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International Psychiatry

Guest editorial
Cultural psychiatry, diversity and political correctness in a shrinking world 27
John L. Cox

Thematic papers – Mental health services in sub-Saharan Africa
Introduction 28
David Skuse

Management of mental health services in Malawi 29
Felix Kauye

Mental healthcare programmes in Kenya: challenges and opportunities 31
David M. Ndetei

Provision of mental health services in Nigeria 32
Olufemi Olugbile, M. P. Zachariah, O. Coker, O. Kuyinu and B. Isichei

Country profiles
Psychiatry in Brunei Darussalam 34
Reehan Sabri and Ajmal-Khan Kudlebbai

Nepal: trying to reach out to the community 36
Pramod M. Shyangwa and Arun Jha

United Arab Emirates (UAE) 38
Valsamma Eapen and Omer El-Rufaie

Original papers
A survey of risk assessment skills and training among health professionals in Pakistan 41
Rameez Zafar, Khurram T. Sadiq and Sylvia A. Khan

The psychological and psychosocial impact of the Pakistan Kashmir earthquake after 8 months: a preliminary evaluation by PACTT 43
PACTT: Pakistan–Aberdeen Collaborative Trauma Team

Traditional health practitioners and mental health in Kenya 46
Marx Okonji, Frank Njenga, David Kiima, James Ayuyo, Pius Kigamwa, Ajit Shah and Rachel Jenkins

News and notes 49

Correspondence 50

Forthcoming international events 52

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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.

Cultural psychiatry, diversity and political correctness in a shrinking world

John L. Cox

Secretary General, World Psychiatric Association

It is perhaps unusual for an academic journal like the *Lancet* to spearhead a 'movement' to advocate the scaling up of mental health services in low-income countries. Yet at the movement's launch in London in November 2007, attended by representatives from World Health Organization (WHO), the World Bank, donor agencies, as well as the World Psychiatric Association (WPA) and the Royal College of Psychiatrists, it was clear that a seminal series of papers, published in September of last year, was of the utmost importance for world psychiatry and for our planet. The five papers in the series 'Global Mental Health' had the following titles: 'No health without mental health'; 'Resources for mental health: scarcity, equity, and inefficiency'; 'Treatment and prevention of mental disorders in low-income and middle-income countries'; 'Mental health systems in countries: where are we now?'; and 'Barriers to improvement of mental health services in low-income and middle-income countries' (*Lancet*, September 2007, vol. 370, nos 9590–9593).

These papers, published by a syndicate of experts, succinctly summarise and usefully tabulate evidence that the provision of mental health services and the distribution of mental health personnel in the world are inequitable. They also calculate the cost of the measures that could be undertaken to scale up the services and to promote public mental health more effectively. They review evidence that poverty, discrimination, natural disasters, ethnic violence and stigma are particularly lethal for low-income countries, and that the world community, especially at local government level, should now act to avoid a tragedy that could affect the future of us all.

I was provoked by this series of papers to reconsider the adverse effects of climate change on mental health; also to reflect on the centrality of *Lancet* papers published earlier that year on poverty, maternal mental illness and child development (Graham-McGregor *et al*, 2007), and on the effect of untreated mental disorder on politicians' policies and teachers' effectiveness. The increased risk of student suicide, and the demoralisation and depression of staff that characterised the university campus during the worst years of the Amin regime in Uganda, as well as the lack of therapists, could readily be recalled (Cox, 1975).

The *Lancet* has called not only for a politically correct advocacy group to scale up mental health services in low-income countries (in which, on average, 1 in 16 mothers die in childbirth, and 30% of which have no mental health legislation), but also for a less politically correct movement, the direction of which cannot be precisely foreseen, nor its limits scrutinised in any WPA manual of procedures.

The prestigious academics from India and the UK who led this initiative called for more vision, more focused altruism and more public mental health advocacy. They invoked values as well as science and are aware that the resource-rich countries are part of the problem, as well as being able to provide solutions. The cost of the brain drain, for example, will surely be itemised in the report awaited from the WPA Task Force that will be debated at the WPA General Assembly in Prague in September 2008. Thus the juggernauts, such as the Royal College and the WPA, are now considering how to respond to the *Lancet* movement and where to nail their colours to this particular mast.

There are, nevertheless, several additional factors to consider if this movement is to succeed and to be fully acceptable to those clinicians working at the sharp edge in low-income countries. Cultural sensitivity is vital for the implementation of the vision and promotion of these ideas; hints of paternalism, or a perceived lack of a historical political perspective, are disadvantageous, and the movement needs to retain leaders who are immersed day by day in the rigours of clinical work in the developing world, and so be aware of the sheer hard work necessary to sustain the morale of community mental health professionals, whether these are psychiatric clinical officers in Uganda or family support workers in Chile. The scaling up of services that is called for will benefit from online continuing professional development (CPD), as well as roving CPD advocates equipped with motor bikes or a Land Rover. The College's Volunteer Scheme, its proposed support for the African diaspora, as well as the International Divisions, could make other contributions to this scaling-up programme.

However, institutional lethargy and personal feelings of helplessness when one is confronted by an overwhelming task can intervene and have to be taken into account. Where, for example, is the long-promised College guidance on cultural competence? Is it lost, perhaps, in the politically correct endorsement of 'diversity' and 'values', to the neglect of culture and medical anthropology? Have we really lost clinical and academic interest in intercultural similarities and differences of rituals, symbols and kinship, as well as the understanding of religious beliefs and language pertinent to the management of mental disorder?

Are we really taking for granted the skills necessary to provide mental health services in multicultural Britain, with an increase of recently arrived migrants from eastern Europe, as well as refugees and asylum seekers? If so, this would be regrettable and untimely, because globalisation has increased the need to water cultural roots – including the culture 'within'. Cultural competence includes the development of empathy and 'connected knowledge', as well as the recognition that others may view the world through a different cultural lens (Fitzgerald, 2000). Such general cultural competence is different from culture-specific and

even intercultural competence, and yet can be acquired by critical incident analysis and using role-play. Teachers are, however, required to be fully sensitive themselves to the personal issues such training may evoke, otherwise prejudice and cultural insensitivity can be increased.

The World Federation for Mental Health in 2007 highlighted cultural psychiatry for World Mental Health Day, and the expressed wish of service users that their beliefs, illness assumptions, rituals and family networks are considered and understood. In order for it to succeed, the *Lancet* movement must likewise consider these cultural issues and the roots of culture in language and religion. The need to scale up child development programmes illustrates well the breadth of this general scaling-up agenda. The early years of life are the cradle of cultural acquisition in low- as well as high-income countries, and are adversely affected by poverty and untreated mental disorder. What happens to the foetus and to pre-school infants is of the utmost importance to the child's ability to become a good citizen. It is politically incorrect, therefore, to omit the newborn from maternal child health (MCH) services – MNCH is indeed a more useful acronym (World Health Organization, 2005).

Religious beliefs (including secular humanism), as well as language and dialect, also express the cultural values of societies. Any 'religiosity gap' or 'language gap' between patient and professional is therefore a disadvantage.

These cultural and training issues need to be carefully considered by any movement that sets out to change the world in which we live. But political correctness is not always an asset.

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THEMATIC PAPERS – INTRODUCTION

Mental health services in sub-Saharan Africa

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Within the continent of Africa, mental health services are relatively undeveloped. In the sub-Saharan countries of Malawi, Kenya and Nigeria, similar problems are faced by dedicated psychiatrists who are struggling to create and sustain an educational, management and political structure for psychiatry.

Malawi exemplifies some of the most pressing issues. As Dr Kauye recounts, this is a country with an excessively low gross domestic product (GDP) per capita, even by African standards. Moreover, the overly centralised administrative structure for medical services militates against the provision of adequate community care. There are very few trained psychiatrists, and in most out-patient and in-patient settings nurses take on major responsibilities for the everyday care of patients. However, the shortage of nursing staff means that many psychiatric nurses end up doing general nursing duties. A further issue, pertinent to the need to retain appropriately trained staff, concerns medical staff who are so poorly paid that retention of their services is often linked to private sponsorship. This provides a temporary supplement to their meagre salaries. The supply chain for medication is especially vulnerable to disruption, and procurement at a national level is less secure than it should be, especially for psychiatric treatments. Ways of tackling this continuing concern are discussed by Dr Kauye.

Kenya and Nigeria are wealthier countries than Malawi, but they experience similar problems. Professor Ndetei describes how difficult it has been to retain psychiatrists in Kenya over the past decade, despite the country having made a tremendous effort to train them. Unfortunately, they migrate in ever greater numbers. As in Malawi, trained psychiatric nurses are often redeployed in order to provide general nursing duties, and at a community level there are few appropriately trained staff to deliver services to individuals with mental health disorders. We have discussed in previous issues the potential benefits of using native healers to supplement conventional psychiatric services; this is an issue discussed by Professor Ndetei with approval. As in Malawi, a lack of epidemiological research has meant that relatively little is known about the nature and scale of disorders at the level of community mental health, and there is an associated danger that research expertise is unduly centralised and remote.

Finally, Dr Olugbile and colleagues discuss the issue of mental health education in Nigeria. They provide a relatively structured account of the current state of knowledge about mental health issues in two surveys, the first concerning primary healthcare workers and the second specifically targeted at general practitioners. The authors discuss, first, a survey they conducted with a national sample of primary healthcare centres. Remarkably, none of the centres surveyed had any psychotropic drugs available in their pharmacies, nor were there any medically trained practitioners working in them. The survey was therefore focused mainly upon nurses

and community health workers (without specific psychiatric training). In all categories, knowledge about mental health problems was regarded as poor. It is perhaps more surprising that similar results were obtained in a further survey of general practitioners (the vast majority of whom were seeing psychiatric patients).

Taken together, this set of papers emphasises the remarkable work being done by psychiatrists in some of the poorest countries in the world to provide better care for psychiatric patients, and stresses how important it is that they are supported in their endeavours by links with centres of excellence in the UK and elsewhere.

Management of mental health services in Malawi*

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Malawi is a country in sub-Saharan Africa bordering Mozambique, Tanzania and Zambia. It has an area of approximately 118000 km^2 and is divided into northern, central and southern regions. It has an estimated population of 13 million, 47% of whom are under 15 years of age and just 5% over 60 years. Its economy is largely based on agriculture, with tobacco being the main export. The projected growth in gross domestic product (GDP) for 2007 was 8.8%; GDP per capita was $284 per annum.

The health system in Malawi is centrally controlled by the Ministry of Health. There are subsidiary zonal offices, which offer technical support to district health offices; the latter oversee the running of health services in all 28 districts. All but four of the 28 districts have their own district hospital. Within each district there are health centres, mainly manned by paramedics and nursing staff. These serve as referral centres for the health posts, which are manned by health surveillance assistants (HSAs). Most districts have at least one medical doctor, who usually performs administrative duties as a district health officer. There is a central hospital in each of the three regions; these act as tertiary units for the district hospitals in their regions. The directors of these central hospitals report directly to the Ministry of Health.

Mental health services in Malawi date from 1910. They were initially managed by the prison services, but in 1951 responsibility was transferred to the Ministry of Health. In 1953, a national psychiatric hospital was created in the southern region, in Zomba. It has about 333 beds and admits between 1500 and 2000 patients per year. Additional in-patient psychiatric facilities (run mainly by psychiatric nurses) are provided by the central hospital in the central region. In the northern region a missionary psychiatric unit is run by the Hospitaller Order of St John of God, which provides both community and in-patient services. (See Kauye & Mafuta, 2006, for further details.)

Malawi, like most countries in this part of Africa, faces a number of problems in relation to the provision of mental health services, including inadequate staffing levels, an over-centralisation of services and inconsistent drug supply. Over the years, it has looked at various ways of addressing these problems, which are reviewed here.

The human resource problem

Staffing problems have long affected all levels of service provision. At the Ministry of Health headquarters there is no national mental health coordinator to oversee activities; rather, Zomba Mental Hospital is currently coordinating mental health activities nationally. This has been successful to a certain extent, in that supervision of district mental health activities, revision of the Mental Health Act and preparation of an 'essential drug' policy for psychiatry have all been achieved. Nevertheless, a national coordinator at Ministry level is desirable.

