UK graduates for training opportunities in the UK. The implementation and potential impact of some of the recent policy changes in the NHS specifically with regard to IMGs is discussed here briefly.

Changes to immigration rules

On 3 April 2006, without warning, the UK government announced that the provision of permit-free training would be withdrawn within the short period of a month and that all IMGs wishing to pursue postgraduate training beyond their current visa would have to apply for either a work permit (which meant that they could access training opportunities only for which there were no appointable EEA nationals) or the points-based Highly Skilled Migrant Programme (HSMP), which was contingent on a variety of factors, including qualifications and previous salary. The work permit route was complicated by the worsening employment situation within postgraduate training, leading to the likelihood that EEA nationals in preference to IMGs would fill most training posts. The HSMP provision, besides discriminating against those in the early stages of their training, also was made unfair by the stipulation that the length of the leave to remain granted under this programme should cover the entire duration of the training. This was most improbable given that HSMP visas are initially issued for 2 years, with a provision of further extension for 3 years, whereas all the new run-through training programmes are at least 6 years long.

The main criticism of the new immigration rules is not necessarily that they were conceived at all. It is the fact that these regulations were applied across the board, to new immigrants and those IMGs already in the UK training system, many of whom had settled with their families and had made long-term personal and career commitments to the UK. The greatest irony is that the most vulnerable group of IMGs – those who have not yet had an opportunity to reap any rewards for their struggles, in the form of either financial remuneration or prestigious UK qualifications – are the worst hit by the sudden implementation of these new regulations. A significant number of overseas doctors have taken out considerable financial loans to enable them to travel to the UK and take the PLAB examination. Many have now been left stranded without any qualifications to show for the years they have spent in training in the UK.

Modernising Medical Careers

Modernising Medical Careers (MMC) is a Department of Health initiative to transform and streamline the way postgraduate medical training is structured and delivered (Department of Health, 2004). Many concerns have been expressed about rapidly implementing an excessively rigid and bureaucratic system and the risks this could pose to patient care and service delivery. Even greater concerns were expressed by many of the stakeholders about the computer-based national selection process called the Medical Training Application Service (MTAS) that was being hurriedly implemented without being piloted for validity, reliability, feasibility and acceptability. The failures that have resulted from this system have been widely reported in both the medical and the general press and will not be rehearsed here.

As the national selection process was due to be implemented soon after the new immigration regulations were brought into force, it meant that all trainees at the level of senior house officer would have to apply again for their own jobs – this time under the new visa regulations.

Throughout the development and implementation of MTAS, the rules with regard to IMG applicants, especially HSMP holders, were unclear. This caused great anxiety among immigrant doctors in the UK. It remained unclear until the very last moment before applications opened whether HSMP holders would be considered equivalent to EEA nationals. Official advice remained unclear regarding the length of HSMP required to apply for run-through programmes. Some ambiguity also existed about whether these HSMP holders could even apply for specialty training through MTAS. It was

understood that those without HSMPs would be considered for specialty training posts via the work permit route only if there were no eligible EEA nationals applying for them. As mentioned above, this especially had implications for those early on in their training and not yet eligible for a HSMP visa application.

Mental health of IMGs

There is little published evidence regarding the mental health of UK junior doctors in general and more specifically IMGs. Doctors are known to be at increased risk of stress, mental illness, substance misuse and suicide, compared with other professionals and the general population (Ghodse *et al*, 2000; Tyssen & Vaglum, 2002). In addition, immigration is thought to be a risk factor for mental illness and suicide (Bhugra & Jones, 2001). The significant financial debts incurred by many IMGs, combined with poor job prospects, loss of control and the possibility of discrimination may be further stressors in an already vulnerable group.

Preliminary results of an online survey regarding the mental health of MTAS applicants conducted by the authors suggest the adverse impact of the recent changes in postgraduate medical selection and training on all UK junior doctors (Lydall *et al*, 2007). The final results of the survey, which had 191 IMGs among its 1002 respondents, will be published as soon as the analysis is completed.

Conclusions

Immigrant doctors have traditionally provided invaluable services to the NHS since its inception. The manner in which changes have been implemented in the past year can be characterised as inept, at best. Thousands of immigrant doctors who came to the UK to work in a fair and equitable system have been betrayed by the abrupt change in immigration regulations after they made the effort and investment to come to work in the NHS. The disregard for this group of medical professionals has been made worse by a lack of consideration for IMGs during the constant evolution of the rules during the implementation of and in response to the MTAS debacle.

The commoditisation of overseas doctors by the UK system will have long-term consequences for recruitment, especially in shortage specialties like psychiatry. There are also bound to be serious implications for the mental health not only of those IMGs who have been affected but also of all other IMGs working in the UK, as well as their UK-trained colleagues. If the NHS continues to treat its highly valued and committed front-line staff with such disregard, it is only a matter of time before all that are left are insensitive centralised policy-makers and no one to deliver either their policies or, more importantly, high-quality healthcare.

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Traditional healers

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London WC1 1EH, UK, email d.skuse@ich.ucl.ac.uk

Traditional healers are an important source of psychiatric support in many parts of the world, including Africa. They offer a parallel system of belief to conventional medicine regarding the origins, and hence the appropriate treatment of, mental health problems. In this issue we present a thematic review from three regions of Africa where traditional healers are still important – and probably far more numerous than psychiatrists trained in Western medicine. First, we discuss South Africa, in a report from Professor Tuviah Zabow. Some years ago it was estimated that there were nearly ten times as many traditional healers practising in that country as there were doctors trained in modern medicine (Kale, 1995). The prevailing justification for their interventions, according to traditional beliefs, is that disease is a supernatural phenomenon. Its manifestations are governed by a hierarchy of vital powers. At the apex of this hierarchy is a deity of greatest power, followed by lesser spiritual entities, ancestral spirits, living persons, animals, plants and then objects (Kale, 1995). These entities interact and, should they become disharmonious, illness could be caused. Harmony can, however, be restored through judicious intervention, provided by a suitably trained person who treats the patient holistically, within the context of their family and their community.

In his article, Professor Zabow emphasises that indigenous healers may be regarded as falling into three broad categories: diviners (the majority of whom are female and selected by their ancestors to this calling); herbalists; and faith or spiritual healers (usually within the Christian tradition). South Africa is trying to regulate the activities of

these groups, and to set training standards. Although in the past there had been attempts to ban traditional healing completely, nowadays there is increasingly a collaborative relationship between conventional psychiatric services and those provided by traditional healers.

A very similar situation seems to exist in Nigeria, according to the article from Drs Olugbile, Zachariah and Isichei. The authors arranged a discussion with a group of traditional mental health practitioners. They attempted to derive from that interaction a structure that summarised traditional beliefs regarding the origins and treatment of mental illness. In this report, the authors describe that structure as it pertains to the origins of mental illness. They show that there are clusters of aetiological influences, as perceived by the traditional practitioners, which follow a simple typology of observed behaviour, and link to particular modes of treatment to be employed. The duration of treatment is protracted, up to 6 months, and many such healers claimed they could bring about a complete cure. The authors emphasise the need for a dialogue between health planners, doctors and these traditional practitioners.

Finally, Professor Ndetei discusses the role of such healthcare practices within the context of East Africa. As in South Africa, the prevalence of traditional medicine is very high indeed. He estimates that at least 80% of the healthcare needs of rural inhabitants in East Africa are initially met in this way. The proportion of treatment that is concerned with mental health problems is estimated to be substantial. Traditional approaches may include herbal remedies as well as some form of what Professor Ndetei calls 'psychotherapy'. The latter, he emphasises, is of considerable sophistication and is taught orally from generation to generation, in the absence of any textbooks. Psychotherapeutic work is done at the individual level, as well as with couples, families and with groups. One of the main objectives of such therapy is to reduce stress. The author emphasises that we in the West have a lot to learn from the way these traditional healers manage their patients and challenges us with the question: 'Are we willing to learn from them?'

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Traditional healers and mental health in South Africa

Tuviah Zabow

Emeritus Professor, Department of Psychiatry, University of Cape Town, South Africa, email zabow@networld.co.za

Paper presented at the Royal College of Psychiatrists' annual meeting, 10–13 July 2006, Glasgow, UK

Psychiatric patients access both indigenous healers and services rendered by psychiatric facilities in South Africa. The various groups of healers which are available are clearly not all acceptable to the whole population and variable experiences are reported with different categories of healer and the different treatments provided. An increasing collaboration between psychiatric services and indigenous healers is becoming evident, as in other health services. Reports indicate that many African psychiatric patients seek treatment from indigenous healers while attending psychiatric clinics, in both rural and urban regions. This has led to much discussion and differing viewpoints as to the possible benefits and disadvantages of collaboration and simultaneous use of different treatment modalities. Included in this is the question of the medical competence of traditional healers and the possible neglect of serious conditions.

Use of indigenous healers by psychiatric patients

Even in metropolitan urban areas of South Africa, indigenous healers are still widely used, especially for mental health problems. This is in part related to common beliefs that such problems are caused by bewitchment and that only indigenous healers can treat this, resulting in simultaneous consultations. Despite this, these culturally specific groups are not under-represented among the users of psychiatric services (Ensink *et al*, 1995) and, indeed, many patients still travel from distant areas to get psychiatric treatment in the city-based facilities.

Indigenous healing systems

It is evident that culture-specific concepts of mental illness and related beliefs will affect the delivery of psychiatric services. An understanding of the systems of indigenous healing by healthcare providers is therefore essential in each region of the country, as these may differ regionally. There are specific names and descriptions used for different categories of disorder. The use of these terms does not exclude conventional mental health services being consulted. The healing modality can include psychosocial and other approaches. The medical competence of the traditional healer is frequently addressed and a regulatory framework has recently been introduced that recognises certain groups of 'treatments' in South Africa.

Traditional healers are not a homogeneous group, which makes the situation more complex. The different types of indigenous healers are found in three groupings: the diviners, the herbalists and the faith healers. There are clear differences between these, although it is not unusual for healers to integrate more than one orientation into their practice. Diviners are believed to have access to supernatural powers through their ancestors. This gives them the ability to divine the cause of illness. This ability, it is further believed, may be used in the service of good or evil. The process of diviner training starts when an illness or misfortune is interpreted as a calling from the ancestors (*ukuthwasa*). This may lead to an apprenticeship and participation in rituals and ceremonies of the healers and their *abaqwetu* (trainees). Those who become healers gain entry into a mutually supportive healing network. Herbalists function much like pharmacists and dispense a range of herbal products. Faith healers work from within the popular African churches and use prayer, singing and rituals to heal.

Indigenous names and concepts of mental illness

In conventional health systems there persists a lack of understanding of the way in which indigenous names are used by African psychiatric patients. The various categories illustrate the range of mental disturbance attended to by the traditional healer:

- *ukuthwasa* (calling to be a healer)
- *amafufunyana* (possession by evil spirits)
- *ukuphambana* (madness).

Research suggests that patients and families do not use indigenous names in these fixed and rigid ways, but as explanatory categories (Kleinman, 1988; Ensink & Robertson, 1996).

Utilisation studies

The experiences of African psychiatric patients and their families of psychiatric and indigenous services are variable (Ensink & Robertson, 1999). Many described negative experiences and misunderstandings. Some researchers recommend increased engagement with and understanding of the experiences and beliefs of families. Psychiatric services are seen to be able to assist with symptom control and medication but are considered rarely able to deal with the fears of bewitchment. Improved information on the experiences of users of indigenous services would assist with decisions to refer to them. Indigenous healers also need to be informed what psychiatry can provide that users may find useful.

A study undertaken in Cape Town (Ensink & Robertson, 1999) provides some information about the utilisation of and satisfaction with traditional healers, as well as the related concepts of illness. The study found that, in 71% of a sample of 62 patients, traditional healers had been consulted in the previous 12 months – faith healers by 21 (34%), diviners by 15 (24%), herbalists by 8 (13%). Fifty-three per cent had consulted general medical services in the past 12 months. The reported 'indigenous' causes included bewitchment, failure to do a Xhosa ritual, stepping over a dangerous track, evil spirits, poisoning with ants and soil from the grave, and witch familiars (e.g. snake of the river, bird of evil, *tokeloshe* or bogey man). In addition, the study revealed that patients believed the causes of *amafufunyana* (possession by evil spirits) could in addition be 'nerves', relationship problems, drug and alcohol misuse or God's will.

Box 1 Indigenous illness names used by patients and families ($n = 62$)

Indigenous names
Amafufunyana (11 instances)
Ukuphambana (11)
Amafufunyana/ukuphambana (1)
Amafufunyana/ukuthwasa/ukuphambana (1)
Isiphoso (2)
Umbilini (1)
Ukuthwasa (1)
Umlingo (1)
Isiphephetho (1)
Ukuphoselwa (1)
Bewitchment (1)

Other terminologies
Nerves and related (18 instances)
Nerves (8)
Worried too much (2)
Stress (2)
Workload (2)
Mental exhaustion (1)
Depression (3)
Brain injury (1)
Diabetes (1)
Damaged veins (1)
Pregnancy problems (1)
Overdose (1)
Unsure/no name for illness (3)
Other (12)

Indigenous illness names used by patients and families in the study by Ensink & Robertson (1999) are listed in Box 1.