Overall, there is a major shortage of clinicians with psychiatry as a specialty. District mental health services are mainly run by psychiatric nurses. Malawi has a general shortage of nursing staff, and although we have been training psychiatric nurses for a number of years, they end up doing general nursing duties and minimal mental healthcare. One way we are approaching this problem is by introducing a degree programme in mental health and clinical psychiatry for clinical officers with a diploma in clinical medicine. We hope clinical officers will be motivated to enrol as graduate students by the possibility of promotion on successful completion of the course. We are hoping that these graduates will mainly work in the districts and be at the forefront of promoting mental health, especially at community level.

The government of Malawi has been supplementing the salaries of health workers to a certain extent, in order to reduce their migration to developed countries. An improvement in the conditions of service of general health workers would influence mental health services both directly and indirectly. Having adequate numbers of nurses in the districts will mean that psychiatric nurses can be released to do more mental health activities. Sustaining the programme

*This paper was presented to the African Division of the Royal College of Psychiatrists, June 2007.

to supplement salaries in the longer term is something the government will have to consider.

Centralisation of services

Mental health services are very centralised and most districts treat few psychiatric patients. There is little community psychiatry done within districts. Mental health is not effectively integrated into primary healthcare, in contrast to our national mental health policy. Most primary healthcare workers do not feel competent and confident in dealing with psychiatric patients. Consequently, they refer nearly all psychiatric patients to the tertiary units, which are often far away. This makes it difficult for their relatives to visit them.

Plans have been made to train clinicians and nurses in all the districts of Malawi in the management of common mental health disorders, as effective integration of mental health services into primary care will mean that these disorders can be managed at district level by general medical staff. Two health workers from each district will undergo two weeks of intensive training using a special syllabus originally designed by the World Health Organization's collaborating centre at the Maudsley Hospital and Institute of Psychiatry; this syllabus has already been used for training equivalent workers in Kenya. The two health workers will then act as trainers for others in their respective districts, with support from the tertiary units. Once the training programme has been completed, we are hoping that the syllabus can be modified to be used for training of HSAs, so that they can include mental health as part of their activities in the community.

Teaching of psychiatry

Malawi has one medical school, with an intake of 60 students each year. It also has schools of health sciences, which train paramedics. The long-term sustainability of the decentralisation of mental health services will be achieved through good undergraduate teaching of psychiatry at both. The paramedics and general medical officers are the backbone of primary healthcare in Malawi.

The curriculum at the medical school has just been reviewed, and psychiatry teaching was increased from five to eight weeks. There are also plans to provide a standardised syllabus of psychiatry for all the schools of health sciences. Our teaching goals are being achieved through partnerships with institutions outside Malawi, including institutions in Scotland and Norway.

Drug supply

A shortage of drugs, including psychiatric medications, is one of the big challenges we face in Malawi. There are certain periods when most psychiatric medications are not available in the district and psychiatric hospitals. There are also problems with the procurement of drugs at national level. Central Medical Stores is the government department mandated with the procurement of drugs for government hospitals. This has faced a number of problems over the years and recently the government has engaged a consultancy firm from the USA to run the services in order to improve the situation.

We have incorporated psychiatric medications into the central procurement process. Estimates of drug requirements for all the district and tertiary mental health units have been submitted, based on figures from previous years. The plan is for Central Medical Stores to procure 6 months' supply in advance and to be given at least 2 months' notice when the drugs are about to run out. It is our hope that if this system is implemented, the supply of drugs will become more stable and patients will not have to go without them.

Research

Research on mental illness in Malawi is minimal. Most of it has been done through the work of the St John of God charitable service. Lack of funding opportunities and insufficient people with skills in research in mental health have contributed to this situation. Knowing that it can be a problem to get funding for big projects, Zomba Mental Hospital started an initiative whereby at least two small research projects are undertaken per year, using government funds. All cadres of staff, from junior nurses to psychiatrists, are encouraged to get involved. Small projects have been started in the past year, and we are also collaborating with overseas universities like Michigan State University in order to find funding for bigger research projects. We hope also to collaborate with universities in London and Manchester in this initiative of promoting mental health research in Malawi.

Conclusion

Staff shortages, over-centralisation of mental health services, inadequate drug supply and a lack of local data on mental health are some of the major challenges Malawi is trying to address in the context of its available resources. Decentralisation of services is closely linked to potential improvements in human resources at the district level. This need for decentralisation is being addressed in a number of ways, including the introduction of a degree programme for psychiatric clinical officers, strengthening of undergraduate teaching and training of primary healthcare workers in psychiatry using a special syllabus. Small-scale research projects using government funds are being done to fill some of the gaps in local data on mental illness, while bigger projects are being pursued in conjunction with universities outside Malawi. The government of Malawi has recently engaged a consultancy firm to address deficiencies in drug procurement and supply, which have been affecting all hospitals in Malawi, including psychiatric units, for a number of years. In the long term, it is important for countries like Malawi, with limited resources, to find sustainable solutions to run effective programmes for people with mental illness.

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Mental healthcare programmes in Kenya: challenges and opportunities

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The mental healthcare programmes in Kenya fall into four inter-related categories: service provision; training; research; policy and advocacy.

Service provision and training

Service provision and training in mental health are interconnected. Currently, Kenya has 67 psychiatrists for an estimated population of 35 million, giving a psychiatrist-to-population ratio of 1:522 400. In mid-1997, Kenya had 53 psychiatrists for an estimated population of 28.8 million, or 1:543 400. Thus, there has hardly been any improvement in the ratio over the last 10 years, despite an enormous allocation of resources for the training of psychiatrists. Some of the contributing factors are high population growth and migration (Ndetei *et al*, 2007). Most of the other countries in sub-Saharan Africa have one psychiatrist serving a population of between 1 000 000 and 7 000 000. In Nigeria the estimated ratio was 1:1 000 000 in 1997 and 1:1 600 000 in 2007 (Ndetei *et al*, 2007). However, the overall national ratios can be highly misleading, since there is great variation within countries, as is illustrated by the situation in Kenya in April 2004 (Table 1).

The fact that the overall ratio has not improved over the short term and the uneven national distribution mean that Kenya will not have sufficient psychiatrists in the foreseeable future. This has far-reaching, almost radical, implications for both clinical practice and overall mental health policy. In the short to medium term (perhaps even over the next two or three decades), the role of psychiatrists in Kenya will be mainly to provide academic and managerial leadership, with the provision of clinical services delegated to mid-level health professionals (non-university graduates), including nurses, clinical officers (with 3–4 years of training in clinical medicine), occupational therapists and social workers. Others will include university graduates in paramedical specialties, such as counselling and clinical psychology.

Table 1 Distribution of psychiatrists by province in Kenya

Province	No. of psychiatrists	%	Population	Psychiatrist: population ratio
Nairobi	34	64.1	2 143 254	1:63 007
Central	3	5.7	3 724 159	1:1 241 386
Coast	4	7.5	2 487 264	1:621 816
Eastern	5	9.4	4 631 779	1:926 355
North-Eastern	0	0	962 143	–
Nyanza	1	1.9	4 392 196	1:4 392 196
Rift Valley	5	9.4	6 987 036	1:1 397 407
Western	1	1.9	3 358 776	1:3 358 776

Source: Ndetei *et al* (2007).

These groups are less costly to train and will generally be available where their services are needed. Their training curricula will of necessity have significantly greater mental health input, so that their function in relation to mental health is as good as that in relation to other medical disciplines. Psychiatric nurse training is in place in Kenya, but it does not attract enough applicants to fill the training vacancies. Related to this is the common practice of most qualified psychiatric nurses being assigned general nursing duties, thus denying them the opportunity to serve in their areas of specialisation. At the moment, there are no clinical officers who have specialised in psychiatry and there is no training of psychiatric clinical officers. Yet, in Kenya, they offer the bulk of medical services. Their training should therefore be accorded top priority.

Another significant aspect of training is the equipping of medical students with adequate clinical skills in psychiatry so that their competence in psychiatry is at a par with their competence in other disciplines. Currently, Kenya produces about 300–400 medical graduates annually. The impact of training 300 medical graduates appropriately will be far greater than training five psychiatrists a year (the current average yearly output).

At the undergraduate level, training in mental health takes place in a few centres in Kenya. At the University of Nairobi it consists of 160 hours in the behavioural sciences and a total of 720 hours of formal lectures in clinical psychiatry, clinical exposure and tutorials during the fourth and fifth (final) years of medical school. The students must pass a university examination during their final year of study.

Postgraduate specialist training for psychiatrists is available only at the University of Nairobi. This training has been conducted since 1983. It consists of a 3-year programme, which is offered after a prerequisite 2- to 3-year pre-entry experience after graduation from the medical school. The students are required to write a research dissertation on a subject of their choice. Some of these dissertations have been published in peer-reviewed journals. After the students qualify in their postgraduate university examinations, a further 2 years of practice (during which they work independently) is required before they can be recognised as specialists in psychiatry.

Other mental-health-related postgraduate training programmes are in clinical psychology, psychiatric social work, substance misuse and psycho-trauma, all of which are undertaken at the Department of Psychiatry at the University of Nairobi. It is worth noting that all the teaching described above is carried out by a full-time staff of nine psychiatrists, one psychiatric social worker and two psychologists. The only office space and facilities available consist of three rooms

measuring about 3 m × 3 m and three computers, which have only recently been connected to the internet. Psychiatric training of registered nurses is conducted by the Kenya Medical Training College but registration for this course is currently below the stipulated quota. Several public and private universities and colleges offer training in counselling psychology.

Finally, it has been suggested that traditional and faith healers play a significant role in mental health (Ndetei *et al*, 2007). Working with them and improving their skills through simple diagnostic training without seeming too keen to understand their trade (which they guard) may win their confidence and improve collaboration and referrals to the formal mental health services.

Research, policy and advocacy

There is still a lot that is not known about the prevalence rates of the whole spectrum of mental health problems across the continuum of life, in different situations and environments, for example poverty and mental illness, and how these complement each other. Other areas not yet adequately researched are the people who come into contact with the law, particularly prison populations, orphans, and community mental health and well-being. Research on the provision of good, affordable, accessible and appropriate services in particular socio-cultural and economic contexts should also be conducted. Research on simple issues of concern such as the regional distribution of psychiatrists within the country over time has led to the stark realisation that, rather than waiting until there are enough psychiatrists, radical policy strategies on how best to meet the service and training needs of Kenya have to be devised. Although some progress has been made through research in schools on issues such as substance use and misuse, psycho-trauma and anxiety and depressive disorders, there is still much that needs to be done.

Research is necessary not only for good practice but also for appropriate, evidence-based policies that are cost-effective. The final policy makers (the politicians) will listen to technocrats only if the latter are armed with locally generated evidence that relates to the mental health of the electorate (which is what the politicians value most).

In Kenya today, a lot of mental health research is done through masters and doctoral theses, mainly in the Department of Psychiatry at the University of Nairobi and a few departments in other universities which offer health-related courses. The remaining (non-dissertation) mental health research is done mainly by a few individuals and non-governmental organisations (NGOs). Notable among the NGOs is BasicNeeds UK (Kenya), which spearheads research in mental health in relation to poverty. Through this programme, a community research laboratory in an urban area has now been put in place and a rural one is being considered. It will be possible to conduct epidemiological research on community mental health and well-being across the continuum of life, as well as to carry out intervention studies through these laboratories; in due course these studies can be replicated in other parts of the country.

At present, most of the research related to mental health is being undertaken by the Africa Mental Health Foundation (AMHF), which brings together interested researchers from different backgrounds and different universities within and outside Kenya. The AMHF fosters collaborative research and supports research by BasicNeeds UK (Kenya) and other international collaborators. It also supports annual award schemes for outstanding students in mental health/psychiatry (both clinical and research) at the University of Nairobi and the best nurse in mental health.

Perhaps the most significant recent development is the formation of the University of Nairobi's Medical Students Association for Research and Statistics. The Association has plans to extend to other medical schools within the region and also to foster collaboration with similar organisations world-wide. Its patron is the author, and one of the main objectives is to sensitise students to the importance of research during their formative years.