A range of psychiatric diagnoses was recorded by the psychiatric services. The majority of patients presented with one or more diagnoses of acute psychosis, organic syndrome or mood disorder.

The majority explained their problem in terms of more than one cause. A combination of indigenous, psychosocial, physical and religious dimensions was frequently invoked.

Competency, regulation and quality assurance

Competency, regulation and quality assurance issues are addressed in South Africa by the Traditional Health Practitioner Act 2003, which aims to ensure the quality of the health services provided by this group. A national body has been established to set training standards and regulate entry into the profession. Professional associations of traditional healers have been established and have been encouraged to develop practice guidelines and a code of ethics.

Discussion

Knowledge of traditional concepts and systems on the part of Western-trained psychiatrists is essential, in particular because of the widespread parallel use of services, as well as the problems experienced with unregulated and sometimes problematic indigenous services. Descriptions of indigenous categories differ from Western ones and need to be understood by all health practitioners. There is a need to improve psychiatric services for the population identified as attending traditional practitioners simultaneously.

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Nosology and modalities for deciding on the management of patients with psychiatric illness among traditional healers in Lagos, Nigeria

Olufemi Olugbile FRCPsych,[1] N. P. Zachariah PhD[2] and B. Isichei MSc[3]

[1]Department of Psychiatry, Lagos State University Teaching Hospital, Ikeja, Lagos State, Nigeria, email femi_olugbile@yahoo.com

[2]Department of Psychiatry, Lagos State University Teaching Hospital, Ikeja, Nigeria

[3]Department of Social Welfare, Lagos State University Teaching Hospital, Ikeja , Nigeria

Many patients in Nigeria consult traditional healers before, or in parallel with, modern psychiatric services. Part of the attraction of traditional medicine for the populace, apart from its lower cost and easier accessibility, may lie in its 'cultural' explanatory concepts of the nature and course of mental disorder.

The aims of the present study were to define the understanding of the generality of traditional mental health practitioners in Lagos about the nature and causation of mental disorder, and to obtain explanations of their classificatory systems, treatment approaches and expected outcomes of treatment.

Method

A gathering of traditional mental health practitioners was arranged, facilitated by the Lagos State Board of Traditional Medicine. In the course of a day-long, free-flowing interaction, a questionnaire was administered to the 15 practitioners present. All 15 completed and returned the questionnaire.

Results

Aetiological clusters

The following aetiological clusters emerged:

- cursing/spiritual attack/quest for spiritual power ('*Epe*', '*Asasi*', etc.)
- ingestion/smoking of drugs of misuse
- diseases of the body (smallpox, chronic disease affecting the brain)
- disturbance of mind ('excessive thinking', 'excessive studying')
- stress-related conditions ('unexpected shock', loss of child or spouse, poverty, etc.)
- heredity.

Typology based on observed behaviour

There were seven thematic clusters of types of behaviour, which were not mutually exclusive:

- withdrawn/silent
- violent
- excessive talking to self
- laughing without reason
- temporary abnormal behaviour ('*asinwin*')
- sluggish behaviour ('*arindin*')
- '*ode ori*' (typified by a combination of somatic symptoms affecting the head and body).

Treatment modalities employed

The following types of treatment were often employed in combination:

- herbal (the commonest reported intervention)
- incantations
- animal or other sacrifice
- body incisions/scarifications
- special diet/nutritional support.

Duration of treatment was generally around 2–6 months.

Expected treatment outcome
Complete cure (irrespective of typology) was the outcome claimed by the majority of respondents (86.6%). The achievement of only symptom relief and the possibility of relapse were acknowledged by a minority (13.4%).

Rehabilitation issues and stigma
Participants were asked whether the educational or professional aspirations of treated patients should be limited. Just over a quarter agreed (27%) and the remainder said no (73%).

Discussion

There is a need for health planners, researchers and the practitioners of modern medical therapies in Africa to develop some kind of a relationship with traditional healers. The following is a broad classification of the attitudes of medical practitioners to traditional healers:

- Curiosity (traditional practitioners are viewed as creatures from another planet, dressing in strange attires and performing bizarre rituals) (Jilek & Jilek, 1967).
- Grudging acknowledgement of traditional medicine as a temporary nuisance which will disappear as modern services become more generally available.
- Acknowledgement of traditional medicine as a reality which may be 'elevated' by contact with modern concepts and practices (Adelekan & Makanjuola, 2001).
- Recognition of it as a distinct entity that deserves to be respected and explored without preconception (Makanjuola, 1987).

What impact, if any, is traditional mental healthcare having even now on the members of society in low- and middle-income countries, where it is most prevalent? Haliburton (2004) analysed the follow-up data of patients in India who patronised the three recognised systems of mental healthcare in the country: Ayurvedic (indigenous), 'allopathic' (Western psychiatry) and 'religious healing'. He found that patrons of all three showed improvement on follow-up. Some people found one therapy model more useful than the others. Many used more than one model. The researcher suggested that the availability of such diverse options increases the chances that any one patient will find a mode of treatment that will suit their needs. He postulated that this may lead to better outcomes for psychotic illness in that part of the world than in higher-income countries.

How is the profession of psychiatry to relate to traditional mental healthcare? By studiously ignoring it, hoping it will die out? By acknowledging it and seeking to 'educate it' about modern medical concepts? Or by an uncritical acceptance of all its concepts and claims?

Unfortunately, there is great variety in thinking and practice among traditional practitioners. There is little standardisation, and no corpus of belief or knowledge that is accepted by everyone.

Should traditional medicine be taught in medical schools?
The College of Medicine, Usman Dan Dodio University, Sokoto, in northern Nigeria, some years ago introduced a programme whereby 90 hours of instruction in traditional medicine was added to the undergraduate medical course. The justification was that since the patients that the students will treat when they become doctors will see traditional healers anyway, it is appropriate that the students get to know what traditional medicine is all about.

Conclusions and recommendations

Psychiatrists in Africa must recognise the existence of traditional mental healthcare and initiate dialogue with it. Such dialogue has been proposed or is actually in process in Malaysia, India and China. Some of the immediate gains of such dialogue would be to drive forward the pace of standardisation and codification of the conceptual framework, nosology and practice of traditional medicine. It would also help to expunge the most unsavoury elements, such as cruel physical restraint and punishments, from the practice of traditional healers. It would help to bring in such modern ideas as the need to respect patients' legal rights to humane and decent treatment. It would create a platform for comparative studies of the efficacy and outcome of interventions in both the short and the long term. An added bonus may be the discovery of new drugs from 'age old' remedies.

A first step in the organisation of such a process would be for governments to set up boards, such as the one in Lagos, with the legal authority to register and control the practice of traditional medicine in their area of authority.

Acknowledgements

We are grateful to Dr Bunmi Omoseindemi, Chairman, Lagos State Traditional Medicine Board, and all the staff of the Board for their assistance with the research.

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Traditional healers in East Africa

David M. Ndetei FRCPsych

Professor of Psychiatry, University of Nairobi; Founder and Director, Africa Mental Health Foundation (AMHF), email dmndetei@mentalhealthafrica.com

Paper presented at the Royal College of Psychiatrists' annual meeting, 10–13 July 2006, Glasgow, UK

Since time immemorial, people from East Africa, and beyond, depended on traditional healers for treatment of all types of disorders, including those related to mental health. Even today, the use of traditional healers is common, despite the introduction of modern drugs. Alternative medicine is growing fast all over the world.

It is estimated that traditional practitioners manage at least 80% of the healthcare needs of rural inhabitants in East Africa. Research statistics from Kenya and Uganda suggest that 25–40% of all people seeking medical care at primary health level have problems purely related to mental health and another 25–40% have a combination of both mental health problems and physical problems (Ndetei & Muhanji, 1979). It can therefore be expected that at least half of all patients who go to see traditional healers have mental health problems. Data from general hospitals in Kenya suggest that 30–40% of patients admitted to those facilities have a mental health problem which is not recognised as such by the medical professionals working there. It is also common knowledge that many patients would use both modern medicines (as offered in general hospitals) and traditional healers.

So, whichever way one looks at it, traditional healers have as much share, if not a much bigger share, of all the patients seeking medical help at any particular time. This was recognised in Kenya by Dr Otsyula, who reported in 1973 that patients went to hospital only to look for the cure of their illness, whereas they went to see traditional doctors for both the cure and also to find out the cause of their illness. Further, several studies have suggested that many cultures have names for various mental health disorders, implying that they have long recognised them (Otsyula, 1973).

The types of management prescribed by these traditional healers (often concurrently) fall into several main groups. These include the use of herbal preparations (pharmacotherapy) and several types of psychotherapy.

At this point, it is important to differentiate between traditional medicine and witchcraft, although overlaps can be seen, especially in theories of causation. Traditional healers have theories that recognise genetic, social, psychological and environmental factors in the causation and maintenance of illness. They also embrace spiritual causation, usually ancestral. Witchcraft focuses on evil designs, usually on or by close relatives, associates or competitors, and its prescriptions are usually designed to bring pain and suffering or even death to assumed or alleged enemies, based on jealousy, the need to obtain wealth, fame, popularity and so on. This is usually done through agents known as witches. Witches are generally shunned and are often thrown out of their own communities. Witch-doctors are the people who hunt for and bring to book the witches (Otsyula, 1973).

Pharmacotherapy

The range of herbs used is broad and such herbs are widely available. They are still under study using modern pharmacological assays. An example of a plant with medicinal properties is *Rauwolfia*, which is rich in reserpine. This plant is found as an ornamental plant in many parts of Kenya and Tanzania, especially around the Mt Kilimanjaro area, where it also grows in the wild. It is known for the treatment of 'madness', by which is meant psychosis, regardless of the cause or type. There is a story of Chief Adetona from Nigeria who travelled to the UK in 1925 with *Rauwolfia* extracts to treat a Nigerian who had become psychotic there. This was long before any known psychotropic was available in the West (Prince, 1960).

Psychotherapy

The practice of psychotherapy and behavioural therapy is so very much advanced in traditional practice in East Africa that these therapies as practised in the West are not a match. This is illustrated by a statement by Rappoport & Dent (1979) on family therapy in Tanzania. They remarked 'nothing we had seen in a Western clinic could compete with the deep power of this ritual'.

In the early 1980s, the present author had the opportunity to sit in on a clinic of a traditional healer deep in a rural area in Kenya. This healer specialised in the treatment of sexual dysfunctions using herbs and psychotherapy. The herbs must have acted very much like Viagra, for they helped men to achieve and sustain erection. But most impressive was the psychotherapeutic and behavioural approach, involving couple therapy. Without ever having heard of the Masters and Johnson technique, and himself never having travelled far from his home, and also being totally illiterate, this traditional healer prescribed almost to the letter that technique for sexual dysfunction. Asked how he learnt about it, he said he had done so from his father, who had learnt from his own father and so on. There were no textbooks. They learnt simply through pupillage.

Family therapy groups and group therapy are prescribed as a form of psychotherapy by many traditional healers. Of course, they do not call it psychotherapy, but in practice it is psychotherapy as we psychiatrists understand it today. The operational procedures are much the same as those practised in the West. In the process of these types of psychotherapy, individual psychodynamics are explored. Compare this with Freud's and others' psychodynamic procedures at the end of 1800s and early 1900s and ask yourself who really invented psychotherapy and when!

Spiritual therapy

Spiritual therapy attempts to bring peace and harmony between the living and the spiritual world, especially spirits of the ancestors, which are believed to live on after death and continue to influence events in the living world.

Without going into the merits and demerits of their beliefs about the ancestors, what really matters are the effects of the perceived harmony, which, translated into today's thinking, amounts to stress reduction. The effect of reduced stress, especially in relation to immunological response, is not in any doubt, even by today's science. Although psychiatrists may not accept an explanation that does not make sense in terms of modern science, the explanation is not the issue here: what matters are the perceived effects by those who practise spiritual therapy. George Brown and Tirril Harris from London used the word *meaning* to explain this phenomenon when they wrote about contextual threat (Brown & Harris, 1978).

Surgical

A classic example of a traditional surgical intervention is craniotomy as practised by the Kisii and Turkana peoples of Kenya, for the treatment of psychosis related to diseases thought to be located inside the skull. This is, however, not practised today. What are still very much practised are small cuts on various parts of the body to relieve pain or for the insertion of medicines.

Conclusions

Traditional healers see and manage most of the mental health problems in East Africa. Our understanding of the pharmacology of the herbs they use is limited, but this is not so with psychotherapy. Indeed, the West has a lot to learn from traditional healers in East Africa.

The challenge is to psychiatrists trained on the Western model. Are they willing to learn from the traditional healers? Are they willing to work with them? They can say no to this only to the detriment of the patients they seek to heal, and more significantly to the detriment of science, which they seek to embrace. An even greater challenge is whether they can work together so that they each benefit from what is good from the other.

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COUNTRY PROFILE

The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributions. Please email ip@rcpsych.ac.uk

Psychiatry in Austria

W. Wolfgang Fleischhacker[1] and Johannes Wancata[2]

[1] Department of Biological Psychiatry, Medical University Innsbruck, Austria, email wolfgang.fleischhacker@uibk.ac.at

[2] Department of Social Psychiatry, Medical University Vienna, Austria

Austria covers an area of some 84 000 km^2 and has a population of 8.1 million. According to World Bank criteria, Austria is a high-income country. The overall health budget represents 8% of gross domestic product (World Health Organization, 2005). The state of Austria is divided into nine federal provinces, which have significant legislative rights, including in healthcare provision.

Life expectancy at birth is 76.2 years for males and 82.3 years for females (in 2005). The proportion of the population under the age of 15 years is 15% and the proportion above 65 years is 17%. Austria is among the 19 countries worldwide which are projected to have at least 10% of their population aged 80 years or over by the year 2050. Since some mental disorders, such as dementia, increase with age, the number of psychiatric patients will probably rise dramatically.

Mental health policy and services

The number of psychiatric hospital beds has decreased substantially. In the year 2001 there were 4696 psychiatric beds in total (i.e. 59 per 100 000 population), down from nearly 12 000 beds in 1974 – a decrease of more than 60%.

The National Hospital Plan includes suggestions for the establishment of psychiatric units in general hospitals. Ten psychiatric units in general hospitals have been established, and several others are planned. Most traditional mental hospitals have been transformed to meet the needs of patients with acut mental illness. In addition, some of them have extended their services to people with physical diseases.

Each of the nine provinces has developed a mental health plan. Although there are regional differences between these, the key points of all plans are: a focus on community

psychiatry, the decentralisation of psychiatric services and the social reintegration of persons suffering from mental disorders. The planning and provision of community psychiatric services are the responsibility of the provinces. Although some provinces now have a comprehensive network of community services, others are less advanced. The majority of these services (for vocational rehabilitation, supported housing, counselling, etc.) are provided by private organisations, but are predominantly funded by government agencies. The staff includes a variety of different professions (e.g. psychiatrists, social workers, nurses, psychotherapists, psychologists).

Primary healthcare is usually offered by self-employed general practitioners (GPs), working in solo practices. Most GPs treat patients with psychiatric disorders, but they may decide to refer patients to self-employed psychiatrists or other psychiatric services. Spread between office-based psychiatry, community-based services and psychiatric departments in hospitals, Austria has 11.8 psychiatrists per 100 000 inhabitants. In addition, some GPs have trained in psychosocial medicine/psychotherapy.

In 1991, the Psychotherapy Act established a certified profession of psychotherapists. In Austria, psychotherapy is provided by a variety of different professions. Anyone is allowed to provide it after completing training in psychotherapy and being certified by the Ministry of Health. Nearly all psychiatrists and many psychologists have a certificate in psychotherapy. In the year 2002, overall 5495 persons (i.e. 68 per 100 000 population) were certified psychotherapists.

The healthcare system (including mental healthcare) is predominantly financed via health insurance. This is mandatory for all employed and self-employed persons. There are no specific allocations for mental health within the health budget. The majority of the costs for primary care and secondary care (including psychiatric services) are covered by health insurance. This includes the costs of all psychotropic drugs. Interventions by psychologists as well as by psychotherapists are partly reimbursed. Psychiatric in-patient treatment is fully covered. Disability benefits are available for persons with mental disorders, but local regulations differ.

The fact that psychiatric community services are usually not directly financed by health insurance but via government agencies often complicates overall service provision.

Mental health legislation

There is no comprehensive mental health act in Austria. Compulsory admissions to psychiatric hospital departments are regulated by the Compulsory Admission Act 1991. According to this law, only persons who pose a threat to their own or other people's health or life because of a mental illness can be admitted compulsorily. Professionals called 'patient advocates' were established by this legislation and they act on behalf of patients in order to protect their rights. The number of compulsorily admitted patients has significantly increased since the new law became effective.

Persons with mental disorders who have committed a crime and are sentenced to jail fall under two main categories: those who are regarded as fit to stand trial; and those who are not. Both groups are detained in special institutions in the prison system, although those who are not regarded as fit to stand trial may also be detained in psychiatric hospitals.

Research

Psychiatric research is mainly based in universities – three public and one private. The public universities (in Innsbruck, Graz and Vienna) presently receive lump funds from the Austrian government, but there are plans to award at least a proportion of the money based on research output and teaching achievements. All three institutions supplement these funds through third-party funding. The private medical university in Salzburg basically taps into the same funding sources but has no direct support from the Austrian government, although it does receive some from the local government of Salzburg.

The majority of research at these four universities is clinical: Innsbruck focuses strongly on schizophrenia, dementia, neuropsychoimmunology, alcoholism, psycho-oncology and quality of life, whereas Vienna has a strong interest in affective disorders, social psychiatry, genetics and illegal substance misuse. Both centres have neuropsychology/neuroimaging groups. Consultation–liaison psychiatry, forensic psychiatry as well as research in adjustment and somatoform disorders are the stronghold of the Medical University in Graz. Researchers in Salzburg deal mainly with suicidality and bipolar illness. Most academic institutions have close ties to basic science departments with a strong focus on preclinical neurobiology and neuropsychopharmacology.

Some research is also done in non-academic institutions. It includes studies of drug safety and stigma.

Education and training

Psychiatry is an integral part of the medical curriculum in Austria's universities. Students are first exposed to the field as part of courses on the nervous system in the first year. They also receive some basic training with regard to communication strategies, for which psychiatrists are among the teachers. In the clinical semesters, psychiatry is taught in both theoretical and practical courses, and in the last year students can do a 4-week elective in psychiatry.

Postgraduate training is governed by law in Austria. The Austrian Medical Association (Österreichische Ärztekammer) prepares – after consulting with professional societies such as the ÖGPP – a curriculum, which has to be approved by the Ministry of Health. The latter has passed new regulations, effective as of 27 February 2007. Postgraduate specialist training in psychiatry now comprises 5 years of psychiatry, complemented by a half year each in neurology and internal medicine. Trainees have to take a final examination before being licensed as psychiatrists. The main change to the old curriculum is that the new one includes formalised psychotherapy training as an integral component. This has also led to a change in title from 'Specialist in Psychiatry' to 'Specialist in Psychiatry and Medical Psychotherapy', which is relevant to the question of reimbursement, insofar as specialists who hold a psychotherapy title are also eligible for health insurance coverage for psychotherapeutic services.

Most of the training is provided by hospitals, both academic and non-academic. As most psychiatric departments include both in- and out-patient facilities, trainees are expected to gain experience in different aspects of the field. A training in consultation–liaison psychiatry is also encouraged but, unfortunately, is not available everywhere. In addition, more

specialised services, such as alcohol detoxification/rehabilitation, old age psychiatry and the like, are part of the training programme wherever such facilities exist.

Child and adolescent psychiatry has now also been given full specialist status, whereas it used to be a mere add-on specialty to psychiatry, neurology or paediatrics. Training includes 4 years in child and adolescent psychiatry as well as 10 months in paediatrics, 6 in neurology and 8 in adult psychiatry.

Psychiatric associations

Two major psychiatric associations exist in Austria. The Österreichische Gesellschaft für Psychiatrie und Psychotherapie (ÖGPP, Austrian Association for Psychiatry and Psychotherapy, http://www.oegpp.at), an association of psychiatrists, has close to 900 members and is the professional forum for most Austrian psychiatrists. It officially represents psychiatry in the Austrian Medical Association and is consulted in most psychiatry-related matters by both government and non-governmental organisations.

Pro Mente Austria (http://www.promenteaustria.at) is the umbrella organisation of most community psychiatric services in Austria. The focus of Pro Mente Austria is mental health policy, partly in cooperation with ÖGPP. It has many non-psychiatrist members.

Hilfe für Psychisch Erkrankte (HPE, an association for family carers, http://www.hpe.at) is Austria's largest and best organised transnational advocacy group.

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COUNTRY PROFILE

Mental healthcare in Singapore

Siow-Ann Chong

Senior Consultant Psychiatrist, Vice Chairman, Medical Board (Research) of the Institute of Mental Health, Buangkok Green Medical Park, 10 Buangkok View, Singapore 539747, email siow_ann_chong@imh.com.sg

Singapore is a modern city state and the smallest nation (land area of 699 km^2) in South East Asia. Its population of over 4 million is multiracial, with the Chinese (76.8%) constituting the majority of the population, followed by the Malays (13.9%) and the Indians (7.9%). The present health system is one that stresses individual responsibility, based on a system of compulsory medical saving accounts and on market mechanisms for the allocation of scarce healthcare resources. There are both public and private healthcare sectors. Since 1985, every public sector hospital has been 'restructured' – to grant some degree of autonomy in operational matters, with the intention of creating competition and financial discipline, although the government still retains 100% ownership of the hospitals.

Mental health services

Singapore has not engaged in a large move towards de-institutionalisation, and community care for patients with a mental illness has not received high priority. The Institute of Mental Health (IMH) is the largest mental hospital, with a total bed capacity of 2200, and is the largest provider of mental healthcare. It provides a range of sub-specialties, such as child and adolescent psychiatry, geriatric psychiatry, substance misuse, affective disorders, sleep disorders, early psychosis, psychiatric rehabilitation and forensic psychiatry. It provides a range of pharmacological and psychological treatments, as well as psychosocial rehabilitation.

More recently, however, there has been a resurgence in the recognition of the need for community psychiatry, with the establishment of a department of community psychiatry in 2001 within the IMH. The department provides an array of services, including community-based programmes such as the assertive community treatment (ACT) programme, the mobile crisis team (MCT) programme (a rapid-response team for crises in the home) and the community psychiatric nurse (CPN) service (Lim *et al*, 2005).

The IMH is the only statutory institution, in that patients can be admitted, detained and discharged in accordance with the Mental Disorders and Treatment Act 1985 and the Criminal Procedure Code 1985 of Singapore. The services include assessment of accused persons suspected to be of unsound mind and the psychiatric treatment of offenders who are mentally unwell. Powers to detain persons for treatment exist under the Mental Disorders and Treatment Act. There is currently no community treatment order or other provision to mandate the compulsory treatment of patients in the community.

Three of the restructured general hospitals in the public sector provide a psychiatric service. The numbers of mental health workers and beds in these services are small, however; for example, the number of beds in each ranges from 15 to 26. There are also psychiatric services in the Singapore armed forces, prison services and hospitals in the private sector (there is only one private hospital which solely provides care for people who are mentally ill).

Another important facet of mental healthcare in Singapore is the complementary and supplementary services provided

by voluntary welfare organisations (VWOs). The VWOs receive government aid and provide a range of services, from counselling, residential care and day care, to employment and other rehabilitation services, for persons with mental illness.

One characteristic of the present mental health service is the relative lack of involvement of family physicians, especially in relation to patients with chronic mental disorders. The care of such people still very much rests with the specialised services in both the public and private sectors. In the effort to 'right site' the care of those with stable chronic mental disorders to the community, the IMH initiated a programme to induct general practitioners in the care and management of stable patients.

The three major ethnic groups of Singapore contain significant minorities who rely on a mixture of Western and traditional medicines, or who use Western medicine only as a last resort (Somjee, 1995). The practitioners of traditional medicine therefore constitute another important source of help for people who are mentally unwell. Cultural and religious beliefs often prompt patients to turn to spiritual healers (Kua, 2004; Chong *et al*, 2005) but their clinical and socioeconomic impact is unknown.

The emphasis on individual responsibilities demands that the populace is appropriately educated in relation to health matters. This is principally undertaken by a body called the Health Promotion Board. It runs a public education programme called 'Mind Your Mind', initiated in 2001. The programme is spear-headed by the IMH with other partners, including the Ministry of Education, the Ministry of Community Development and Sports, VWOs and other professional bodies. It focuses on raising awareness and the early detection of the major mental disorders, such as depression, anxiety disorders and schizophrenia. It also works towards destigmatising mental disorders and promoting mental well-being (Yeo, 2004).

Research

In the past 6 years, there has been an emphasis on biomedical research and heavy investments have been made by the Singapore government. Singapore has the potential to conduct world-class mental health research because of the unique characteristics of the population, the consolidated organisation of psychiatric services and the presence of sophisticated scientific technological platforms like the Genomics Institute of Singapore, which provides cutting-edge technology. There has been a steady growth in research activities, particularly in the areas of psychiatric epidemiology, first-episode psychosis, dementia, pharmacogenetics of tardive dyskinesia, brain imaging and clinical drug trials.

Workforce issues and training

The quality of mental healthcare depends on the availability and adequacy of the relevant mental health workers: psychiatrists, psychologists, medical social workers, case managers, nurses and occupational therapists.

There are now two medical schools in Singapore, producing between 200 and 250 doctors a year. Psychiatric training, which has been enhanced in the undergraduate curriculum in the past few years, now comprises an 8-week posting in a psychiatry department in a restructured hospital.

Table 1 Numbers of mental health professionals in Singapore

Mental health professionals	Number	Per 100 000 general population
Psychiatrists	108	2.6
Clinical psychologists	30	0.7
Registered mental health nurses	462	11.1
Occupational therapists	22	0.5

Postgraduate training in psychiatry takes a minimum of 6 years. All specialist doctors, including psychiatrists, are certified by a specialist accreditation board appointed by the Ministry of Health. There are only 108 psychiatrists on the specialist register, giving a psychiatrist:population ratio of about 2.6:100 000.