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Provision of mental health services in Nigeria

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Nigeria, like other African countries, is short of personnel trained in mental healthcare. Efforts to tackle the problem have often focused on increasing the numbers of psychiatrists and nurses in the field. These efforts, over the past 20 years, have not appeared to have greatly improved service delivery at the grass roots. Most of the specialist centres where such highly trained personnel work are in urban areas and for a large part of the population access to them is limited by distance and cost.

Mental healthcare is one of the recognised elements of primary healthcare in Nigeria. Primary health centres (PHCs) are supposed to have a reasonable amount of competence in recognising and dealing with some of the more common mental disorders. They are the first point of contact for many

individuals and serve as the first link in the referral system. The population ratio of psychiatrists is 0.4:100 000, while for psychiatric nurses it is 4:100 000 (World Health Organization, 2001).

In this paper we describe two audits in Lagos State undertaken (as part of a larger survey of core personnel and facilities available for psychiatric services) to evaluate the use of non-specialist resources, specifically PHCs and general practitioners (GPs), potentially available for the provision of mental healthcare, and examine their present state of functioning and participation in it. Insights are derived about how they could be harnessed to provide more effective coverage for mental healthcare.

Methods

The audit of PHCs focused on available personnel and physical resources (drugs and equipment) relevant to the care of people with mental illness. An evaluation of the knowledge base and attitudes of the identified personnel in these centres, as they pertain to mental illness, was conducted using specially designed questionnaires. These instruments were pre-tested in five pre-selected PHCs, and were found to be appropriate and adequate. Five of the 20 local government areas of the state were randomly selected. Within each area, three PHCs were randomly selected for assessment. Thus a total of 15 PHCs were included in the study. These centres together had a total of 73 personnel, who were all included in the survey.

The knowledge base and attitudes of GPs as well as appropriate physical resources (drugs and equipment) available in their respective clinics as they pertain to the treatment of mental illness were also audited, using another specially designed questionnaire. This instrument was pre-tested on 10 GPs and was similarly found to be adequate and appropriate.

Items in the questionnaires used for both the PHC and GP surveys were independently scored by two experts (both psychiatrists). Four core questions in the PHC instrument (Table 1) and three core questions in the GP study (Table 2) were rated by these two experts on a five-point scale (0 indicating no knowledge and 4 indicating very good knowledge). The mean of the scores assigned by the two experts for each response was given as the response score for each participant in the study. Composite scores for each participant were also computed to reflect overall knowledge and attitude. The expert inter-rater correlation (Pearson product–moment) was significant (for the PHC survey, $n = 73$, correlation coefficient $= 0.70$, $P < 0.001$).

Results

Audit of PHCs

A general finding was that none of the PHCs surveyed had any stock of psychotropic drugs in its pharmacy.

The 73 staff in the PHCs comprised the following professional categories:

- 21 nurses (29% of the sample)
- 18 community health workers (25%)
- 15 community health extension workers (20%)
- 8 administrative officers (11%)
- 6 pharmacy technicians (8%)
- 5 cleaners (7%).

There were no doctors working in the PHCs at the time of the survey. The core clinical functions were carried out by nurses, community health workers and community health extension workers. These three categories also formed the bulk of the workforce. Pharmacy technicians provided technical support.

The expert ratings of the knowledge and attitudes of these staff are summarised in Table 1. More than half the personnel had had at least graduate-level education; three (4%) were postgraduates. Most of the remaining staff had completed their secondary education, although five (7%) had received only primary education.

Table 1 Knowledge and attitude ratings of the PHC personnel

Item	Mean	s.d.	Range
Knowledge of definition of mental disorder	1.41	0.65	0–3
Knowledge of categories of mental illnesses	1.32	0.76	0–3
Understanding of causation	1.57	0.63	0–3
Knowledge of treatment modalities	1.16	0.69	0–3
Overall rating	1.39	0.49	0–2.88

Expert ratings of knowledge and attitude, where 0 = no knowledge and 4 = very good knowledge. A generally poor level of knowledge regarding mental illness, its manifestations and management emerged across all categories.

Table 2 Knowledge and attitude ratings of the GPs

Item	Mean	s.d.	Range
Knowledge of basic classification	1.49	1.19	0–4
Diagnostic ability	1.39	0.95	0–3.5
Management	1.04	1.05	0–3
Overall rating	1.32	0.90	0–3.33

Expert ratings of knowledge and attitude, where 0 = no knowledge and 4 = very good knowledge. A generally poor level of knowledge across all levels emerged. Knowledge of basic classification was rated highest, while management knowledge was the poorest.

Audit of GPs

General practitioners from all across Lagos State were surveyed. The venue of the survey was the meeting of the Association of General Medical Practitioners. Of the 51 surveyed, one failed to return the questionnaire. Fifty participants thus were included in the study.

Most of the GPs (44 out of 50) saw psychiatric patients in their practices, but this left a sizeable number (6) who did not see psychiatric patients at all. Moreover, only 30 (60%) of the practitioners actually treated patients for psychiatric disorders; the remaining 20 (40%) would not treat mental illness even if they recognised it. Such individuals were presumably referred to specialist facilities for management.

The expert ratings of the knowledge and attitudes of the GPs are summarised in Table 2.

Psychotropic drug stocks

Only 8 (16%) of the GPs stocked a broad range of psychotropic drugs, and only 4 (8%) stocked both antipsychotic and antidepressant medications. Twenty (40%) had only antipsychotic drugs and 10 (20%) had only antidepressant drugs, while 8 (16%) did not stock any psychotropic medications at all.

Discussion

The burden and pattern of psychiatric morbidity can be seen from available epidemiological data (Gureje *et al*, 1992; Abiodun, 1993). An idea of what is attainable within the primary health system can be seen from research done in other countries (Bilsker *et al*, 2007; Kates & Mach, 2007; Paria & Perez, 2007).

Nigeria is under-resourced in terms of psychiatric personnel and infrastructure. Access to care for the majority of people with mental illness is severely limited. Efforts to address this problem have so far been targeted at increasing the numbers of psychiatrists and psychiatric nurses, who are often located in urban specialist units.

The PHCs are the facilities closest to the majority of citizens. The research presented here shows that the knowledge base and interest of staff in the PHCs concerning mental illness are low. Further, unlike earlier reports on the matter (Gureje, 2005), it also shows that they do not have even the most basic drugs for treatment.

General practitioners have been a neglected force in mental healthcare planning in Nigeria. If the awareness, knowledge level and attitudes of GPs and PHC workers about mental health could be upgraded in a targeted way, it would lead to an increase in the numbers of people treated for their mental illnesses, especially those with 'minor' disorders. It could also create the beginning of a referral chain that would help to prevent the loss to clinical follow-up of individuals who have had specialised treatment in distant teaching hospitals or psychiatric hospital units.

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COUNTRY PROFILE

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Psychiatry in Brunei Darussalam

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Brunei Darussalam occupies a sliver of land on the north-west coast of the island of Borneo with a geographical area of just 5765 km² (Government of Brunei, 2004). It is divided into the four districts: Brunei-Muara, Temburong, Tutong and Belait. Two-thirds of the land is covered by lush tropical rainforest and the climate is perpetually warm and humid. It is ruled by Sultan Hassan Al-Bolkiah, the head of a dynasty which has governed Brunei for 650 years.

The population of 374 000 (United Nations Population Fund, 2005) enjoys one of the highest standards of living anywhere in the world, thanks to the discovery of oil in 1929, but the economy remains almost entirely dependent on oil and gas. The Bruneian population is 66% ethnic Malay and 15% ethnic Chinese; the rest are a mixture of indigenous and other races, such as the Ibans, who were once the feared headhunters of Borneo. There is also a large population of expatriate workers from the Indian subcontinent, South-East Asia, Australasia and Europe.

Religion and culture

The different cultural groups in Brunei have interesting beliefs about physical and mental health (Kumaraswamy, 2007). These often present a challenge to medical practitioners and psychiatrists in particular. In spite of the official state adoption of Islam, many Malays adhere to beliefs that are a mixture of Islam, misunderstandings of Islam, animism and Hinduism, and this religious stance is a major influence on their beliefs about health. The Chinese and indigenous communities also have their superstitions and forms of traditional medicine.

Unsurprisingly, therefore, the first line of help for any kind of ailment among Bruneians, particularly psychiatric, is the Malay shaman or *Bomoh*. *Bomohs* practise a type of folk medicine under the veneer of Islam but their heretical practices are frowned upon by the religious authorities. Their knowledge is passed from generation to generation (Abdul

Kadir, 2006) and their treatments include calling upon spirits as well as the prescription of herbs, spells and charms. Three-quarters of all Malay psychiatric patients will have consulted a *Bomoh* before resorting to mental health services (Salleh, 1989).

Healthcare in Brunei

Brunei has an extensive primary healthcare network, with accessible local clinics in most parts of the country. There is one hospital in each of the four districts, although most specialist services are provided in the capital city, Bandar Seri Begawan. There are a few individual private medical practitioners and one major private hospital.

Psychiatric services

There are two psychiatric departments in Brunei: one in the country's main hospital, Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital in Bandar Seri Begawan, and a smaller department in Suri Seri Begawan (SSB) Hospital, in the town of Kuala Belait, in Belait District. There is significant stigma associated with mental illness and a certain amount of justified fear of psychiatric services. Before RIPAS Hospital was built, in 1984, there was a psychiatric unit in the old hospital known as 'Ward 5', which, by all accounts, was a classic asylum-style ward. The legacy of this unit continues to haunt Brunei's present-day mental health services. Even today, locals often refer to the hospital's modern mental health unit (MHU) as 'Ward 5' and recount with horror tales of screams and the sight of restrained patients.

There are four consultant psychiatrists (or 'specialists' as they are known in Brunei) in RIPAS Hospital and one in Kuala Belait. Although the specialists have expertise in different sub-specialties, there are no formal sub-specialist services.

The RIPAS MHU is a 20-bed ward with a virtually constant occupancy rate of at least 100%. At any one time, almost half the patients are 'bed-blockers' with chronic mental illness, abandoned by their families and so lacking any appropriate discharge destination. In Brunei, there are no residential facilities for people who are mentally ill. The RIPAS MHU also doubles up as a day hospital but activities and the interventions of the highly able occupational therapists are severely limited by a lack of space. SSB Hospital has a handful of long-term in-patients. There is a nascent community psychiatric service based at RIPAS Hospital which administers depot antipsychotic medication in patients' homes and follows up some of the difficult-to-engage patients.

Electroconvulsive therapy is available and there is a reasonable array of modern antipsychotic drugs. However, the range of antidepressants is limited and hopelessly outdated. Drugs not on the formulary, such as clozapine and venflaxine, can be acquired on a named-patient basis, but delays of, on average, 3 months are usual. Their clinical usefulness is, hence, severely limited. Another curious problem is the highly variable supply of drugs. It is not uncommon to run out of stock without any prior warning.

Until recently, there was a single trained clinical psychologist, in RIPAS Hospital. With his recent departure and the absence of a successor, there is no effective alternative to pharmacotherapy, which exacerbates the problem of limited supplies and types of psychotropic drugs. However, there is a day centre for the rehabilitation of those with chronic mental illness, which has succeeded in helping a number of individuals back to employment.

Mental health legislation

The Lunacy Act 1929 (Attorney General's Chambers, 2004) allows for the detention of persons suspected of having a mental illness who are at risk. Unfortunately, the text of the Act is rather brief and imprecise. In practice, the relatives of any person suspected of having a mental illness may approach a magistrate and obtain a court order that authorises the involuntary detention of their family member. There is no right of appeal for the patient. Neither psychiatrists nor social workers are involved in this process; hence, there is potential for abuse of the law.

One of the laudable social welfare developments in Brunei is the Mental Health Allowance, which is a modest sum of money given monthly to those who are long-term mentally ill and incapable of working. The children of such individuals also receive an allowance. Furthermore, the Religious Department's treasury or 'Bait ul-Maal' distributes charitable donations to the needy members of Bruneian society, including those with psychiatric disorders and, in the case of converts to Islam, it also provides housing. Hence, it is unusual to see the type of grinding poverty often seen in Western countries among those who are mentally ill.