Table 1 shows the number of mental health professionals in Singapore; in each of these categories there is an acute shortage. One reason for this shortage is the absence of local training. For example, there is no doctoral-level programme for clinical psychologists in any of the academic centres in Singapore. Steps are now being taken to address this, for instance with the establishment of a bachelor's degree in nursing at one of the local universities.

Professional bodies

These include the Chapter of Psychiatrists of the Academy of Medicine, the Singapore Psychiatric Association, the Singapore Psychological Society and the Singapore Association of Counselling.

Mental health policy

The principal problems with the current mental health system include the fragmentation and lack of coordination of services, the rudimentary community mental health services and the shortage of mental health workers. Other challenges facing the country are its ageing population, increasing divorce rates, changing family structures and economic pressures.

The Ministry of Health appointed a National Mental Health Committee in 2005 to draft a national mental health policy and blueprint for Singapore, which aimed to promote mental health in the community, to prevent mental disorders and to allow the early detection, treatment and rehabilitation of persons with mental illness. The Committee has identified four key areas that require the attention of policy-makers and mental healthcare providers over the next 5 years. These are: promotion of mental health and prevention of mental illness; integrated mental healthcare, featuring greater collaboration with general practitioners and the embedding of psychological services into medical teams; the development of the mental health workforce; and mental health research.

Conclusions

The formulation of the above-mentioned policy and blueprint is a positive step in addressing the gaps in the mental health service. The strategies should include taking an integrated approach to the mental well-being of children and adolescents, measures to reduce the stigma of mental illness, such

as reviewing employment policies and practices to reduce discrimination, establishing support networks for adults to promote positive mental health, and the early detection and treatment of mental illness. The intention is to develop an emotionally resilient and mentally healthy community with access to community-based, comprehensive and cost-effective mental health services.

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COUNTRY PROFILE

Mental healthcare in Laos

Ken Courtenay[1] and Chantharavady Choulamany[2]

[1]Consultant Psychiatrist, Barnet, Enfield and Haringey Mental Health NHS Trust, Unit 5, St George's Estate, London N22 5QL, UK, email Ken.Courtenay@beh-mht.nhs.uk

[2]Psychiatrist, Mental Health Unit, Mahosot Hospital, Vientiane, Lao PDR, email chantharavady_c@hotmail.com

Laos (officially the Lao People's Democratic Republic) is a land-locked country in South East Asia, and one of the three former French colonies of Indochina. Since 1989, when it was opened to foreigners, there has been an influx of non-governmental organisations (NGOs) and tourists. From 1998 tourist numbers have increased every year, and Laos has become the 'must see' destination in a travel industry that craves the exotic. It has an old and rich culture with a diverse population. The climate is tropical, with a cool dry season and a hot wet season, when temperatures reach 38°C.

Laos is bordered by five countries: China, Thailand, Myanmar, Cambodia and Vietnam. It is equal in area to the UK. The country was subjected to heavy bombing during the Vietnam War, which has left a legacy of unexploded ordnance (UXO) in many rural areas. NGOs undertake the decommissioning of UXO. Some 10% of the population emigrated during the Vietnam War.

It is the poorest country in the region and 80% of its population of 5.9 million live in rural areas (World Bank, 2006). Life expectancy is 59 years (UK 78 years) and the child mortality rate is 83 per 1000 (UK 5 per 1000) (World Health Organization, 2006).

Lao people adhere to the principles of Buddhism (60%) and animism (40%). Traditionally, people have gained most social support from their families and Buddhist monks. With economic development, these supports are under threat from the many social changes taking place in the country.

Economic and social changes

Laos is a one-party, communist state established in 1975. It is one of the 50 poorest nations in the world and is described as one of the 'least developed countries' by the United Nations Conference on Trade and Development (2002). Since 1998 economic and social change has been rapid, especially under the influence of neighbouring Thailand. Inevitably, changes are having an impact on the lives of the people. Telecommunications technology has transformed a society that once cultivated isolation from the outside world. Changes on the land have included deforestation and the creation of dams for hydroelectricity. Migration from rural to urban areas, with the displacement of people, especially the minority ethnic groups, has affected social networks, which in turn has had an effect on the mental health of Lao people (Bertrand & Choulamany, 2002).

Healthcare in Laos

Health personnel are concentrated in the bigger towns. Access for people in rural areas is difficult because of poor road infrastructure. Consultations with doctors in primary and secondary care are free, as is nursing care. However, patients pay for investigations and medication, as well as the cost of hospital in-patient stays. Medication can be bought without prescription at pharmacies. The government spends 4.6% of its budget on health (UK 16.1%) (World Health Organization, 2006).

Mental healthcare

Two units in Vientiane (the capital city) are the only facilities in Laos that provide in-patient and out-patient mental healthcare. One is dedicated to the military (103 Hospital) while the other, based in Mahosot Hospital, is in the public healthcare system.

Two senior psychiatrists work at Mahosot Hospital. The professor was educated in Hungary and the second psychiatrist was educated in France. The psychiatric unit opened in 1979 under the guidance of a Soviet psychiatrist. The unit is staffed by these two psychiatrists, a neurologist, ten nurses and four general medical doctors. It has 15 beds. Patients are referred to the unit from the accident and emergency department of Mahosot Hospital and from doctors in other parts of the country; also, families make direct referrals. The duration of stay in the in-patient unit is 21 days, regardless of progress. Patients pay US$1 per day for their care. Family members provide direct care to their relatives while nurses administer drug therapy. After discharge from the hospital out-patient follow-up is available, but it is often not taken up by those who live far from Vientiane. The out-patient department is open every day to review people living in the community.

The general medical doctors in the service have not received formal training in psychiatry. They work in the in-patient unit, providing day-to-day care and advice on drug therapy. They review those who attend the out-patient department and the accident and emergency department of Mahosot Hospital. There are no psychologists in the service. Psychologists from the university academic department advise on the teaching of psychology to medical students but are not actively involved in the clinical work of the mental health unit. In the main, nursing staff provide direct physical healthcare to in-patients and administer drug therapy. They do not undertake psychotherapeutic programmes. Occupational therapy is not available in the service.

The diagnoses among the in-patients include substance misuse, psychotic disorders, catatonia, delirium, epilepsy and neurotic disorders. The physical conditions on the hospital wards are poor. Air conditioning is not available and so open windows and doors give general ventilation to the wards.

Drug therapy is the mainstay of treatment but the formulary is limited to haloperidol, chlorpromazine, flupentixol, diazepam, carbamazepine and amitriptyline. Private pharmacies sell medication to patients but often families cannot afford to buy it. The adherence to drug regimens is questionable on account of the cost of drugs and erratic out-patient attendance.

Mental health legislation

Article 18 of the Penal Code relates to the care of people with mental health problems and offending behaviour. There is no legislation on the detention of people who are not suspected of involvement in crime.

Medical education

Medical undergraduates receive 2 weeks' tuition in psychiatry; however, the course is not popular among students. The academic department is located in Mahosot Hospital but there is a paucity of textbooks, especially ones written in the Thai and Lao languages. The physical conditions of the in-patient unit do not enhance the appeal of working with patients who are mentally ill.

There is no formal postgraduate training for doctors in psychiatry, so doctors must seek it outside Laos. As a result, community doctors, who manage most mental health problems, do not receive training in assessment and treatment. On occasion, they resort to using psychotropic medication.

Problems and solutions

The economic and social changes of the past decade are affecting the mental health of the people, through the loss of the traditional social systems for supporting and sustaining people with mental illness. The explosion of substance misuse among teenagers and young adults is putting pressure on the psychiatric services and the social cohesion of Lao society. A flexible response to these societal changes is required but is difficult to implement in a country that lacks the infrastructure to support mental health services.

The education of students and postgraduate doctors is poor; further, they have few resources and models of care available to them. The education of staff would help to reduce the stigma attached to mental illness. The four general medical doctors who work in the psychiatric unit in Mahosot Hospital are a resource with great potential because of their interest in working in the service, and yet they have not received training in mental healthcare.

The decrepit state of the in-patient facility reflects the low esteem of mental healthcare in the health service. It contrasts with the state-of-the-art cardiology department in Mahosot Hospital, which has been established by foreign aid. The Ministry of Health needs to invest in mental healthcare to enhance the service that people receive. Improvements in in-patient care are necessary and could happen in conjunction with the development of community care to provide a more robust service for the treatment and after-care of patients. In the absence of established in-patient resources nationwide, there are opportunities to develop local, community-oriented services utilising the health personnel in place to manage mental illness with the support of families and religious leaders. Such innovations would require additional trained personnel at a local level to meet the mental health needs of the people.

Other areas of service need include child mental health, epilepsy, services for people with war-related post-traumatic stress disorder and the development of mental health policy and legislation. The absence of mental health legislation leaves people vulnerable to abuse. The introduction of robust mental health legislation is essential to protect the human rights of patients suffering from mental disorders and prisoners with mental health difficulties.

The problems require investment by the Lao government and foreign aid agencies in health services infrastructure and the education of medical and nursing staff. The current economic and social changes that are taking place in Laos, as it develops economically, provide an opportunity for government to undertake improvements in services that could integrate tradition with modern practice.

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SPECIAL PAPER

Psychiatric morbidity among patients on haemodialysis in the Mosul district of Iraq

Hellme Najim MB ChB Mosul DPM London MRCPsych[1], **Emad Al-Badrani** MB ChB Mosul[2] and **Khalid Omar Sultan** MB ChB Mosul MD[3]

[1]Consultant Psychiatrist, Mental Health Unit, Basildon Hospital, Basildon, Essex SS16 5NL, UK, email hellmenajim@yahoo.co.uk
[2]Consultant in Renal Medicine, Department of Medicine, Mosul College of Medicine, Mosul, Iraq
[3]Consultant Physician, Mosul Teaching Hospital, Mosul, Iraq

Patients on chronic haemodialysis experience a wide range of physical and psychological stresses. The specific sources of stress include: loss or threatened loss of possessions; relationship problems (e.g. staff–patient relationships, changed roles within the family); restrictions related to physical health status and the dialysis regimen; loss of body function and impaired body image; increased dependency and aggression; the threat of death; impairment of vocational function and financial security; and decreased participation in leisure, social and community activities (Phipps & Turkington, 2001). A review of psychological maladjustment in patients on haemodialysis found that about 55% exhibited significant emotional distress, a prevalence three to five times that found in the general population (Aghanwa & Morakinyo, 1997). The present study aimed to ascertain the prevalence of psychiatric morbidity among patients attending a renal dialysis unit in Mosul, Iraq.

Patients and method

The renal dialysis unit in Mosul comprises a 12-bed ward with two British graduate consultants and one Arab Board graduate. Haemodialysis and peritonial dialysis are carried out on an in- and out-patient basis. The unit serves the Mosul district, which has an urban population of about 1 million.

A standardised schedule (the Crown–Crisp Experiential Index, CCEI), as translated and validated for use in Iraqi culture by Maghazaji *et al* (1982), was administered to all patients who attended the unit over a 6-month period. It is a self-rated, 48-item questionnaire with six scales (anxiety, phobia, obsession, somatic symptoms, depression and hysteria). Patients who were critically ill or who refused to participate were excluded. The questionnaire was also administered over the same period to an age- and gender-matched sample of healthy nursing staff on the unit.

For the statistical analyses, *t*-test, analysis of variance (ANOVA) and regression were used. Because of the small size of the sample, it was decided to set significance at the 10% level.

Results

A total of 62 patients attended the unit during the study period; of these, two were too ill to complete the questionnaire, seven refused to participate and two withdrew their consent at a later stage. There were more women than men in the sample (55%). The majority of participants were under 45 year of age (88%). Approximately half (49%) came from urban areas. Hypertension was the most common cause of renal failure (45%), followed by renal calculi (24%) and glomerulonephritis (20%); other causes (12%) were

Table 1 Mean (s.d.) scores on the CCEI scales of patients and controls

Scale	Patients ($n = 51$)	Controls ($n = 50$)	t	P
Anxiety	7.9 (3.1)	5.1 (3.1)	8.00	> 0.1
Phobia	4.7 (2.7)	2.9 (2.2)	5.00	> 0.01
Obsession	8.1 (2.9)	5.8 (3.1)	4.03	> 0.01
Somatic	7.7 (3.0)	3.2 (2.4)	8.32	> 0.1
Depression	8.2 (3.2)	3.3 (2.3)	8.90	> 0.1
Hysteria	5.9 (2.7)	7.1 (3.1)	2.20	> 0.05

Table 2 Mean (s.d.) scores on the CCEI scales of male and female patients

Scale	Males ($n = 23$)	Females ($n = 28$)	t[1]	P
Anxiety	6.8 (2.8)	9.0 (3.3)	2.42	< 0.05
Phobia	4.7 (1.8)	4.6 (3.5)	2.04	NS
Obsession	8.7 (2.7)	9.4 (3.1)	0.80	NS
Somatic	6.7 (3.5)	8.6 (2.5)	2.09	< 0.05
Depression	7.5 (3.3)	8.8 (3.0)	1.56	NS
Hysteria	5.2 (3.0)	6.7 (2.4)	1.29	NS

1. *t*-test for unpaired case, degree of freedom $(n_1 + n_{2-2}) = 43$.
NS, no statistically significant association.

Table 3 Mean (s.d.) scores on CCEI scales of urban and rural patients

Scale	Urban ($n = 25$)	Rural ($n = 26$)	t^1	P
Anxiety	9.1 (2.8)	6.4 (3.1)	3.04	<0.01
Phobia	6.4 (3.4)	4.9 (2.5)	1.51	NS
Obsession	9.3 (3.2)	8.1 (2.9)	1.19	NS
Somatic	8.6 (2.5)	5.8 (4.0)	2.94	<0.01
Depression	8.8 (3.3)	5.6 (2.9)	3.21	<0.01
Hysteria	6.2 (3.0)	4.6 (2.8)	1.69	NS

1. t-test for unpaired case, degree of freedom $(n_1 + n_{2\text{-}2}) = 43$.
NS, no statistically significant association.

Table 4 Mean (s.d.) scores on the CCEI scales of patients by length of dialysis

Scale	Dialysis for up to 2 years ($n = 30$)	Dialysis for more than 2 years ($n = 21$)	t^1	P
Anxiety	8.0 (3.1)	10.6 (2.7)	3.80	< 0.025
Phobia	5.1 (3.0)	7.5 (2.8)	2.83	< 0.01
Obsession	8.7 (3.2)	10.4 (3.3)	6.05	< 0.01
Somatic	7.2 (3.2)	11.8 (2.8)	5.15	< 0.01
Depression	8.7 (2.9)	10.9 (3.0)	5.15	< 0.025
Hysteria	6.4 (2.8)	7.4 (3.1)	4.62	< 0.025

1. ANOVA degrees of freedom, $v_1 = 2$, $v_2 = 43$.

tuberculosis of the kidney, renal tubular acidosis and Fanconi syndrome. There were no statistical differences in the distribution of these syndromes by gender.

Table 1 compares psychiatric morbidity between the control and patient groups. It shows statistically significant differences between the two groups on all six scales of the CCEI.

Table 2 presents differences in psychiatric morbidity between males and females. There were statistically significant differences on the anxiety and somatic scales, with females more affected. Table 3 presents the relationship between CCEI scores and rural *v*. urban residence. It shows that there were statistically significant differences on the anxiety, somatic and depression scales, with the urban population more affected. Table 4 presents CCEI scores in relation to duration of haemodialysis. It shows statistically significant differences on all scales, with scores proportional to the duration of dialysis. Finally, Table 5 relates CCEI scores to the aetiology of renal failure. It shows statistically significant differences on two scales, anxiety and hysteria.

Discussion

In the present study, 88% of patients were below 45 years of age, which is consistent with a haemodialysis sample from European countries in 1964–71 (Gurland *et al*, 1975) (thereafter the mean age of patients starting haemodialysis started to increase in Europe). There was also a slight excess of females, again consistent with the study by Gurland *et al* (1975), in which the female:male ratio was 1.42.

Hypertension was the most common cause of the need for haemodialysis (45%), which is different from studies in high-income countries; for example, only 1% of patients were undergoing dialysis as a result of hypertension in the study by Gurland *et al* (1975). This finding can be explained by the poor prognosis associated with other causes of renal failure in Iraq, which may result in under-representation of these diseases in the sample.

The statistically significant differences in psychiatric morbidity on all CCEI scales (Table 1) of patients compared with controls indicate that those on renal dialysis have more vulnerability to psychiatric illness, owing to the physical and psychological stress they are under, which is consistent with previous studies (Aghanwa & Morakinyo, 1997).

There was a statistically significant gender difference on two scales: anxiety and somatic. Other studies have reported that psychiatric morbidity (neurosis) is greater in females than in males. However, in the present study, the surprising result was that scores on the hysteria scale did not differ between the genders. As men should find it easier to move around a male-dominated society, the male sample might have been disproportionately drawn from rural areas, and men in rural areas may be similar to women from urban areas in terms of their propensity to dissociation.

There was no statistically significant difference between age-groups in the present sample. This may have several explanations: first, it could be due to the relatively young age of the sample overall; second, it could be due to their relatively recent diagnosis and start on haemodialysis; and lastly, it might indicate that haemodialysis has no relationship with age and psychiatric morbidity.

There were statistically significant differences between rural and urban patients on the anxiety and depression scales. These might have been due to the exaggerated impact of the diagnosis and treatment as understood by patients from rural areas, and their fear of dealing with machines, compared with the urban population, who might be expected to be more technology oriented and more socially enlightened, and to understand better the implications of their disease and their dependence on the machine for the rest of their lives. Patients from a rural background also expressed significantly more somatic complaints and this similarly can be explained on the basis of their greater tendency than urban patients to somatise (Racy, 1980), in addition to the physical stresses of life in rural areas and difficulties of transport to town.

When the sample was divided by duration of dialysis, there were statistically significant differences on all scales. This is likely to reflect how patients come to appreciate, over time, that they are bound to machines for the rest of their lives

Table 5 Mean (s.d.) scores on the CCEI scales of patients according to the aetiology of their renal failure

Scale	Hypertension ($n = 23$)	Glomerular nephritis ($n = 10$)	Stones ($n = 12$)	Other ($n = 6$)	t^1	P
Anxiety	23.0 (13.8)	7.4 (3.7)	7.9 (5.1)	8.6 (2.3)	8.14	< 0.005
Phobia	5.9 (2.3)	5.1 (3.5)	5.8 (3.0)	4.9 (2.9)	0.39	NS
Obsession	8.8 (2.5)	9.0 (2.8)	8.0 (2.4)	10.8 (4.1)	1.40	NS
Somatic	8.4 (2.9)	6.7 (2.9)	7.6 (4.0)	6.3 (3.8)	1.09	NS
Depression	7.7 (3.0)	6.4 (3.1)	8.1 (3.9)	9.4 (3.5)	1.08	NS
Hysteria	5.5 (2.2)	3.7 (2.4)	5.6 (3.1)	8.8 (2.0)	6.35	< 0.005

1. ANOVA degrees of freedom, $v_1 = 3$, $v_2 = 43$.
NS, no statistically significant association.

and the physical stress the dialysis makes in terms of brain metabolism and toxic metabolites in general (Kemph, 1982).

Psychiatric morbidity in relation to the aetiology (Table 5) of the renal failure was reflected in significant differences on the anxiety and hysteria scales. Many variables may play role here, such as type of personality and its relation to susceptibility to physical illness (e.g. those with hypertenson scored more on anxiety), medication (e.g. antihypertensives), type of therapeutic procedure (e.g. surgery) and type of disability the patient has. All these variables need to be studied further.

Acknowledgements

The authors would like to thank Professor Tom Craig and Professor Simon Wessely for their comments and guidance on the original manuscript.

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SPECIAL PAPER

A 12-year follow-up of a sample of patients dependent upon heroin

Saima Niaz,[1] Nadia Arshad,[2] Mariam Haroon,[3] Fahd A. Cheema,[4] Khalid A. Mufti[5] and Haroon Rashid Chaudhry[6]

[1]Assistant Professor, Department of Psychiatry, Fatima Jinnah Medical College/Sir Ganga Ram Hospital, Lahore, Pakistan, email niazpsych@yahoo.com

[2]Deputy Manager Research, College of Physicians and Surgeons, Pakistan

[3]Medical Officer, Department of Psychiatry, Services Hospital, Lahore, Pakistan

[4]Medical Officer, Department of Psychiatry, Fatima Jinnah Medical College/Sir Ganga Ram Hospital, Lahore, Pakistan

[5]Medical Director, Ibadat Hospital, Peshawar, Pakistan

[6]Professor and Head, Department of Psychiatry, Fatima Jinnah Medical College/Sir Ganga Ram Hospital, Lahore, Pakistan

Heroin addiction is a chronic, relapsing and remitting condition. Each year 2–5% of addicts discontinue drug use permanently and 1–2% die, mostly of overdose (Robins, 1993). A study of 129 opiate-addicted patients on a monthly maintenance regimen found that those with a family history of opium use had an earlier age at onset (Chaudhry *et al*, 1991). Long-term follow-up studies of people who misuse opiates have revealed that opioid dependence appears to run a chronic, relapsing and remitting course with a significant mortality (10–15%) over 10 years (Robson, 1992). Metrebian *et al* (1998) reported that long-term heroin abstinence was associated with less criminality, psychological distress and morbidity; Hser *et al* (2001) reported it was associated with higher employment rates.

In another study, 78 opiate users were followed up after successful in-patient detoxification. Eleven categories of lapse precipitant were identified: cognitive, mood, external withdrawal, interpersonal, leaving a protected environment, drug availability, drug-related cues, craving, priming, and social pressures and young age (Bacchus *et al*, 2000). Substantial periods of employment and marriage are pointers to a good outcome (Zhang *et al*, 2003). Rasheed *et al* (1992) showed that earlier age at first consumption of the drug was associated with the misuser faring better on substitution programmes.

Method

This was a hospital-based, 12-year follow-up study. The sample comprised 137 male heroin-dependent patients, aged 20–40 years, admitted to the Free Psychiatric Clinic at Ahbab Hospital. The Clinic, run by grant from the community, has provided services for 22 years. It is located in the urban slums of Lahore. Written consent was obtained. The patients' mean age was 26.4 years at first assessment. Most patients (115) were inhaling heroin, but 22 were smoking it. A semi-structured interview (including demographic details), thin layer chromatography (TLC) and intranasal naloxone challenge tests were used as screening instruments. In the naloxone challenge, papillary response, pulse rate and blood pressure were measured, and TLC is useful for separating organic compounds.

The intervention did not comprise a comprehensive rehabilitation programme for the patients but there were regular educational programmes addressing the hazards of drug addiction during the stay. The average duration of treatment was 2 weeks. The special programmes addressing the hazards of drug addiction were arranged for patients and caregivers fortnightly for 3 months, and later monthly for 9 months (15 sessions in total), with the help of a local non-governmental organisation, Project for Environmental Protection, Antinarcotics Community Education (PEACE).

Table 1 Distribution of participants by factors associated with relapse

Factors associated with relapse	Relapsed ($n = 63$)	Drug free ($n = 25$)	P
Sessions of educational programme attended			
≥9	14 (22%)	18 (72%)	< 0.05
< 9	49 (78%)	7 (28%)	
Age at onset, years			
≤25	38 (60%)	10 (40%)	NS
> 25	25 (40%)	15 (60%)	
Marital status			
Married	22 (35%)	16 (64%)	< 0.05
Unmarried	41 (65%)	9 (36%)	
Family history of addiction			
Positive	44 (70%)	5 (20%)	< 0.05
Negative	19 (30%)	20 (80%)	
Employment status			
Employed	21 (33%)	22 (88%)	< 0.05
Unemployed	42 (67%)	3 (12%)	

NS, not significant.

After 12 years, in 2002, an attempt was made to trace the sample with the help of local social workers.

Results

Of the 137 patients, 49 (36%) had dropped out and 88 (64%) were followed up. Among the 88 followed up, 63 (72%) had relapsed and 25 (28%) had maintained their drug-free status. Among those who had relapsed, 42 (67%) were using heroine, while 21 (33%) had started using other drugs, such as benzodiazepines, alcohol and cannabis, in addition to heroin.

Of the 25 who had maintained their drug-free status, 18 (72%) had attended 9 or more of the 15 sessions of the educational programme, whereas among the 63 who had relapsed, only 14 (22%) had attended 9 or more sessions.

Of the 63 patients who had relapsed, 38 (60%) had been aged 25 years or below at the onset of addiction, 22 (35%) were married, 44 (70%) had a family history of addiction and 21 (33%) were employed.

Of the 25 patients who had maintained their drug-free status, 10 (40%) had been aged 25 years or below at the onset of addiction, 16 (64%) were married, 5 (20%) had a family history of addiction and 22 (88%) were employed.

Results indicated that factors preventing relapse included regular attendance at follow-up educational visits ($\chi^2 = 19.1$, d.f. = 1, $P < 0.05$), being married ($\chi^2 = 6.16$, d.f. = 1, $P < 0.05$), absence of family history of drug addiction ($\chi^2 = 18.0$, d.f. = 1, $P < 0.05$), and employment ($\chi^2 = 21.4$, d.f. = 1, $P < 0.05$) (Table 1).

Discussion

In the present study, out of 137 patients, 88 (64%) could be traced and 49 (36%) could not (some had changed their residences or gave the wrong address, and some had died). The relapse rate was high, at 72%. Drug-free status was associated with employment, being married and no family history of addiction, similar to the findings of Bacchus *et al* (2000).

In this study, the majority of the participants who maintained their drug-free status attended 9 or more of the 15 sessions of the educational programme, whereas those who relapsed attended fewer. A similar result was reported by Perneger *et al* (1998) in Geneva. They found that a heroin maintenance programme is a feasible and clinically effective treatment for heroin users who fail in conventional drug treatment programmes.

In the present study, a majority of those who were drug free were married. Being married protects against relapse. It provides a confiding relationship, support and a sharing of responsibilities. The lower relapse rate among those who had no family history of addiction may be due to stable living conditions, adequate social (family) support and a healthy home atmosphere (Loimer *et al*, 1992).