Types of mental illness

There are no documented prevalence studies of psychiatric disorders in Brunei, but the common illnesses which psychiatrists are familiar with are assessed and treated by the mental health services. Notably, suicide is virtually unheard of, as are cases of eating disorder. As one may expect, given the country's prohibition of alcohol, alcohol-related psychiatric disorder is uncommon, although not absent, since supplies are smuggled from across the border with Malaysia and small quantities can be legitimately brought into the country by non-Muslims, for personal consumption. Perhaps for the same reason, violence is also uncommon in Bruneian society. Any form of aggression often causes great consternation and may lead to a referral to psychiatric services.

One very worrying trend is the widespread use of methamphetamine, or *Syabu* (pronounced 'shaboo') as it is known locally. Despite severe laws on drug trafficking, there is anecdotal evidence of a pending methamphetamine epidemic among Bruneian youth. Consequently, people with methamphetamine-induced disorder are frequently admitted. Other common drugs of misuse include cannabis and solvents.

Future developments

Brunei Darussalam faces a number of challenges over the next few years, all of which are likely to affect its mental health services. Perhaps the most significant issue is the

effect of the country's depleting oil reserves. The economy has not significantly diversified; if the prosperity dries up along with the oil wells, foreign workers are likely to leave. An exodus of Brunei's expatriates would be devastating for the mental health services, whose medical staff is composed entirely of foreigners. Psychiatry remains an unpopular choice of career with Brunei's small number of medical graduates, who are mostly trained in the UK, where they usually have a few weeks' exposure to psychiatry as undergraduates. A handful of Bruneian junior doctors are currently training as psychiatrists in nearby countries, but it is unlikely that a fully trained Bruniean psychiatrist will emerge for a number of years.

The mental health services face a number of tasks. The priorities are to raise the profile and understanding of psychiatry, as well as to undertake epidemiological research. There are plans to expand specialist services but these developments are already facing paralysing bureaucracy. Furthermore, there is a need for psychological treatments as well as better and newer drugs to be made available. The most ominous of unmet needs, however, is the establishment of drug treatment services. Finally, a new Mental Health Act is being drafted; it is hoped that it will afford greater protection to patients and will take account of the opinion of psychiatrists in the process of involuntary detention.

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COUNTRY PROFILE

Nepal: trying to reach out to the community

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Sandwiched between India and China, Nepal is a small landlocked lower-middle-income country in South Asia. Once a peaceful country, it is striving to overcome the legacy of a 10-year Maoist rebellion, a royal massacre and continuing political chaos. Nepal has been in dispute with neighbouring Bhutan over the repatriation of hundreds of thousands of refugees in several camps in Nepal. In addition, the country experiences frequent natural disasters (floods and landslides) and faces several environmental challenges, including deforestation and a population explosion in southern Nepal.

Slightly bigger than England in size, Nepal is 885 km long and 200 km wide, with an area of 147 181 km^2. It has a total population of nearly 28 million, and an annual population growth rate of 2.2%. Life expectancy at birth is 63 years. Almost 90% of the population still live in rural areas and 38% live below the poverty line. Nepal has an annual per capita income of less than US$300 (compared with US$800 in India and over US$1700 in China).

Health resources and statistics

Healthcare facilities in Nepal are generally poor (Box 1) and beyond the means of the majority. The provision of health services is constrained by low government spending, rugged terrain, lack of health education and poor public expectations. Most hospitals are located in urban areas; rural health facilities often lack adequate funding, trained staff and medicines and have poor infrastructure. In rural areas, patients sometimes have to be carried in a basket through the mountains for 3 or 4 days to reach the nearest primary care centre, which may in any case be devoid of trained medical personnel.

For administrative purposes, Nepal has been divided into five developmental regions, 14 zones and 75 districts. According to the institutional framework of the Department of Health Services, which is one of three departments under the Ministry of Health and Social Welfare, the sub-health posts (SHPs) are the first contact point for basic health services. Each level above the SHP is a referral point in a network from SHPs to health posts to primary care centres, and to district, zonal and regional hospitals, and finally to the specialist tertiary care centres in Kathmandu. Nepal currently has 10 tertiary care centres, 83 hospitals, 700 health posts and 3158 SHPs. There are a few private non-profit hospitals as well. Almost all the private sector hospitals, including those run by non-governmental organisations, and private, profit-oriented nursing homes are situated in the urban areas.

There are no national epidemiological data on mental health problems in Nepal, but data from other developing countries can help estimate the situation reasonably well.

Box 1 Health-related facts and figures about Nepal

National health budget for 2007/08	US$187 million
Current per capita health expenditure	US$6.9
Health budget as a proportion of national budget	
2007	5%
2009 (projected)	7%
WHO-recommended EHCS (essential healthcare services) package (minimum)	US$35
Number of registered doctors in Nepal	6719
Number of doctors employed by the government	1259
Doctor:population ratio	1:5000
Total number of registered nurses	11 637
Maternal mortality ratio/100 000 live births	
1996	539
2009 (projected)	300
Infant mortality rate/1000 live births	
2001	64
2009 (projected)	45

Box 2 Mental health services and resources in Nepal

Population	28 million
Mental health budget as a proportion of the total health budget	0.8%
Number of psychiatrists	39
Numbers of psychiatric beds	
government sector	94
medical college hospitals	196
private hospitals/nursing homes	25
non-governmental organisations	70
total number of psychiatric beds	385
Psychiatric bed:population ratio	1:70 129
Child psychiatrists	0
Old age psychiatrists	0
Neurologists	8
Clinical psychologists	> 9
Psychiatric nurses	48
Psychiatric social workers	0
Occupational therapists	1
NGOs in mental health	> 8

According to the largest international psychiatric epidemiological study so far, by Wang *et al* (2007), unmet needs for mental health treatment are especially worrying in low-income countries. That study, which involved almost 85 000 people in 17 countries, revealed that at least two-thirds of people who are mentally ill receive no treatment. One Nepalese study indicated a high point prevalence (35%) of 'conspicuous psychiatric morbidity' (Upadhyaya & Pol, 2003). Common mental illnesses recorded at a recent mental health camp in eastern Nepal included depressive illness, anxiety disorders, schizophrenia, bipolar affective disorder, substance misuse and dementia (Jha, 2007); the camp was also inundated by people with learning disability, epilepsy and complaints of headache. Most people still think that mental illness means becoming crazy or lunatic, being possessed by spirits or losing control of oneself (Regmi *et al*, 2004). Although such perceptions are changing, the majority of the public and even of mental health professionals still believe that mental illness is caused by bad fortune (Shyangwa *et al*, 2003).

The number of psychiatrists has grown from one in 1961 to 40 at present. Although the increase looks dramatic, it is less than one psychiatrist per year. Even in relation to South Asian countries with a comparable cultural and political history, Nepal is under-resourced in terms of mental health staff and services (Box 2). There are fewer than 400 psychiatric beds, only 39 psychiatrists and 48 psychiatric nurses, for a population of some 28 million. There are neither child nor old age psychiatrists, nor any psychiatric social worker in the country. The total number of professionals working in mental health facilities, including the private sector, is only 0.59 per 100 000 population (World Health Organization, 2006).

Mental health policy

The national mental health policy and plan were developed and adopted by the Nepalese Ministry of Health in 1997, but, over 10 years later, they still exist only on paper. The policy nevertheless is meant to ensure the availability and accessibility of mental health services for the entire population, through an integrated mental and general health system, to prepare an adequate mental health workforce, to formulate mental health legislation and to improve mental health awareness among the general public.

On the positive side, there has been some improvement in terms of postgraduate psychiatric training and the introduction of mental health topics in the curriculum of community health workers. Other developments include programmes for traditional healers on orientation and sensitisation to mental disorders and epilepsy.

Mental health legislation and human rights

There is at present only a draft Mental Health Act in Nepal, and existing practices are based on obsolete laws. The draft Act has created a risk of introducing mental health legislation without the resources necessary to implement it and safeguard human rights. It has a provision for the detention of people who are mentally ill, for assessment and treatment at the only mental hospital, in Kathmandu. Moreover, as happens in some parts of India, treatment and restraint of acutely disturbed unwilling patients are being done in a way which is full of good intentions but which is not technically legal and which is fraught with possibilities of human rights violations (Kala & Kala, 2007).

There are no psychiatric services in any prison and no separate forensic psychiatric service in the country (World Health Organization, 2006).

Medical education

Medical education started in Nepal in 1978 and the first batch of doctors graduated in 1984. Until 1996, there were only two medical schools; now there are 12 of them (including private schools), which produce over 1000 doctors a year. Several schools run postgraduate medical programmes, but only two have facilities for higher psychiatric training. The quality of these training programmes, including their research components, requires improvement to suit local needs.

In terms of training for primary care staff, only 2% of the training for both medical doctors and nurses is devoted to mental health. One non-governmental organisation is running a community mental health service in seven of the

75 districts of the country. In these seven districts, primary health workers receive regular refresher mental health training (World Health Organization, 2006).

Mental health services

The World Health Organization (2001) has recorded extremely low levels of mental health service in most developing countries, and Nepal is no exception. A recent assessment of Nepal's current mental health system revealed that the services are not organised in terms of catchment areas (World Health Organization, 2006). There are 18 out-patient facilities, 3 day hospitals and 17 psychiatric in-patient units, in addition to one mental hospital, to serve the entire country.

As the community mental health services are conspicuous by their absence, there is no follow-up care. Community mental health services are limited to a small area in Nepal. The United Mission to Nepal (UMN) initiated community work in 1984 and carried out a series of successful community surveys and training programmes (see, for instance, Wright *et al*, 1989). The development of a national community mental health programme is the most important issue for the Ministry of Health to address. While the importance of psychosocial rehabilitation is recognised, its practice is extremely limited. Similarly, there are no specialist psychiatric services for children or older people, and for those with substance-related disorders the only specialist provision is a de-addiction ward at Tribhuvan university teaching hospital, Kathmandu.

Challenges and outlook

The near-term future of Nepalese psychiatry does not look bright. If basic mental healthcare is to be brought within reach of the mass of the Nepalese population, this will have to be done through the implementation of the national mental health policy. The World Health Organization (2006), in conjunction with the Nepalese Ministry of Health, has mapped out mental health services and resources for the first time. This is a welcome development and may pave way for future initiatives.

Finally, people affected by the decade-long Maoist civil war, especially women and children, may present with trauma-related psychiatric problems requiring culturally sensitive interventions. Nepal would require international help and support to carry out relevant research to understand and address new and existing mental health challenges.

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COUNTRY PROFILE

United Arab Emirates (UAE)

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This paper will focus on the current state of mental health services in the United Arab Emirates (UAE) and reflect on the various public health, socio-economic and psychosocial factors that have a major impact on the mental health needs of the population. It is to be borne in mind that the services described in this paper are in a state of rapid change, as the country is witnessing one of the fastest rates of development in the world.

Society and culture

Situated in the Arabian Gulf, the UAE has an approximate area of 84 000 km^2 and a population of 4.1 million (UAE Census, 2005). Males constitute 67.6% of the population and females 32.4%; 20% are under the age of 15 years and only 1.8% are aged over 60 years (UAE Census, 2005). The literacy rate is 75.6% for men and 80.7% for women. Only 21.9%

of the residents of the country are Emiratis (UAE citizens), while the remainder comprise expatriates from nearly 120 countries who have come to work in this oil-rich country. The largest ethnic group among the resident population is Asian, with the majority from the Indian subcontinent. The official language is Arabic and the official religion is Islam.

The UAE federation, formed in 1972, consists of seven emirates (Abu Dhabi, Dubai, Sharjah, Ajman, Um Al Qaiwan, Fujairah and Ras Al Khaima). The UAE is a high-income country, itself rich in oil reserves and also lying in a strategic location along the transit route of the world's crude oil. The proportion of gross domestic product (GDP) spent on health is 3.5%. Life expectancy at birth is 71.3 years for males and 75.1 years for females (World Health Organization, 2004).

Sociocultural and traditional influences

In the UAE, tradition and religion are paramount. Mental health, reflected in good behaviour and conduct, is expected, as outlined by the Muslim religion. This also leads to the notion that supernatural forces can cause mental health problems. Consequently, self-blame and guilt resulting from the belief that mental health symptoms are a punishment for sins are not uncommon among people with mental disorders.