This study found that the majority of patients who relapsed (38, 60%) had an age at onset of addiction of 25 years or less, although age difference at onset had no statistically significant effect on drug status in this sample. Chaudhry *et al* (1991) suggested that there is an increased prevalence of opium use in the younger age-group and mentioned the relationship between family history of addiction and age at onset. In spite of using different research designs, the results of both studies were in a similar direction.

In the present study, a strong association was seen between employment status and relapse rate. Employment may be protective against relapse because it enhances social stability and mental health. This finding is similar to that reported by Hser *et al* (2001).

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Mental health legislation in contemporary India: the need for inter-sectoral dialogue

D. S. Goel

Consultant Psychiatrist, Southland Hospital Mental Health Services, PO Box 828, Invercargill 9812, New Zealand, email coldsgoel@hotmail.com

It is said that war is far too serious a matter to be left to the generals alone. The same could be said for the interface between law and mental health. With our narrow, and sometimes myopic, treatment-centric vision we are ill equipped to claim hegemony over the complex domain of legislation as it relates to mental health, even more so in the multicultural Indian subcontinent, where the medieval exists alongside the modern and where abject poverty jostles with ostentatious wealth:

> 'The mental health scene in India at the dawn of the twenty-first century is a bewildering mosaic of immense impoverishment, asymmetrical distribution of scarce resources, islands of relative prosperity intermixed with vast areas of deprivation, conflicting interests and the apparent apathy of governments and the governed alike.' (Goel *et al*, 2004)

Interfacing the core issues

Kala & Kala in the July 2007 issue of *International Psychiatry* (vol. 4, no. 3, pp. 69–71) approach the subject of mental health legislation in India almost exclusively from the psychiatrist's perspective. This is one of three domains (the last listed below) of interaction between law and mental health:

- *Capacity and civil status*. In judgments of the legal validity of a transaction, for example a contract under the Indian Contract Act 1872, the state of the mind of the individual assumes relevance. Does the fact of psychiatric illness alone make a person incapable of entering into a contract, or continuing with a marriage, or retaining a job? Should the use of medical records be allowed in legal contexts to decide the civil status of an individual with mental disorder? There has been little or no input from mental health science to the normative content of legislation.
- *Rights and immunities*. Legislative measures like the Persons with Disabilities (Protection of Rights, Equal Opportunity and Full Participation) Act 1995 recognise the need for affirmative action in respect of persons with mental illness in view of their psychosocial and economic vulnerabilities. Included in this domain are laws which provide for diminished accountability for persons with mental illness, as illustrated by the provision for defence by reason of insanity contained in section 84 of the Indian Penal Code 1860. Although there has been some debate on revising the archaic McNaughten rule, the fate of the accused granted such immunity has received little attention and he or she could be kept in indefinite confinement. If such is the consequence of a successful defence on grounds of insanity, why seek to expand its scope?
- *Care and treatment*. The procedures for voluntary and involuntary treatment of mental disorders are prescribed in the Mental Health Act 1987. This is the domain Kala & Kala (2007) focus on.

Indian mental health law

Laws generally reflect the prevailing values, attitudes, aspirations and practices in a society at any given point of time. The Indian Lunacy Act 1912 did just that. Primarily designed to protect society from the insane, while providing a modicum of protection to the latter against gross abuse, it did not significantly hinder progress and the reasons for India's under-performance in the mental health domain lie elsewhere (Goel *et al*, 2004). The underlying malaise affected the search for a new mental health law as well, which began way back in 1949, when the Indian Psychiatric Society (IPS) constituted a committee under the chairmanship of Major R. B. Davis for drafting an Indian Mental Health Bill. Three decades and many abortive drafts later, the Law Ministry stepped in and introduced a patchwork Mental Health Bill in the Lok Sabha (equivalent to the UK House of Commons) in 1979. After a tortuous 8-year journey through the parliamentary maze, the bill was finally passed in April 1987 and became law after receiving the President's assent. But it took another 6 years before the 1987 Act was notified for implementation, from 1 April 1993, 44 years after the work had first begun (Goel, 2004).

It all began with a fire

The tragic incident at Erwady in August 2001 – when 25 people with a mental illness died in a fire at night, while chained to pillars – evoked the ire of the Supreme Court and, armed with its interim order dated 15 October 2001, the government of India proceeded to conduct a detailed survey of the mental health scene in the country, using the same format which had failed to evoke any response from the various state governments when it was first circulated in June 2001. The survey revealed severe staff shortages in all categories of mental health personnel, as well as stark asymmetries in the regional distribution of these scarce resources. Basic psychiatric facilities were available in only 219 out of 520 districts for which information was available (out of the total 593) and, with the country producing fewer than 70 psychiatrists per year, there is little prospect of significant

improvement in the near future (Goel *et al*, 2004). In such a scenario, the mere prescription of utopian staffing scales in the 1987 Act is unlikely to improve the lot of people who are mentally ill. The government's proposal to revise these unrealistic standards, unattainable in the foreseeable future, needs to be viewed in this context.

It was, however, a subsequent order of the Court, pertaining to strict implementation of the regulatory provisions of the 1987 Act in respect of private psychiatric facilities, which suddenly aroused the conscience of the Indian psychiatric fraternity. This recently evident concern for the rights and welfare of people with a mental illness is often based on a superficial reading of the law. Contrary to what has been stated by Kala & Kala, sections 19 and 20 of the 1987 Act scrupulously avoid any reference to a psychiatrist, and an involuntary patient may be hospitalised on the basis of certificates from two medical practitioners, one of whom should be in government employ. In practice, though, a psychiatrist is likely to be involved, since admission will be to a psychiatric hospital or nursing home. This by itself does not, however, offer any additional safeguard. The most blatant abuse of the system happened with the connivance of two psychiatrists (neither of whom had ever met or examined the patient) who were subsequently indicted by the Supreme Court, which, in a historic departure from convention, functioned as a trial court, recorded oral evidence and arrived at a finding of fact (Anamika Chawla *v*. Metropolitan Magistrate, 1997). Considering the realities in general hospital psychiatric units within the public sector and in order to prevent such abuse and the consequent alienation of the consumers, the government has deliberately decided against disturbing the status quo.

Amid this preoccupation, a more critical issue appears to have escaped attention. If one goes strictly by the definition contained in section 2r of the Act, many practising psychiatrists in India would not be deemed qualified psychiatrists, as their postgraduate degrees may not be recognised by the Medical Council of India, whereas the state governments remain arbitrarily empowered to designate any medical officer as a psychiatrist merely on the basis of 'knowledge and experience in psychiatry' (Dhanda *et al*, 2004).

Mental health review tribunals

Kala & Kala have flagged an important issue which needs to be debated in depth. International experience with mental health review tribunals has been mixed. In New Zealand, for example, initially two tribunals, one for the North Island and another for the South Island, were established under its Mental Health (Compulsory Assessment and Treatment) Act 1992. The subjectivity inherent in this quasi-judicial process was reflected in wide variations in the success rates of appeals for discharge from compulsory treatment – 22% for the Southern *v*. 10% for the Northern tribunal – and the tribunals were eventually merged (O'Brien *et al*, 1995). Despite considerable investment in terms of the consultants' time, a majority (56%) regarded the legislation as significantly flawed, 71% felt that it resulted in inappropriate discharges and most described it as 'time consuming and cumbersome' (Currier, 1997). The tribunals have been also criticised for their 'tunnel vision' and isolation from mainstream law (Petrila, 2003).

Experience in the UK does not appear to be substantially different (Perkins, 2003) and the Australian system has been criticised for tokenism (Swain, 2000). It has been suggested that the tribunals' reliance on imprecisely defined phrases such as 'lack of insight' and 'non-compliance' may be part of the problem (Diesfeld & McKenna, 2005). The situation is perhaps best summed up by Wood (1995):

> 'Although the practice of psychiatry has made rapid strides over the past few decades, there is no doubt that one of the difficulties of structuring constructive systems of legal detention is the continuing uncertainty and debate on many aspects of psychiatric care and control.'

The situation is infinitely more complex in India, a federal union of autonomous states with widely varying standards of governance and populations several times those of countries like New Zealand. Creating another layer of quasi-judicial tribunals, often capriciously constituted on political rather than juristic considerations, is likely to result in a nightmarish scenario, far worse than the mainstream judicial system.

Law and social engineering

It is tempting to view law as an instrument of social engineering, but there are inherent limitations to this approach (Mukhopadhyay, 1998). This caveat is particularly relevant to the Indian situation, where the quality of implementation is the critical, and often the weakest, link. Landmark pieces of legislation, such as the Child Marriage Restraint Act 1929 and the Dowry Prohibition Act 1961, have remained ineffective, despite bipartisan political support.

Judicial activism is no panacea either, as illustrated by the litigation around section 309 of the Indian Penal Code, which categorises attempted suicide as an offence, which often arouses strong passions among liberals and mental health professionals. After holding the statute to be unconstitutional in 1994 (P. Rathinam *v*. Union of India, 1994), the Supreme Court was forced to do a 180-degree turn just 2 years later and restore the attempted suicide to the status of an offence (Gian Kaur *v*. State of Punjab, 1996), because it found that punishment for abetment of suicide (in India a number of women are pushed into taking their lives) was not possible without the act itself being an offence (Dhanda *et al*, 2004).

Section 377 of the Penal Code, which criminalises homosexuality, is currently under judicial review. Following an appeal filed by the Naz Foundation, a sexual rights non-governmental organisation, the Supreme Court recently returned the Foundation's 2001 Public Interest Litigation (PIL) to the Delhi High Court, which had earlier dismissed it, for reconsideration. The final verdict on this sensitive issue is being awaited with interest, because a legislative initiative in this political minefield is unlikely.

The consumer perspective

Historically, mental health legislation in India has tended to marginalise the consumer perspective (Dhanda, 1996), despite widely shared concerns relating to the coercive component of such laws:

> 'Modern mental health laws confer on psychiatry a portion of the powers of the state, particularly the power to confine

> and treat people against their will and the power to determine the standards by which people are selected for confinement.' (Minkowitz, 2006)

These concerns, however, need to be balanced against wider societal interests (Wessely, 1997) and the mental agony of the affected families, poignantly articulated by an author and father whose son has schizophrenia:

> 'Can anyone explain to me wherein lies the value of freedom to refuse medication, go round the bend and end up detained in hospital?' (Salmon, 2006)

A detailed examination of these critical issues is outside the scope of the present communication, but they must inform any discussion of a new mental health law.

Future directions

It is no one's case that India's Mental Health Act 1987 is perfect. However, any demand for a new mental health law must be tempered with realism, keeping in mind the tortuous law-making process and weaknesses in the crucial domain of implementation, as well as the need to find a broad consensus among the many competing interests. This will require a comprehensive, multi-sectoral dialogue among the various stakeholders, led perhaps by the National Human Rights Commission. In this complex process, mental health professionals in general and psychiatrists in particular will have to give more than they get and any colonial vision of playing the traditional paternalistic role must be put to rest. Even then, the outcome is unlikely to satisfy everyone and, as Mukhopadhyay (1998) articulates this gloomy prognostication:

> 'it is not sensible to expect that law can ever be a potent force for change in the existing social structure: the hope of ensuring gender justice using law as an instrument of social engineering is an altogether impossible dream.'

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SPECIAL PAPER

Forced marriage

Kiran Rele MBBS DPM DNB (Psychiatry) MRCPsych

Specialist Registrar in General Adult Psychiatry, Intensive Treatment Service, Longley Centre, Norwood Grange Drive, Sheffield S5 7JT, UK, email Kiran.Rele@SCT.NHS.UK

This article examines factors that are salient to understanding forced marriages and provides an overview of the issue. It aims to promote awareness in the UK, where there is a need for services to develop appropriate responses, as primary care and the local psychiatric services are not geared up to tackle such transcultural issues.

Forced marriage is an abuse of human rights. Forced marriage occurs within diverse cultures, traditions,

nationalities, races and religions, although it seems that the incidence of such cases in the UK is highest among Muslim, Hindu and Sikh women in the Bangladeshi, Pakistani and Indian communities.

Ann Cryer was the first MP to raise the issue of forced marriages in the House of Commons, in February 1999. Following on from her adjournment debate, the government established a working group on forced marriages, whose report, *A Choice by Right* (Home Office Working Group on Forced Marriage, 2000), highlighted this as a serious but neglected issue. Recently, forced marriage has attracted the attention of the media in the UK. The government's Forced Marriage Unit has recently unveiled a campaign backed by actor and writer Meera Syal and former EastEnders star Ameet Chana. *Forced Marriage: A Wrong Not a Right*, a consultation paper on forced marriage, was published in 2004 by the Foreign and Commonwealth Office (FCO) to prompt public debate on whether the criminalisation of forced marriage would help to combat forced marriages in the UK, although a plan to create a new criminal offence of forced marriage was in fact shelved by the government in June 2006. The government has initiated a £250 000 programme to improve liaison between British and overseas police forces and to train FCO staff to help them deal with the victims of forced marriage. Oxfordshire NHS has set up a website dedicated to the issue (http://www.forcedmarriage.nhs.uk/index.asp).

The distinction between forced marriage and arranged marriage

It is important first to understand how forced marriage differs from arranged marriage. In the latter, the families of both the spouses take a leading role in arranging the marriage but the choice of whether or not to accept the arrangement remains with the young people. In forced marriage, one or both spouses do not consent to the marriage and some element of duress is involved (either physical or emotional, or both). The crucial factor, which the Home Office Working Group on Forced Marriages (2000) used to differentiate between forced and arranged marriage, is consent. It is important to note that forced marriage is not sanctioned within any culture or by any religion.

Incidence of forced marriage

As the majority of cases are not reported, because of their controversial nature, it is difficult to know the exact number of cases. Currently about 250 cases of forced marriage are reported to the FCO each year. Conservative estimates suggest that about 1000 women in the UK are annually subjected to forced marriage, either within the UK or during a visit to Bangladesh, Pakistan or India under the guise of a vacation or visiting a sick relative. The not-for-profit organisation Southall Black Sisters (2001) reported that it deals with 1000 cases of forced marriages annually, while the Bradford Police deal with 70 cases annually. Most cases involve young women and girls aged between 13 and 30, although there is evidence to suggest that as many as 15% of victims are male (Foreign and Commonwealth Office, 2004). The FCO's Community Liaison Unit deals with approximately 250 cases and the figures have increased year on year since the establishment of the Unit. This is the government's central unit dealing with forced-marriage case-work, policy and projects. There is considerable under-reporting and the figures are a small fraction of what is estimated to be the real scale of the problem.

Psychological problems

There are no published studies encompassing the psychiatric morbidity in this population. However, isolated case studies have come to the attention of the police and social services departments. The majority of responses to the consultation paper *Forced Marriage: A Wrong Not a Right* were from women's groups and domestic violence forums, with the next most represented categories being local governments and individuals (Forced Marriage Unit, 2006).

Common psychological effects of forced marriage are feelings of depressed mood, irritability, low self-esteem, rage and frustration, sleep problems, difficulty in forming relationships and difficulty trusting others. Victims may have other mental health problems and display behaviours such as self-harming, self-cutting or anorexia, as well as drug and alcohol misuse.

Isolation is one of the biggest problems facing victims of forced marriage. Those who attend services seeking help are likely to be under severe stress when running away from the situation. In addition, the victims have feelings of guilt, as they have run away from their families and thus brought shame, leading to social ostracism and harassment from the family and community. In response to the stress, the victims may harm themselves and may have suicidal thoughts. Raleigh & Balarajan (1992) stated that the suicide rate among 16- to 24-year-old women of Asian origin was three times that among 16- to 24-year-old women of White British origin. This high rate has been attributed to cultural pressures, conservative parental values and marriage issues which may clash with the wishes and expectations of the young women themselves. The person who has been forced into a marriage may become trapped into a cycle of abuse, with long-term psychological and physical consequences.

Feelings of isolation, depressed mood and on occasions self-harm should be dealt with delicately. Victims will find it difficult to confide in their family and close friends. In addition, they may have to cope with financial and accommodation pressures when they leave the family home and have to deal with the reality of independence (Foreign and Commonwealth Office, 2004).

Warning signs

There have been instances where the victims have been withdrawn from education, thus restricting their personal and educational development. Students may present with a sudden decline in their performance, aspirations or motivation, or may show a decline in their punctuality and may be subject to excessive restrictions and control at home. Teachers can play an important part and should be alert to potential warning signs – such as a sudden drop in performance, a history of domestic violence, truancy, extended absence through sickness or overseas commitments, a history

of older siblings leaving school early and marrying early. It is, though, important not to assume that forced marriage is an issue simply on the basis that a student presents with any of the above problems.

The education and health authorities should be trained to identify and respond to victims' needs at an early stage, by not only offering practical advice and referral to counselling services or support groups but also, if required, referral to social services. Social services will often play a key role in protecting the interests of the young person and have a duty to make enquiries into allegations of abuse or neglect against a child (under section 47 of the Children Act 1989). They can also provide information about their rights and choices and refer young people, with their consent, to appropriate local and national support groups or counselling services; they can also encourage access to advocacy services (Foreign and Commonwealth Office, 2004).

Health professionals should be aware of the impact of forced marriage. General practitioners should be aware of the issues regarding forced marriage and especially of the need to keep the information confidential from the victim's parents (Foreign and Commonwealth Office, 2004).

Role of mental health services

The author recommends that primary care and psychiatric services should be geared up to identify this particular issue and appropriate guidelines should be laid down to tackle it. It is important to treat the various mental health disorders secondary to the stress of forced marriage and ensure victims' safety. There should be provision for the mental health team to be able to liaise with the specialised transcultural team for the Black and minority ethnic population so as to be able to understand the culture and give emotional support. This team should be able to provide psychological support. Mental health workers should be made aware of the issue of forced marriage, especially when dealing with young adolescents. In complex cases, there should be appropriate liaison between the police, social services and the forced marriage unit. The development and implementation of strategies to address forced marriage must be underpinned by an understanding of the practice as constituting a breach of fundamental human rights and possibly demanding legal action, rather than a view that it is no more than a 'family affair'.

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NEWS AND NOTES

For contributions to the 'News and notes' column, please email ip@rcpsych.ac.uk

Pan-American Division Newsletter

This year's symposium, 'Women and Psychiatry Around the World: The Importance of Gender and Culture', at the meeting of the American Psychiatric Association (APA) in San Diego, was very successful. The speakers were from Pakistan (Haroon Chaudhry), Kenya (Frank Njenga), Egypt (Nasser Loza), Trinidad (Gerard Hutchinson), Mexico (Asuncion Lara) and Australia (Jayashri Kulkarni), and Sheila Hollins, President of the College, was the discussant.

The liveliness and fun of the reception hosted by the Pan-American Division/Royal College of Psychiatrists at the Omni Hotel was not affected by San Diego's untimely cold misty weather, even though it was partly on an outside balcony. The President and nearly all the other officers of the College and several of the staff were there and there was a large contingent of APA officers, including the President, President elect and several past Presidents, and many officers and members of the APA Assembly.

The Pan-American Division put on an excellent session at the College annual meeting in Edinburgh, organised and chaired by our financial officer, Simon Brooks. Stephen Kisely from Nova Scotia spoke on community treatment orders and Sue Bailey, from the Adolescent Forensic Service, Manchester, England, on the ethics of detaining child patients.

Independently of the Pan-American Division, the College and APA have been working closely together. There was a joint Presidential symposium, 'Health Inequalities for Persons with Mental Health Problems and Developmental Disabilities', at the APA meeting. Professor Hollins spoke to the Assembly and to the Board of Trustees of the APA. There was a joint business meeting and one of the topics pursued was a joint programme to provide training and consultation by volunteer psychiatrists to other countries covered by the Pan-American Division. There were also two joint sessions at the College annual meeting in Edinburgh: 'Recovery and Its Meaning for Minority Groups', covering disparities in mental healthcare in the US and UK, and 'Recovery and Intellectual Disabilities'.

There was a very small attendance at the executive meeting in San Diego but the generous offer of support for someone from the Caribbean or Central or South America to attend the APA is still open. Contact Dr Bark for further details.

The Secretary of the Pan-American Division, due to present at the APA in San Diego, was unable to attend because the US embassy did not grant him an entry visa. They maintain they issue only a certain number of visas every year for meetings and this year the allocation had been met. Others from 'developing countries' have experienced similar problems. It is hard to see how this could help 'homeland security' – rather the opposite. Please contact Dr Bark with your experiences, views and recommendations for the appropriate response of the Division.

Dr Nigel Bark
Chair of the Pan-American Division (email nbark1@pol.net)

African Journal of Psychiatry

The *African Journal of Psychiatry* (formerly known as the *South African Psychiatry Review*) launched its first issue in August this year. The journal is affiliated to *International Psychiatry* and it is hoped this will stimulate exchange of news and knowledge and be of benefit to readers globally. Please contact Dr Christopher Szabo, Editor-in-Chief, for further details (email Christopher.Szabo@wits.ac.za).

The BPPA Young Researcher of the Year Award

The British Pakistani Psychiatrists Association (BPPA) recently announced the BPPA Young Researcher of the Year Award. Its aim is to promote interest in psychiatric research among young Pakistani health professionals and to recognise research published in peer-reviewed scientific journals. The award is not restricted to any particular psychiatric subspecialty and work carried out in any field will be considered. There are two awards each year, one for research carried out in Pakistan and the other for research carried out in the UK and Ireland. The winners and runner-up in both categories will be entitled to cash rewards equivalent of £250 and £150 respectively. For further information visit the BPPA website (http://www.bppauk.org/bppayoungresearcher.htm).

Books wanted for review

It is intended that *International Psychiatry* will feature reviews of books published in low- and middle-income countries. Authors of books broadly on the topic of mental healthcare are invited to contact the Editor, Hamid Ghodse, email hghodse@sgul.ac.uk.

Scotland Malawi Psychiatry Project

The Scotland Malawi Psychiatry Project (SMPP) is a collaboration that supports mental health training in Malawi while providing experience in international/cross-cultural psychiatry for UK trainee and senior psychiatrists. Malawi is a sub-Saharan country with one qualified psychiatrist for a population of 12 million. In early 2007, five volunteers worked with colleagues from the College of Medicine, Malawi, to provide undergraduate teaching to 60 students. SMPP plans to build on this successful experience by sending eight psychiatrists to support an expanded medical student teaching programme in 2008 (and future years). Placements are for 3–6 weeks and are based at Malawi's main government hospital in Zomba. The project is supported by the Royal College of Psychiatrists' Volunteer Scheme. If you are interested in volunteering, or would like to support the project financially, please contact Leonie Boeing (email lwboeing@googlemail.com) or Robert Stewart (email robcstewart@mac.com).

Corrigendum

The 'Report on current themes in child and adolescent psychiatry', in the News and Notes section of the July issue of *International Psychiatry* (p. 76), was contributed by Dr Sheela Biswas, Consultant Psychiatrist, Child and Adolescent Unit, New Street Health Centre, Barnsley.

CORRESPONDENCE

Correspondence should be sent to: Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk

Journal of Pakistan Psychiatric Society

Sir: The article by Khan (July 2006, p. 21) and letter by Abbasi (January 2007, p. 25) in *International Psychiatry* unfortunately tend to overlook many positive aspects of mental healthcare and services in Pakistan. Some of their views seem to relate more specifically to experience in the private healthcare system or are based on a distant view and very little information about the current situation. Both seem to be genuine attempts to highlight the inadequacies in the system, but these are well known.

The statement in the letter by Abbasi about the *Journal of Pakistan Psychiatric Society* (*JPPS*) is an example of this and is factually incorrect. I would like to point out that *JPPS* is in regular publication and it is incorrect to say that the journal has not been produced since 2003. It restarted publication in 2005 and two volumes have been published since then.

The *JPPS* is available free (full text) on http://www.jpps.com.pk. It is indexed by WHO, EMRO Index and also in a number of regional and local indexes. The journal has played an important role in the continuing professional development

of psychiatrists in the region, as well as helped to disseminate research findings. In fact, *JPPS* brought out a special issue devoted to the 2005 earthquake, the very subject of Abbasi's letter. Since restarting its publication, it has played an important role in promoting evidence-based medicine. I would request your readers to contribute to the journal.

Dr Saeed Farooq
Editor, JPPS (Journal of Pakistan Psychiatric Society), email sfarooqlrh@yahoo.com

Ethno-psychopharmacology and the clinical relationship

Sir: Although the three linked articles on ethnopharmacology in the July 2007 issue of *International Psychiatry* were necessarily heavily biologically focused, I must take issue with the fact that culture and clinical relationship attracted such brief comment. It is not possible, let alone desirable, to reduce people to the biological functions of their brains. The development of tools for testing individual genotypes opens up interesting possibilities, but represents a dangerous distraction from the challenge of addressing the realities represented by the global burden of disease. According to the World Health Organization, low- and middle-income countries, which will represent 80% of the world's population by 2020, are expected to bear the brunt of the projected increase in the burden of mental illness. The acquisition of approval by Roche of its Amplichip by the USA and European Union, as David Skuse mentions in his introduction to the series of papers, is a distortion of this reality by the pharmaceutical industry. Addressing the needs of most of the 400 million people disabled by neuropsychiatric conditions globally cannot be done without challenging these priorities. Those interested in international psychiatry need to reach a clear consensus about their agenda.

A thorough understanding of the culture of a patient (or patient group a service is supporting) is of course an essential bedrock on which to build sensitive relationships. The dynamic nature of any relationship is central to its positive development. A clinician should gradually know a patient or community better with time, and service users also gain a greater understanding of the opinions and attitudes of clinicians and services as they access care. An attitude of sensitive response to needs and aspirations is an important way for trust to develop, even when the starting points have been far apart. This can be fostered with good service design and continuous constructive evaluation at the formative, process and outcome stages, so that a service remains responsive to its intended users. It is with this attitude at a personal clinical level and as a component in system design that we can move forward in our complex world and not see cultural diversity as an obstacle to delivering care.