The usual first stop on the help-seeking route for mental illness is the traditional healer. In a study of the help-seeking preference for mental health problems in children, Eapen & Ghubash (2004) found that only 37% preferred to consult a mental health specialist. Alternative remedies are also much sought after, including Ayurvedic, homeopathic and herbal medicines.

The effects on mental health of social change associated with the rapid pace of development and Western influences have been the subject of several studies (e.g. Ghubash *et al*, 1994). While education, employment and social opportunities have started to improve perceptions of and attitudes to mental illness, the stigma associated with mental disorder is still a major factor that prevents individuals from seeking appropriate treatment.

Mental health policy and legislation

Since the formation of the country 36 years ago, significant progress has been made in the area of health, with most infectious diseases being eradicated. Vaccines as well as state-of-the-art treatments are available for most diseases. However, mental health is lagging behind in terms of policies, facilities and staff.

As yet there is no mental health policy at national level, although efforts have been initiated. A newly commissioned national committee is expected to develop proposals for a national mental health programme. A previous committee, established in 1991, made proposals for the universal provision of mental health and substance misuse services through primary healthcare, but this has not been satisfactorily implemented.

Federal Law 28, enacted in 1981, contains sections on the definition of 'mental disorders', 'next of kin' and 'specialist'. There is also a section on the role of authorities and police in relation to psychosis and the detention of involuntary patients. The question of criminal responsibility is addressed by Sharia Islamic law and the courts rely on psychiatric reports for addressing the issue of insanity. Attempted suicide is a crime and homicide may result in the death penalty.

Mental health services

The psychiatric services, like physical health services, are primarily delivered through a public health system administered by the Ministry of Health. The recent formation of separate health authorities and the introduction of health insurance cover for all employees as stipulated by the government are rapidly changing this scenario, particularly in the emirate of Abu Dhabi and to some extent in Dubai. As a result, both private sector establishments and private–public partnerships are coming into existence. For example, in the emirate of Abu Dhabi, partnerships exist between the Health Authority of Abu Dhabi and leading international healthcare providers such as the Johns Hopkins International, the Cleveland Clinic, the Medical University of Vienna and Bumrungrad International Limited. The government of Dubai, in collaboration with Harvard Medical International, is developing the Dubai Healthcare City as the world's first 'healthcare free zone'; this is a self-regulated environment providing a platform for regional and international medical institutions to set up their own facilities in Dubai.

Psychiatric services are delivered primarily through out-patient clinics in general hospitals and polyclinics, as psychotropic medication requires prescription by a specialist. Primary care facilities play a limited role, while community psychiatric services are nonexistent. In-patient facilities are available in the emirates of Abu Dhabi (Abu Dhabi Psychiatric Hospital, with 163 beds, and Al Ain Hospital, with 30 beds), Dubai (Al Amal Hospital, with 80 beds at present and a plan for considerable expansion; as well as a small unit at Rashid Hospital) and Ras Al Khaima (which has a hospital with 10 beds). Individuals needing in-patient treatment in other emirates are referred to one of the nearest general hospitals with psychiatric staff (e.g. Sharjah). The purpose-built Abu Dhabi Psychiatric Hospital also has a dedicated unit for child psychiatry, a day care facility, a secure forensic psychiatry facility (30 beds) and a unit for addiction disorders. Police and prison services are integral to the substance misuse programmes, although treatment is offered on a voluntary basis for those who comply with the regulations of the treatment unit.

The delivery of psychiatric services through primary care is best developed in the city of Al Ain, which hosts the only academic psychiatry department in the country. This initiative was launched in 1991, and is accompanied by ongoing efforts to train primary care physicians and carry out psychiatric research (El-Rufaie & Absood, 1993). A similar initiative was started in 1995 for mental health problems in children at the primary care level through the school health services. This was followed by the launch of a school mental health screening programme (Eapen, 1999).

Psychiatric training

The Academic Department of Psychiatry at the Faculty of Medicine and Health Sciences, UAE University, was started in 1990 with the primary mission to contribute to the

undergraduate educational programme in psychiatry and behavioural sciences, which is oriented to the needs of the UAE community. The psychiatry clerkship is an 8-week programme, and every effort is made to meet the highest international standards of quality in training, to enable its graduates to compete for advanced training at top centres around the world.

The graduate training programme currently offered is a structured multi-centre 4-year residency programme. The clinical training is complemented by an academic component organised by the university department, Al Ain, and the residents take the Arab Board Examination in Psychiatry.

Psychiatric sub-specialties and allied professions

The Academic Department of Psychiatry in Al Ain was instrumental in establishing child psychiatry services in the Al Ain Medical District. The Department is solely responsible for providing these services, which include out-patient, in-patient and consultation–liaison services at the two teaching hospitals in Al Ain, and receives referrals from other emirates. In the absence of the sub-specialty for intellectual disability, provision of services in the area of developmental psychiatry is also undertaken. At the community level, the Department has pioneered the introduction of a comprehensive school mental health screening programme initially in Al Ain, and then at national level, utilising the structure and resources of the school health services.

Main areas of research

The Academic Department of Psychiatry in Al Ain is the centre for psychiatric research. The main areas of activity are:

- epidemiological studies (e.g. Abou-Saleh *et al*, 2001; Eapen *et al*, 2003)
- diagnosis and classification of disorders (e.g. Hamdi *et al*, 1997)
- translation, development and validation of psychiatric instruments (e.g. Daradkeh *et al*, 2005)
- personality and psychosocial aspects of physical illness (e.g. Eapen *et al*, 2006)
- transcultural psychiatry (e.g. Salem, 2006)
- biological and genetic research (e.g. Bayoumi *et al*, 2006)
- mental health and special populations (e.g. Swadi & Eapen, 2000).

Workforce issues and resources

In general, psychiatric services are limited, with an estimated 1.4 psychiatric beds per 10 000 population. The services are considerably understaffed when compared with other high-income countries, with only 2 psychiatrists, 1 psychologist, 1.2 social workers and 11 psychiatric nurses per 100 000 population. Proficiency in Arabic is considered desirable, which poses a considerable challenge to recruitment.

Outlook

Since the formation of UAE as a federation of seven emirates 36 years ago, the country has made phenomenal progress in all areas, including health, but mental health has not received the attention it deserves. In this regard, development of a national mental health policy and a comprehensive review and implementation of legislation should take priority.

Programmes are needed for special populations, such as children and the elderly. Currently, psychiatric services are primarily hospital based, but there should be a broader vision in service delivery, with initiation of community outreach services, strengthening of clinical services, and integration of mental health with primary care services. The staff shortage is significant and urgent attention should be given to improving training opportunities. Significant research data exist regarding the nature and occurrence of mental disorder, as well as on some of the culture-specific risk factors and unique clinical presentations. These data could form the basis for the planning and development of a comprehensive mental health service in the country.

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ORIGINAL PAPER

A survey of risk assessment skills and training among health professionals in Pakistan

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Over the past two decades, psychiatric services have evolved globally and generally there has been a gradual transition from hospital-based practice to a more community-based approach. The stigma associated with psychiatry has somehow diminished and society in general can now relate better to this field of medicine.

Risk assessment is an integral part of mental healthcare, and mental health professionals should be well versed and trained in it, but this is not always the case. There are large differences in the way mental health professionals from the higher-income and lower-income countries perceive psychiatry, particularly risk assessment. Training in the recognition and management of suicidal risk is of crucial importance for the prevention of suicidal behaviour. This perception formed the basis of the survey reported in this paper, the purpose of which was to obtain a comprehensive picture of risk assessment conducted with patients presenting with self-harm to health professionals in Peshawar, Pakistan.

Peshawar is the capital of North West Frontier Province (NWFP), one of the four provinces of Pakistan. Although rich in culture, it is deprived in relation to health services.

Psychiatry is still not appreciated as a healthcare service in Pakistan, and an attempt to commit suicide is still considered a crime, to be reported to the police, even before any medical help is sought (Khan, 1998). Most people who have harmed themselves are admitted to general medical wards because they need physical intervention and are not usually referred to psychiatry owing to the stigma attached (Karim *et al*, 2004).

The aim of this study was to explore the attitudes of trainees from a range of clinical backgrounds towards self-harm and their clinical experience in dealing with the problem. It looked at the risk assessment skills and training provided to trainees working in different specialties in two different hospitals in Peshawar, Pakistan. It also explored the aetiology, manner and subsequent management of self-harm among patients.

Methods

A questionnaire was designed and distributed among trainees in internal medicine, general surgery and accident and emergency medicine, as well as a few psychiatric trainees (see Table 1). They all worked in Khyber Teaching Hospital or Lady Reading Hospital, Peshawar, Pakistan. Fifty-six of the 80 questionnaires distributed were returned. The questionnaire dealt with the training which the trainees had received in risk assessment, the use of guidelines and protocols, and their understanding of the motives and the methods used for self-harm. It also examined the subsequent management as well as follow-up procedures.

Results

The respondents were 39 men and 17 women, with an age range of 25–45 years (Table 1). Fifty-one (91%) of the trainees had regularly seen patients presenting after self-harm at some stage of their routine practice. None of the trainees, including the psychiatric trainees, had received any formal training in risk assessment; however, 15 (27%) of them had seen some sort of guidelines or protocols for risk assessment.

Despite the fact that the police have to be involved in every case of self-harm, the majority of the trainees (31; 55%) thought that the medical staff should be the first contact for these individuals (Table 2).

Three-quarters of the trainees thought that medication overdose was the most common method of self-harm (Table 2). According to the trainees surveyed, the most common age group presenting with self-harm was 20–30 years. Thirty-four (61%) of the trainees reported that the majority of those who self-harmed were female, while 9% of them suggested

Table 1 Attributes of the survey respondents

	n	(%)
Age (years)		
25–35	51	(91)
36–45	5	(9)
Gender		
Female	17	(30)
Male	39	(70)
Specialties		
Medicine	44	(78)
Psychiatry	6	(11)
Accident and emergency	5	(9)
Surgery	1	(2)
Training		
Formal training	0	(0)
Awareness of guidelines	15	(27)

Table 2 Perception of respondents of the nature of self-harm

	n	(%)
Gender more commonly involved in self-harm		
Male	17	(30)
Female	34	(61)
Similar	5	(9)
Best first port of contact		
Medical staff	31	(55)
Relatives	22	(39)
Police	3	(5)
Common methods of self-harm		
Overdose on medication	42	(75)
Overdose on illicit drugs	8	(14)
Laceration/cutting	3	(5)
Other	3	(5)
Reasons for self-harm		
Social constraints	31	(55)
Life events	11	(19)
Frustration	6	(11)
Mental health problems	6	(11)
Impulsivity	1	(2)
No response	1	(2)
Choice of treatment		
Combined pharmacotherapy and psychological therapy	30	(53)
Pharmacotherapy	24	(43)
Psychological treatment	2	(4)
Further follow-up		
Necessary	16	(29)
Not necessary	40	(71)

that the ratio of self-harm behaviours between males and females was about equal (Table 2).

A majority of the trainees felt confident in doing some form of self-harm assessment, while the others felt either embarrassed or anxious about the whole issue.

Thirty-one (55%) of the trainees believed that self-harm was mainly the result of social constraints. Another 19% attributed it to life events. Interestingly, only 11% thought that it was due to mental health problems (Table 2).

A majority of the trainees believed that pharmacotherapy alone or in combination with psychological therapy was the preferred means of management, while only two (4%) favoured psychological treatment alone.

Because of lack of awareness, more than 70% of the trainees did not think that a follow-up appointment was necessary; however, the remaining trainees felt that some community or out-patient follow-up should be considered for these individuals (Table 2).

Discussion

There were no major differences between the psychiatric and non-psychiatric trainees in terms of their training in risk assessment when dealing with self-harm patients. Only 11% of the trainees considered self-harm to be a result of mental health problems. The fact that self-harm is reported to the police indicates that it is treated as some sort of crime rather than being considered a mental health issue (Khan, 1998). However, trainees are aware that assessment is still warranted.

Apart from a few exceptions there is no well-defined training system in general psychiatry in Pakistan (Farooq, 2001). Therefore, the current scenario is far from ideal. This prevented us from comparing a group of psychiatric trainees with a group of non-psychiatric trainees. Nevertheless, further research could be conducted to examine whether this study reflects the general pattern across most hospitals, in different cities in Pakistan.

The sample in our study was fairly small, but taking into account the fact that the concept of proper risk assessment was new to most of them, the response rate was still good. It would have been useful to include more psychiatric trainees but the study was limited to two hospitals with relatively small psychiatric wings.

The study was based on the self-reported accounts of the trainees working in different departments and the records of the patients were not checked. Therefore the actual proportions of self-harm methods and age groups were not known. However, the general impression and views of the trainees did give us useful insight into this area.

This study was conducted in a relatively deprived part of the country, where resources are somewhat limited; therefore the conclusions cannot readily be generalised to other areas of the country.

In Pakistan, mental ill-health is still strongly stigmatised (Karim *et al*, 2004). Individuals presenting after an episode of self-harm are dealt with in general wards and they are reluctant to be referred to psychiatric services. In fact, more than 50% of the trainees surveyed felt that if self-harm was associated with mental illness, this would lead to a greater stigmatisation of the patients.

Pakistani society in general is very reactive and sensitive about the social implications of any suicidal behaviour. Patients are often accompanied by their friends and family members and word of mouth spreads rapidly. Keeping information confidential about this client group is sometimes not possible.

Forty-four (78%) of the trainees in this study were from general medicine and only six (11%) were from psychiatry, which strongly indicates that non-psychiatric trainees play a key role in assessing patients who present after an episode of self-harm. Women were reported to form the majority of the patients (61% of trainees believed this to be the case), with the common trigger being their social circumstances (Haider & Haider, 2001). This may have some cultural implications in an orthodox society where attitudes to self-harm are in any case quite negative (Khan *et al*, 1996). The care of female patients by female clinicians may be considered appropriate.

As psychiatrists are not involved in most cases of self-harm, non-psychiatric trainees need to be better trained in clinical risk assessment. Some trainees did recognise that there were deficits in practice which impaired the quality of care. It was suggested that supervision and further training through workshops, seminars and conferences, as well as enhanced policies and procedures for dealing with self-harm, were urgently required to reduce the risk of stigmatisation within the medical establishment and wider society. To this end, care pathways for the management of this client group and guidelines for ensuring confidentiality would help a great deal.

Keeping in view the lack of proper training and exposure to this aspect of medicine, the trainees in this study still showed at least some understanding of proper risk assessment. There is clearly a need to do further studies in this field, especially in the major teaching hospitals in the country, to ascertain the current trends and practices in self-harm assessments, as well as attitudes of doctors towards psychiatric

disorders in general (Farooq *et al*, 2005). Studies of this kind should promote better awareness and understanding among trainees of the importance of carrying out proper risk assessment and management. Substantial resources also need to be invested in order to restructure the whole system.

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ORIGINAL PAPER

The psychological and psychosocial impact of the Pakistan Kashmir earthquake after 8 months: a preliminary evaluation by PACTT

PACTT: Pakistan–Aberdeen Collaborative Trauma Team*

Natural disasters are complex events that challenge the coping abilities of individuals and communities (Alexander, 2005). They are characterised by substantial loss, physical injury and economic hardship, as well as by extensive internal displacement and damage to the infrastructure, as exemplified by the Pakistan Kashmir earthquake of 8 October 2005. Measuring 7.6 on the Richter scale, it affected an area of 30 000 square miles and a population of 3.6 million. Approximately 90 000 were killed, 200 000 were injured and 3.5 million were left homeless (Khan, 2006). Based on a literature review and estimates from the World Health Organization (WHO), the National Plan of Action for Mental Health and Psychosocial Relief of Earthquake Survivors anticipated high levels of trauma-related psychopathology (Rana *et al*, 2006).

A disaster of such magnitude poses enormous problems for mental health and psychosocial care (Ghodse & Galea, 2006), particularly in the context of high levels of untreated pre-earthquake morbidity in Pakistan (Mirza & Jenkins, 2004) plus the estimated post-earthquake morbidity (Rana *et al*, 2006). The absence of evidence-based 'best practice' for culturally sensitive psychological interventions in relation to such a disaster led to a miscellany of unintegrated interventions being implemented in the earthquake-affected region (Khan, 2006). The blanket provision of such interventions is not a cost-effective or efficient strategy and may even be harmful (Alexander, 2005).

Fundamental to informing a culturally sensitive disaster response strategy is an epidemiological and needs assessment approach (van Ommeren *et al*, 2005), but post-disaster ethical, methodological and logistic factors may impede the use of representative sampling methods and culturally validated instruments (Klein & Alexander, 2007).

To test the feasibility of undertaking a culturally informed, epidemiological, community-based survey of the traumatic effect of the earthquake, the Pakistan–Aberdeen Collaborative Trauma Team (PACTT) conducted a pilot study in the earthquake-affected region of Azad Jammu and Kashmir (AJ&K). A key objective of the pilot was to test the acceptability of the assessment instruments in terms of their cultural and linguistic sensitivity (e.g. with regard to symptom expression), length, comprehensibility and process of administration. Assessment instruments comprised a trauma-modified version of the Composite International Diagnostic Interview (CIDI-TM) developed by PACTT and the Screening Instrument for Traumatic Stress in Earthquake Survivors (SITSES; Basoglu *et al*, 2001). This paper reports on the outcome of that evaluation and presents preliminary findings derived from the SITSES in relation to the psychological and psychosocial impact of the Pakistan Kashmir disaster after 8 months.

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Methods

Conducted in May 2006, this 1-month pilot study was based on a convenience sample of 112 consenting adult survivors (aged 18 years and older) selected from camps in the three AJ&K districts of Muzaffarabad, Rawalakot and Bagh (the major earthquake-affected regions). For pragmatic reasons, families within each district were identified with the assistance of the Imam Masjid (religious leader of the area) and the head teacher of the local school. A statement of confidentiality was read by the interviewer before each face-to-face interview.

Assessment

As an earthquake-specific instrument, the SITSES was included in the assessment to enable comparisons with studies of survivors of a Turkish earthquake with features similar to those experienced in Pakistan Kashmir (e.g. the scale of devastation and number of casualties, as well as the resource-poor environment). The SITSES was translated into Urdu according to the specifications of the WHO translation protocol, and administered face to face by 14 trained lay interviewers (eight of whom were female). Familiar with the local community and bilingual in English and Urdu, each interviewer completed a workshop on standardised interview techniques conducted by WHO certified trainers.

The SITSES comprises three sections:

- The 28-item Survivor Information Form (SIF) records socio-demographic characteristics, and the features of the earthquake and its effect on survivors (including severity of disability, the nature and level of the loss experienced in relation to family, possessions and livelihood, and fear experienced at the time of the earthquake).
- The Traumatic Stress Symptom Checklist (TSSC) comprises ratings for 17 DSM–IV symptoms of post-traumatic stress disorder (PTSD) and six depressive symptoms, for the diagnosis of PTSD and comorbid depression, respectively. All symptoms are assessed in relation to the past week, on a four-point scale (0 = 'not bothered', 1 = 'slightly bothered', 2 = 'fairly bothered', 3 = 'very much bothered'). Validated by Basoglu *et al* (2001), against the Clinician-Administered PTSD Scale (CAPS; Blake *et al*, 1990) and the major depressive episode module of the Structured Interview for DSM–IV (SCID; First *et al*, 1996), the TSSC has high internal consistency and satisfactory sensitivity and specificity in predicting the diagnosis of PTSD and major depression. The recommended optimal cut-off point of 25 and above for the total score based on the 17 PTSD symptoms was used to identify PTSD. The optimal cut-off point of 38 and above for the total score calculated from the 23 TSSC items determined the presence of comorbid depression.
- The Severity of Disability Scale, comprising just two items, measures the global severity of stress resulting from the symptoms reported in the TSSC in relation to work, family and social functioning, using the same four-point scale.

Analysis

Data were analysed by the Statistical Package for the Social Sciences (SPSS for Windows; version 14.0). A two-tailed $P < 0.05$ denoted statistical significance. Due to skewed distributions and/or heterogeneity of variance, non-parametric methods, including the Mann–Whitney *U* and chi-square tests, were applied.

Results

Sample characteristics

Satisfactory data were available on 111 of the 112 individuals sampled (99.1%). The median age of the sample was 34 years (interquartile range, IQR = 25–45.25) and 50% were female. The median number of children per family was 3 (IQR = 2–6). The socio-demographic and health profile of participants is shown in Table 1. A family history of mental illness was reported by 11.8% ($n = 13/110$) and 5.6% ($n = 6/108$) reported a personal history of mental illness requiring treatment before the earthquake.

Impact of the earthquake

Of those who had been in a building at the time of the earthquake, a quarter ($n = 15/60$) reported that they had been trapped under rubble. Most participants (82.7%, $n = 91/110$) rated the intensity of fear or terror experienced during the earthquake as either 'severe' or 'extremely severe'. Over half (56.4%, $n = 62/110$) of the sample participated in rescue work. Table 2 shows the impact of the earthquake in terms of physical injury sustained, loss of life and loss of property.

Table 1 Socio-demographic and health profile of the participants

	n	%
Marital status (n = 111)		
Single (never married)	22	19.6
Married	75	67.9
Widowed	11	9.8
Separated	2	1.8
Divorced	1	0.9
Level of education (n = 110)		
No schooling, illiterate	40	36.4
No schooling, literate	7	6.4
Primary school	19	17.3
Secondary school	21	19.1
High school	20	18.2
University/postgraduate studies	3	2.7
Employment status (n = 110)		
Employed	30	27.3
Self-employed	10	9.1
Looking for work	14	12.7
Temporarily laid off	5	4.5
Retired	2	1.8
Housewife	25	22.7
Student	8	7.3
Disabled	2	1.8
Never worked	5	4.5
Other	6	5.5
Refused to answer	3	2.7
Rating of current overall physical health (n = 108)		
Excellent	11	10.1
Very good	10	9.2
Good	32	30.3
Fair	31	28.4
Poor	24	22.0
Rating of current overall mental health (n = 108)		
Excellent	6	5.6
Very good	15	13.9
Good	33	30.6
Fair	27	25.0
Poor	27	25.0
Rating of overall health compared with 1 year ago (n = 106)		
Much better now	5	4.7
Somewhat better now	6	5.7
About the same	19	17.9
Somewhat worse now	50	47.2
Much worse now	25	23.6
Refused to answer	1	0.9

Table 2 Earthquake-specific characteristics and experience of the participants

	n	Sample size	%
Suffered serious physical injury			
Personally	16	106	15.1
Family member(s)	33	104	31.7
Relative(s)	43	110	39.1
Witnessed serious physical injury of:			
Family member(s)	23	35	65.7
Relative(s)	19	29	48.7
Death of:			
Family member(s)	45	110	40.9
Relative(s)	59	103	57.3
Friend(s) and/or neighbour(s)	84	109	77.1
Witnessed death of:			
Family member(s)	20	44	45.5
Relative(s)	22	61	36.1
Friend(s) and/or neighbour(s)	46	108	42.6
Witnessed others being seriously injured or killed	90	111	81.1
Loss of property			
Personal possessions	79	101	78.2
Land	3	101	3.0
Animals	4	101	4.0
Vehicles	1	101	1.0
Business	1	101	1.0
Other	11	101	10.9
Refused to answer	2	101	2.0

Table categories are mutually exclusive.

Following the earthquake, 46.8% of participants ($n = 36/77$) relocated to a different region.

Estimated prevalence of PTSD and comorbid depression

Eight months after the earthquake, the prevalence rates of PTSD and comorbid depression were 46.8% ($n = 52/111$) and 27.9% ($n = 31/111$), respectively. A significant gender difference was found: women were approximately twice as likely as men to have PTSD (64.4% versus 37.8%; $\chi^2 = 6.40$, d.f. = 1, $P = 0.011$) and four times more likely to have comorbid depression (48.9% *v.* 11.1%; $\chi^2 = 15.29$, d.f. = 1, $P < 0.001$). Women reported significantly more overall distress (median = 2, IQR = 1.5–4 *v.* median = 3, IQR = 2–4; $P = 0.02$) but no significant gender difference was observed for functional impairment (median = 2, IQR = 1–2.5 *v.* median = 2, IQR = 1–3; $P = 0.52$). Thirty-six participants (39.6%, $n = 91$) wanted help from a psychiatrist or psychologist for the psychological and psychosocial problems experienced after the earthquake; no significant difference was found between men and women in this regard ($P = 0.179$).