In my experience of working as a British psychiatrist in Nigeria, I have often been impressed by my clients' ability simultaneously to hold some of the messages of orthodox psychiatry and more traditional ideas. Local service staff such as field workers are also very skilled at working through these issues. Sometimes emphases for treatment plans seem to be in conflict, but much more frequently a plan for moving forward that is mutually acceptable is reached through which all parties involved are enriched.

Julian Eaton **MRCPsych**
Mental Health Advisor, West Africa, CBM International National Coordination Office, PO Box 8451, Wuse, Abuja, Nigeria, email julian_eaton@cbm-westafrica.org

MRCPsych recognition in India

Sir: We read with interest the article by Kulhara & Avasthi on the teaching and training of psychiatry in India in the April issue of *International Psychiatry* (p. 31). We acknowledge the possible options suggested by the authors to overcome some of the difficulties faced in psychiatric training in India.

Mr Ramadoss, Minister of Health, India, in a recent media report highlighted the acute shortage of psychiatrists in India and stated that over 30 000 psychiatrists are required to serve a billion people, while there are only 3300 practising in the country. Currently there are a significant number of doctors of Indian origin who are undergoing basic and higher specialty psychiatric training in the UK.

Owing to changes in immigration policies by the Home Office (i.e. termination of permit-free training for international medical graduates), some trainees are currently experiencing difficulties in progressing and obtaining consultant-grade posts. Some of the doctors who have completed their membership examinations (MRCPsych) and some who have completed their higher specialty training (CCT) are considering a return to establish their psychiatric practice in India. Strong family commitments and a desire to contribute to training and the development of the specialty (as well as economic growth) in India have enhanced their willingness to return home. These highly qualified psychiatrists will be great assets to the country.

Owing to the high standards in training and assessment for the MRCPsych qualification, it has been recognised by the Royal Australian and New Zealand College of Psychiatrists and the Canadian Psychiatric Association. However, the MRCPsych qualification is currently not recognised by the Medical Council of India (MCI). Hence these doctors will be ineligible to work in a teaching hospital or even in the public health services. Given the acute need for qualified psychiatrists in India it is unfortunate that the available resources are not being utilised adequately.

In this context we would like to suggest that there should be collaboration between the Indian Psychiatric Society, the MCI and the Royal College of Psychiatrists to negotiate for the recognition of the MRCPsych qualification by the MCI. If this succeeds, it would be the first step in encouraging psychiatrists trained in the UK to return home.

Dr Sudheer T Lankappa,[1] Dr Ritu Gupta[2] and Dr Abhijeeth R. Shetty[2]
[1]Academic Clinical Psychiatry, The Longley Centre, Sheffield S5 7JT, UK, email s.lankappa@sheffield.ac.uk
[2]Mental Health Unit, Rotherham General Hospital, Rotherham, UK

Indian mental health legislation

Sir: I read with interest the critical review by Kala & Kala on mental health legislation in contemporary India in the July issue of *International Psychiatry* (pp. 69–71). Kala & Kala mention various shortcomings in the Indian Mental Health Act 1987. As a psychiatrist who has worked in both India and the UK (and thus under the Mental Health Acts of both countries) I would like to draw attention to some other gaps which I feel are as important.

First, the Indian Act does not mention involuntary medication at all. Involuntary medication is not synonymous with involuntary admission. Both voluntary and involuntary patients could in principle insist on having only psychological interventions and refuse all psychotropic medication. The powers and duties of a psychiatrist in such cases remain undefined by the Act. The Act similarly omits mention of electroconvulsive therapy. In a wider sense, it is not clear whether involuntary admissions (admission under special circumstances, admission under reception order) give psychiatrists the right to treat patients against their will.

Second, the Act does not define the circumstances under which involuntary admissions are advisable. A psychiatrist and two medical practitioners agreeing that a patient has a mental illness and needs treatment is not enough. Treatment for psychiatric illnesses is also possible in the community. Where do we draw a line?

Third, the Act attempts to define 'psychiatrist' and 'medical practitioner' early in its text. It is not absolutely necessary to have a psychiatric postgraduate qualification to be deemed a 'psychiatrist' under the Act. A medical practitioner with sufficient experience in psychiatry can also be considered a 'psychiatrist' for the purposes of the Act. What constitutes sufficient 'experience' for the purposes of the Act again remains undefined.

Fourth, the Act does not include prescribed forms for involuntary admissions. Without prescribed forms, any kind of uniform, standardised practice throughout a country with dimensions such as India will remain difficult to implement.

Fifth, the Act does not mention the role of psychiatrists in the case of prisoners who are mentally ill. They are a large population who remain for the most part neglected by both the criminal justice system and the health services in India. In my experience, psychiatrists are involved only to the extent of giving reports about whether a person is 'fit to stand trial'. While working in India, I often wondered what happened to prisoners who became mentally ill in prison, or people who were not convicted after making a successful insanity plea but remained dangerous to society because of their psychopathology.

India's resources are limited but that is no excuse to stop planning, to look for what remains missing in this vital piece of legislation. Unless we plan, we do not know what kind of resources we need or whether we can modify and use an existing infrastructure. It is time to act.

Nandini Chakraborty MD DNB MRCPsych
Staff Grade in Forensic Psychiatry, Arnold Lodge, Leicester, email Nandini.Chakraborty@nottshc.nhs.uk

Working conditions in Russia

Sir: Working conditions can have a dramatic impact on the training of psychiatrists. We write about the stark contrast between those in Russia and the UK.

Working conditions for doctors in Russia have deteriorated since the collapse of the USSR. Healthcare in the state sector is free for patients but under-funded. Psychiatrists continue to work under the burden of a huge degree of stigma, both from within the medical profession and from the general public. This stems from the abuse of psychiatry in the former USSR for political purposes.

Psychiatrists in Russia earn much less than those in the UK. Trainees working in a state institution earn approximately €70 a month (£50), compared with between £2000 and £3000 a month for trainees in the UK. A Russian psychiatrist working in the state sector who has been qualified for 5 years and works extra night shifts earns €150 a month (£100). Salaries in the private sector are much higher, with a professor earning between €2000 and €3000 (£1350–£2000), although this is still less than a trainee in the UK. Some psychiatrists in Russia earn less than non-professional workers; for example, security guards earn around €500 a month (£350). Although the wages are substantially lower than in the UK, the cost of living is similar. A month's rent for a single-room apartment in Moscow is on average €800 (£550), which is comparable to London prices. Clearly, this makes it impossible for trainees to survive on their salary and the co-author personally knows many who are supported by their families and work extra shifts and have second jobs. It is not uncommon for patients and relatives who recognise the poor working conditions to offer doctors money to thank them for good care and treatment.

In Russia, psychiatric training lasts for up to 3 years (1 year of internature and 2 years of ordinature), compared with the 6 years of the new run-through training in the UK. In contrast to the current concerns in the UK over the number of training posts, there are plenty of posts for psychiatric trainees in Russia. This is because it is not a popular job, owing to the low salary, and for the same reason there are many specialist jobs available when training is complete. Other medical specialties, such as obstetrics and dermatology, are more popular and better paid.

Trainees in Russia have shorter working hours than their colleagues in the UK. They work approximately 40 hours a week compared with up to 56 hours a week in the UK. They are also entitled to more annual leave, nearly 2 months compared with 5 weeks in the UK.

We hope that increasing cooperation between European psychiatric associations will lead to an improvement in both training and working conditions for psychiatrists in Russia.

Clare Oakley MB ChB MRCPsych[1] **and Amina Nazaralieva**[2]
[1]Senior House Officer, Birmingham and Solihull Mental Health Trust, Lyndon Clinic, Hobs Meadow, Solihull, West Midlands, B92 8PW, UK, email clareoakley@doctors.org.uk
[2]Psychiatric trainee, Moscow Research Institute of Psychiatry, 3 Poteshnaja Street, Moscow, Russia, email nazaralieva@gmail.com

Forthcoming international events

11–13 October 2007
6th Congress on Mental Health in Intellectual Disabilities
Zagreb, Croatia
Organiser: European Association for Mental Health In Intellectual Disability (EAMHID)
Contact: Dr Ljiliana Igric
Email: ljiljana.igric@zg.htnet.hr
Website: http://www.zagrebcongress2007.org

11–14 October 2007
59th Institute on Psychiatric Services, APA's Leading Educational Conference on Public and Community Psychiatry
New Orleans, United States
Website: www.psych.org/IPS2007

11–14 October 2007
US Psychiatric and Mental Health Congress
Gaylord Palms Resort and Convention Center, Orlando, Florida
Website: http://www.cmellc.com

13–15 October 2007
Universal Mental Health Screening and Drugging of Our Children: Risks versus Benefits
Arlington, Virginia, United States
Website: http://www.icspp.org

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)
Buenos Aires, Argentina
Organiser: Argentinian Association of Psychiatrists (AAP)
Contact: Dr Nestor F. Marchant
Email: aap@aap.org.ar
Website: http://www.aap.org.ar

25–27 October 2007
Best Evidence-Based Practice: Prevention, Treatment and Management of Violence at the Individual, Institutional and Governmental Level
5th European Congress on Violence in Clinical Psychiatry
Congress Centre 'De Meervaart', Amsterdam, The Netherlands
Contact: Prof. Dr Tom Palmstierna or Prof. Dr Henk Nijman
Email: nico@oudconsultancy.nl
Website: http://www.oudconsultancy.nl/violenceadam/violence/5theuropeancongc

29–31 October 2007
Transcultural Mental Health in a Changing World: Building a Global Response
World Federation for Mental Health Conference
Minneapolis, Minnesota, US
Contact: Ellen Mercer, Director of the WFMH Center for Transcultural Mental Health
Email: emercer@wfmh.com.
Website: http://www.wfmh.com

2–4 November 2007
Third International Conference of the South Asian Association for Regional Cooperation (SAARC) Psychiatric Federation
Colombo, Sri Lanka
Organiser: South Asian Association for Regional Cooperation (SAARC) Psychiatric Federation
Contact: Harischandra Gambheera; V. D. Sharma
Email:harisg@sltnet.lk; vdsharma@healthnet.or.np

6–8 November 2007
X Pan Arab Congress
Algiers, Algeria
Organiser: Arab Federation of Psychiatrists and Algerian Psychiatric Society
Contact: Dr. Saida Douki and Dr. Farid Kacha
Email: Saida.Douki@gnet.tn; F.Kacha@caramail.com

14–17 November 2007
International Society for Traumatic Stress Studies (ISTSS) 23rd Annual Meeting
Baltimore, Maryland, USA
Email: conference@istss.org
Website: http://www.istss.org/meetings/index.cfm

22–24 November 2007
XII Annual Course on Schizophrenia
Madrid, Spain
Website: http://www.cursoesquizofreniamadrid.com

23–25 November 2007
XVI International Symposium on Sexuality: Pleasures
Caracas, Venezuela
Organiser: WPA Section on Psychiatry and Human Sexuality
Contact: Dr Ruben Hernandez
Email: rubenhernandez@cantv.net

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

28 November–2 December 2007
Third International Congress on Brain and Behavior
Thessaloniki, Greece
Organiser: International Society on Brain and Behavior
Contact: Dr Kostas N. Fountoulakis
Email: Kfount@otenet.gr
Website: http://www.psychiatry.org

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

14–17 March 2008
IV Biennial Conference: Integrative Approaches to Affective Disorders
Cape Town, South Africa
Organiser: International Society for Affective Disorders in collaboration with the WPA Section on Affective Disorders
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
Melbourne, Australia
Organiser: WPA Section on Women's Mental Health
Contact: Dr Donna Stewart
Email: Donna.Stewart@uhn.on.ca
Website: http://www.IAWMHCongress2008.com.au

14–15 April 2008
From Innovations to Practice: The Promise and Challenge of Achieving Recovery For All
Hyatt Regency Hotel, Cambridge, Massachusetts, USA
Organiser: Center for Psychiatric Rehabilitation, Boston University
Contact: Joan Rapp joanrapp@bu.edu
Website: http://www.bu.edu/cpr/workshops/

17–19 April 2008
Annual Conference of the African Association of Psychiatrists and Allied Professions: Mental Health and Social Changes
Ibadan, Nigeria
Organiser: African Association of Psychiatrists and Allied Professions
Contact: Dr Oye Gureje
Email: ogureje@comui.edu.ng

19–21 June 2008
WPA Thematic Conference on Depression and Relevant Psychiatric Condition in Primary Care
Granada, Spain
Organiser: Wonca-Europe, the Spanish Psychiatric Association and the Spanish Society of Family and Community Medicine (SEMFYC)
Contact: Dr Francisco Torres-Gonzalez
Email: ftorres@ugr.es; patricia@fase20.com
Website: http://www.WPA2008granada.org

25–30 August 2008
13th World Congress of the International Association for the Scientific Study of Intellectual Disabilities (IASSID)
Cape Town, South Africa
Website: http://www.iassid.org

27–30 August 2008
12th European Symposium on Suicide and Suicidal Behaviour
Glasgow, Scotland
Email: organising@esssb12.org

19–25 September 2008
14th World Congress of Psychiatry
Prague, Czech Republic
Website: www.wpa-prague2008.cz