Discussion

Disasters are unpredictable events which pose obvious methodological challenges, particularly with regard to identifying a representative sampling frame for the at-risk population (Klein & Alexander, 2007). Because of the limitations associated with selected survival and population movement, the absence of accurate and reliable figures to enumerate and characterise the affected population in Pakistan Kashmir resulted in our reliance on a convenience sample for this pilot. While this sampling method precludes precise generalisation to the affected population and findings should be interpreted accordingly, our preliminary evaluation based on the SITSES suggests the significant and enduring psychological and psychosocial sequelae of a major natural disaster. The substantial loss sustained as a result of the earthquake included loved ones and personal property. A high level of physical injury was experienced, both personally and by family members and relatives. Following the earthquake, many relocated to a different region.

The high prevalence of PTSD (46.8%) and comorbid depression (27.9%) are comparable to the gender-adjusted rates reported for the 1000 Turkish survivors of 43% and 31%, respectively, after 3–10 months (Basoglu *et al*, 2002). That women were more likely than men to report post-traumatic symptoms is a consistent observation from community-based epidemiological studies (Klein & Alexander, 2006).

Three-quarters of the sample reported that their overall health had deteriorated substantially compared with 1 year before the earthquake. Despite community-based population prevalence rates of 34% for anxiety and depressive disorders derived from a systematic review of studies conducted in Pakistan before the earthquake (Mirza & Jenkins, 2004), few reported a personal history of mental illness requiring treatment before the earthquake. This finding may reflect the stigma attached to mental illness by those who are uneducated and live in the more rural areas, including AJ&K, and where mental health facilities are not accessible for geographical, financial and cultural reasons (Karim *et al*, 2004). Alternatively, it may derive from cultural and individual differences in how psychological distress is interpreted, how it is expressed and to what it is attributed (Klein & Alexander, 2007). While this study did not assess the underlying reasons for the non-reporting of medical symptoms of distress and associated treatment, the finding that a third of those who reported emotional problems after the earthquake wanted help from a mental health professional may suggest that the collective experience of the disaster, including participation in this pilot study, helped to reduce that stigma.

Key outcomes of this pilot study included confirmation of the acceptability and cultural sensitivity of the Urdu translation of the SITSES for administration to the target population and the need for further modification of the CIDI-TM in terms of substantially reducing its overall length, revising the core PTSD module and simplifying the logic for ease of administration by the interviewers. With regard to issues relating to the socio-cultural and religious sensitivities of the target population, the reliable assessment of substance misuse was particularly problematic, as evidenced by the high number of refusals obtained for this module.

Overall, this pilot was invaluable in terms of informing the design of a culturally informed epidemiological survey as the first step in enabling the evaluation of a delayed programme (to allow for the natural remission of post-traumatic reactions) of community-based and culturally appropriate psychosocial interventions, delivered by trained grass-roots personnel. This unique research programme constitutes a systematic scientific endeavour to promote conceptual clarity and evidence-based practice in the long-term management of disaster survivors and is in accordance with the WHO's policy on mental health and psychosocial support for disaster victims (van Ommeren *et al*, 2005).

Acknowledgements

We thank all the master trainers, interviewers, senior trainees and consultant psychiatrists (Department of Psychiatry, Military Hospital, Rawalpindi) for their substantial contribution and all those earthquake survivors for their invaluable participation in this pilot study. We also thank Professor Kessler (Co-director of the WHO World Mental Health Survey Initiative) and Dr Basoglu for their assistance in relation to the CIDI-TM and SITSES.

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ORIGINAL PAPER

Traditional health practitioners and mental health in Kenya

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The prevalence of psychiatric morbidity among rural and urban Kenyan primary care attenders has been reported to be as high as 63% (Ndetei & Muhangi, 1979; Dhapdale & Ellison, 1983; Dhapdale *et al*, 1989; Sebit, 1996). For its population of 32 million, Kenya has only 16 psychiatrists and 200–300 psychiatric nurses, but there are just over 2000 primary healthcare centres, staffed by general nurses and clinical officers, and the main burden for assessing and caring for people with mental disorders falls upon members of the primary care teams. However, mental disorders are poorly recognised (Dhapdale & Ellison, 1983) and inadequately treated in primary care (Muluka & Dhapdale, 1986). Moreover, Kenyan primary care workers often lack training in mental health (Dhapdale *et al*, 1989; see also Ndetei, this issue, p. 31).

In contrast to this picture of poor recognition and treatment of mental disorders in primary care, people with mental disorders commonly consult traditional health practitioners (THPs) in African countries, including South Africa (Zabow, 2007), Nigeria (Olugbile *et al*, 2007), Tanzania (Ngoma *et al*, 2003) and Kenya (Ndetei, 2007). Around 50% of Kenyans who consult THPs may have psychiatric morbidity (Ndetei, 2007) and many use both modern medical services and THPs simultaneously (Odejide *et al*, 1978; Ndetei, 2007). In neighbouring Tanzania, the prevalence of common mental disorders among those consulting THPs is high (Ngoma *et al*, 2003), reflecting the failure of primary care services to detect and treat these disorders adequately. Patients may go to hospitals to seek a cure for their illness, and go to THPs to seek both cure and explanation (Otsyula, 1973), particularly if they are not satisfied with modern medical services (Katz & Kimani, 1982). Therefore, this paper reports a qualitative study to examine the views of THPs in Kenya pertaining to the nature, aetiology, symptoms and classification of mental illness, as well as treatment approaches, in order to establish whether there is an adequate shared conceptual basis for further dialogue and liaison.

Methods

Sample

The sample frame was all 70 THPs either registered with ($n = 47$) or otherwise known to ($n = 23$) Kisumu District Cultural and Social Services Office as practising in the Maseno Division, a poor rural area of 50 000 population. All 70 THPs

Box 1 Issues covered in the focus groups

- What diseases are treated by traditional healers?
- How are mental illnesses treated by traditional healers?
- What happens in a consultation?
- How is abdominal pain treated by traditional healers?
- What does mental illness look like to traditional healers?
- How do they treat someone who has been bewitched?
- Who would want to bewitch a child?
- How does a traditional healer neutralise this?
- How can the traditional healer tell the difference between bewitchment and malaria?
- Why do people bewitch each other?
- How do you detect who is a con-man (with regard to traditional healers)?
- What do they do with con-men?
- What treatments are used for 'worrying' patients?
- How do they treat mental illness? What are the main treatments for mental illness?
- Can one person transfer a bad demon to another person, and if so how?
- How do they make a demon go into a lake rather than into another person?
- What causes depression?
- Does AIDS cause mental illness?
- What causes mental illness?
- How can you treat mental illness if you don't know where it comes from?

were invited by the district cultural officer to attend a 1-day workshop at Chulaimbo healthcare centre.

Data collection

The THPs were brought together into the Chulaimbo rural health training centre (RHTC) and divided into two groups, who each met for 2 hours as a focus group. The focus groups were led in Luo, the local language, and moderated by the lead author, Dr Okonji, a consultant psychiatrist originally from the district, and Mr Ayuyo, a public health nurse working in Chulaimbo RHTC.

A range of issues pertaining to the nature, aetiology, symptoms and classification of mental illness and treatment approaches were addressed in the focus groups. The broad areas covered are listed in Box 1. Issues discussed in the focus groups were meticulously documented verbatim and merged for the subsequent analysis.

Data analysis

Documentation of the discussions in the focus group was read and coded by the researchers using a thematic approach to ascertain the views of THPs pertaining to the nature, aetiology, symptoms and classification of mental illness and treatment approaches, and any other emergent issues.

Results

The identified themes are described below.

Illnesses treated by THPs

When asked what illnesses they treated, the THPs replied, in their own words, that they treated typhoid, tuberculosis, cancer, diabetes, infertility and mental illness.

The consultation process

When asked about the process of THP–client consultation, the following thematic clusters emerged: welcoming the patient, history taking from the patient, enquiry about treatment received from the hospital, collateral history from those who bring the patient, provision of treatment, continuing observation and assessment, and monitoring of efficacy. THPs reported having a special way of looking at patients to discriminate between bewitchment and malaria.

Symptoms

When asked how the THPs recognised mental illness, the following thematic clusters emerged:

- ❍ behavioural abnormalities – agitation, hostility and violence
- ❍ affective symptoms – sadness, moodiness, anxiety and fear of dying
- ❍ somatic symptoms – unable to stand, malaise, tiredness, weakness, palpitations, headaches and fever
- ❍ abnormalities of talk – talking loudly, unable to talk and mutism
- ❍ uncertainty about what is wrong on part of the person who brings them.

Aetiology

When asked about their opinion of the causes of mental illness, the following thematic clusters emerged:

- ❍ different mental illnesses have different causes
- ❍ stressful life events – bereavement, household problems, relationship problems, fear of dying, accidents, injuries, poverty and insufficient food
- ❍ heredity
- ❍ alcohol misuse
- ❍ ancestral influence and supernatural possession – devils, demons and evil (demons occur if a child is not given an inhaler to sneeze properly at birth, if insects are not removed from the head, or if one of the parents does 'bad things')
- ❍ people bewitch each other because of quarrels, disputes, pride and showing off
- ❍ anxiety is caused by rapid beating of the heart, severe headaches, blood not circulating properly and a weak brain.

Treatments

When asked about the kinds of treatment which THPs would use for mental illness, the following thematic clusters emerged:

- ❍ treatment depends upon the type of mental illness
- ❍ different methods of treatment are used by different THPs
- ❍ all drugs, including herbs, have side-effects.

The types of treatments used included:

- ❍ herbs prepared in different ways (boiled, ground, soaked in water, mixed with water and drunk, shaken into a bottle and herbal steam baths) and used for smelling and sniffing (to induce sneezing), spreading or spraying on the body and oral intake
- ❍ burning branches
- ❍ scratching of the abdomen and using animal horns to suck out the 'contents' of the abdomen
- ❍ cutting arms and legs and applying herbs
- ❍ talking to patients about stressful life events, counselling and advising patients to dig the *shamba* (farm) and to conduct business
- ❍ spiritual therapy, including prayer by THPs, advising patients to pray, and removal of demons, devils and spirits near a lake and by singing.

There were regular referrals from more generalist THPs to THPs who specialised in certain types of mental illness.

Collaboration

The following thematic clusters pertaining to collaboration with modern medical services emerged:

- THPs certainly felt that they can treat illnesses that doctors and nurses cannot treat, including bewitchment and possession by demons, devils and spirits
- THPs requested a base in primary care centres to facilitate such treatment
- THPs normally send patients who they consider have malaria, tuberculosis, meningitis and AIDS to the hospital
- THPs felt they cannot effectively treat chronic psychosis and ask families to take such patients to the hospital
- THPs requested collaboration with modern medical services to give long-term support to patients with chronic psychosis.

Discussion

This study has significant methodological limitations, including its descriptive design, the relatively large size of the focus groups and the restriction of the study to one region of Kenya. However, the thematic clusters of symptoms of mental illness, aetiology and treatment are similar to those observed in Nigeria (Olugbile *et al*, 2007) and South Africa (Zabow, 2007) and elsewhere in Kenya (Ndetei, 2007). Moreover, many of the symptoms and aetiological features, including recognition of genetic, social, psychological and environmental factors, were similar to those observed in Western psychiatry. Although the THPs were a heterogeneous group with heterogeneous practices, in keeping with previous observations (Zabow, 2007), this study found that their overall stated approach to assessing and treating people with mental illness included history taking, enquiry about treatment received from the hospital, collateral history, provision of treatment, continuing observation and assessment, and monitoring of efficacy.

The THPs reported using several different treatment strategies, including psychotherapy in the form of talking to the patients about stressful life events, counselling and giving practical advice to patients to undertake certain tasks. The practice of relatively sophisticated interpersonal psychotherapy, family therapy and behavioural treatments by Kenyan THPs has been anecdotally observed elsewhere (Ndetei, 2007).

The THPs were unanimous in their expressed desire for collaboration with formal health services. They recognised some of their limitations in treating certain illnesses, including tuberculosis, meningitis, malaria and AIDS, for which they prefer to refer patients to hospital. They also believed that they can treat patients whom doctors and nurses are unable to treat, including those who are bewitched and possessed by demons, devils and evil spirits, and they requested a base in primary care to assist in the treatment of such patients.

There has been encouragement for low- and middle-income countries to develop their own national policies in relation to traditional health practice, national regulatory bodies and professional organisations to address competency, regulation and quality assurance for THPs, similar to those for healthcare professionals (World Health Organization, 2002). This is being implemented in a number of countries, including South Africa (Zabow, 2007), Nigeria (Olugbile *et al*, 2007) and Tanzania (Ngoma *et al*, 2003). Further research and liaison are important to reduce potentially harmful practices, to improve the possibility of early diagnosis and effective treatments for people attending THPs, and to strengthen continuity of care for vulnerable clients.

Acknowledgements

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College signs a memorandum of understanding with Kurdistan

A ceremony for the signing of a memorandum of understanding between the College and the Regional Government of Iraqi Kurdistan took place at the College headquarters on 6 December 2007. Professor Sheila Hollins, College President, signed on behalf of the College, while on the Iraqi side there were two signatories: Dr Khidir Ma'soom, President of the University of Koya, Iraqi Kurdistan, and Dr Abdulla Al-Mousawi, Cultural Attaché, Iraqi Embassy, London. The ceremony was attended by a number of College officers and members of the College Board of International Affairs. The signing was followed by short speeches given by Dr Majid Al-Yassiri, Chair of the Iraqi Subcommittee, Professor Hollins and the two Iraqi guests. The proceedings were filmed by a television crew from Kurdistan and this has since been broadcast locally.

This was the first memorandum of understanding ever to be signed at the College headquarters. The event is an indicator of the two parties' commitment to improving mental health services in Iraq.

Dr Riadh Abed
Iraqi Subcommittee

College at the APA meeting

The 2008 annual meeting of the American Psychiatric Association (APA) will be held in Washington, DC, 3–8 May. The Pan-American Division of the Royal College of Psychiatrists has the pleasure to invite all College members to an international reception, to be held immediately after the Convocation, on Monday 5 May, 6.30–8.30 p.m. in the Russell/Hart Rooms at the JW Marriott Hotel, 1331 Pennsylvania Avenue. Please come and meet the officers of the College and of the APA, bring friends of the College and anyone you know who may be interested in joining the College as an International Associate. It will be an entertaining evening and a great opportunity to meet friends and colleagues from around the world.

There will also be two scientific symposia with College input – 'Poverty and Mental Illness Around the World', organised by the Pan-American Division, and a joint Presidential symposium co-chaired by the Presidents of the APA and the College, 'Advocating with One Voice for Mental Healthcare in the US and UK'.

VSO opportunities in Malawi

International development charity VSO is urgently calling for advanced trainee or consultant psychiatrists to support psychiatric care in Malawi. VSO has 6-month opportunities starting in June and September 2008, and February 2009, to provide a programme requested by Zomba Mental Hospital. The roles involve teaching, training, service development and policy advice. Find out more at http://www.vso.org.uk/volunteering/assignments/healthcare/psychiatrist-malawi.asp.

UEMS 1958–2008

For the 50th anniversary of the European Union of Medical Specialists (UEMS), a series of celebrations will be organised in Brussels. The 3-day event will combine the usual meetings of the UEMS's constituent bodies with a major scientific conference. Printed publications on the UEMS's history and achievements will be issued. This will be an opportunity for the UEMS constituencies to advertise their fields of interest and activities to a wide European audience.

Zlatko Fras,[1] Bernard Maillet[2] and Frédéric Destrebecq[3]
[1]UEMS President; [2]UEMS Secretary-General;
[3]UEMS Chief Executive Officer

WPA position on the role of psychiatrists in executions

The Standing Committees on Ethics and on Review of the World Psychiatric Association (WPA) would like to bring attention to the unequivocal position of the WPA regarding the participation of psychiatrists in executions. Where psychiatrists may be asked to participate (e.g. in the provision of a psychiatric opinion on 'fitness for execution'), it is necessary to state to all parties involved that such practices are against the ethical principles of the WPA. These principles are explicitly stated in the Madrid Declaration on Ethical Standards for Psychiatric Practice and its Additional Specific Guidelines (1996) as follows: 'Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed'. The Declaration was adopted by all member societies during the 1996 WPA General Assembly and adopting the Declaration is an obligation of every new society applying to join the WPA.

It would be highly desirable to convey to the judicial authorities of your country the position of the WPA.

Professor George Christodoulou[1] and
Professor Driss Moussaoui [2]
[1]WPA Standing Committee on Ethics;
[2]WPA Standing Committee on Review

Indian Journal of Psychiatry

The *Indian Journal of Psychiatry* (*IJP*) celebrates its golden jubilee in 2008. There are plans to bring out a special commemorative volume and a special issue of past presidential addresses and editorials. A special exhibition on *IJP* at ANCIPS in Kolkota will also be arranged this year. If any readers of *International Psychiatry* have photographs related to the launching of the journal, subsequent developments, group photographs and so on, please contact the Editor (editor@indianjpsychiatry.org). We would also welcome articles. Of particular interest to us would be details of *IJP* between 1947 and 1956, including copies of the journal under its former name, *Journal of Psychiatry and Neurology*.

Dr T. S. Sathyanarayana Rao
Chief Editorial Advisor, IJP

CORRESPONDENCE

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Psychiatry for the person

Sir: The manifesto set out by Christodoulou, Fulford and Mezzich, 'Psychiatry for the person and its conceptual bases', in their guest editorial for the January issue of *International Psychiatry* evokes a mixture of excitement and disappointment. Bemoaning the withering of person centredness in modern medicine and psychiatry, and initiating attempts to redress current fragmentation and technological pseudo-solutions cannot but be laudable.

But an empty space lies at the heart of their editorial. There is in fact a long-established branch of psychiatry which fulfils all of the stated goals of the Institutional Program on Psychiatry for the Person (IPPP) established by the World Psychiatric Association (WPA). In psychotherapeutic psychiatry (Gabbard *et al*, 2005) the centrality of personhood is key: strengths and weaknesses are celebrated and worked with; the humanity of the clinician is as important as that of the client; it is collaborative; and personal fulfilment for the client is its overarching aim. A developmental account of how one becomes a person, and how things can go wrong through genetics, environmental failure and intentionality, is a central theoretical project within contemporary psychotherapeutic science (Mayes *et al*, 2007). But one searches in vain for any mention of psychotherapy in Christodoulou *et al*'s polemic. There are two passing references to 'psychological bases' and 'psychological … perspectives'. The rest is silence.

The very phrase 'psychiatry for the person' contains echoes of Carl Rogers' 'person-centred' counselling. Psychotherapeutic psychiatry, often involving a combination of psychotherapy and pharmacotherapy, uniquely perhaps, is person centred and evidence based. It is often forgotten that the universally accepted meta-analysis within medicine started as a method for evaluation of psychotherapy.

It is perhaps more understandable that psychoanalysis, with its currently controversial empirical base, controversial status and possibly elitist Western cultural bias, is conspicuous by its absence. Nevertheless, does not Freud deserve a mention, alongside Hippocrates and Aristotle and, implicitly, Confucius? Freud celebrated his patients' personhood, valued their autonomy, promoted recovery and aimed to understand the links between body and mind. His successors, like Balint, pioneered brief therapies and were founders of the very psychosomatic approach which the IPPP endorses.

Perhaps the WPA is understandably frightened of the implications of endorsing psychotherapy, as it might thereby open doors to territorial disputes with clinical psychology, and to the embarrassing fact that, globally, relatively few psychiatric training schemes take psychotherapy seriously (Holmes *et al*, 2007). Yet these are debates that need to be had if we are to move beyond rhetoric to real change.

Isn't it time for the WPA to decide where it stands on psychotherapy/psychological therapies, define those it thinks should form a core part of a decent psychiatric service, and insist that relevant psychotherapeutic skills be part of every psychiatrist's armamentarium?

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Gabbard, G., Beck, J. & Holmes, J. (2005) *Oxford Textbook of Psychiatry*. Oxford University Press.

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Authors' reply

Sir: Professor Jeremy Holmes reviews some important psychotherapeutic approaches, such as those of Gabbard, Rogers and Freud, and we agree with him that these are substantially oriented to the promotion of personhood. In this sense, the perspectives noted are quite consistent with the WPA's initiative on psychiatry for the person. Other prominent and recent clinical care movements oriented to the fulfilment of the person that could have been mentioned include recovery in the USA and Europe, values-based practice in the UK, and need-adapted assessment and treatment in Scandinavia. While our editorial was specifically focused on general conceptual bases, we certainly plan to review psychotherapeutic approaches through our upcoming publications on person-centred clinical care. At the same time, we should also point out that our initiative's principal objective is to address and to fulfil the needs of the person presenting for care, using all biological, psychological and social interventions that may be needed, rather than promoting a single approach.

For your reference and that of the journal's readership please note the additional presentations of the WPA's initiative listed below. Several others dealing with specific diagnostic, clinical care and public health components are forthcoming.

George Christodoulou,[1] Bill Fulford[2] and Juan E. Mezzich[3]

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Mezzich, J. E. (2007) Dialogal bases of our profession: psychiatry with the person. *World Psychiatry*, **6**, 129–130.

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Report on Kenya project

Sir: The Royal College of Psychiatrists has been supporting a Kenyan project to develop a training programme in child and adolescent mental health since 2005. Kenya has a population of 34 million, of whom 40% are aged 14 or under. Many children have moved away from their families, often as a result of AIDS/HIV, family disintegration and rejection, to live on the streets of the major cities and towns. Consequently, there are at least a quarter of a million street children, many of whom are engaged in problematic behaviour such as stealing, begging, prostitution and drug misuse. Many appear in the juvenile courts, with disposals that seldom meet their needs.

In 2003, in the context of a larger mental health development project under the auspices of the World Health Organization Collaborating Centre at the Institute of Psychiatry and the Kenyan Ministry of Health, a situation needs assessment by the International Institute for Special Needs Offenders (IISNO) found that there was a dearth of dedicated services to provide for the special needs of children with mental health problems caught up in legal proceedings. As a result, the College was asked for help to support educational activities that would further the development of mental health services for these children. The initial needs assessment was extended with the help of local experts and a training initiative was developed between the College, IISNO and the Kenyan Ministry of Health, Probation Service and the Department of Psychiatry at the University of Nairobi. This culminated in a 1-week conference for senior staff in September 2006, designed to equip participants with the skills and knowledge to identify mental health disorders in children, as well as to develop comprehensive joint intersectoral intervention strategies for these children.

The University of Central Lancashire, UK, undertook an independent evaluation of the project in June 2007 and concluded it had resulted in significant change. Joint working across agencies dealing with children with mental health problems in the juvenile justice system has markedly improved and new services are being set up. Curricula and standards in related social work courses have been revised and the Vice-President of the Republic has agreed to form a group to develop a new, proactive policy for juvenile offenders. A youth section within the Probation Service has been established and a youth offending team is being developed. The Probation Service has drafted a standard assessment tool that is being piloted, and multidisciplinary child and adolescent mental health assessment centres are planned at Kenyatta and Mathari hospitals, which could also serve as model training centres for the East Africa region.

Further work is planned, including child mental health training for the developing youth offending team and staff at the planned assessment centres.

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The MRCPsych and Hong Kong trainee representation

Sir: Sherry Chan joined our senior house officer (SHO) rotation when she was unable to take the MRCPsych Part I OSCEs due to the SARS epidemic. She was a Hong Kong candidate who was unhappy with the arrangements that the College instituted as a response to the situation. They had imposed a quarantine of 14 days (following Home Office guidance?). Even worse was the lack of adequate information for Hong Kong trainees. As a group they did not have an appropriate mechanism to communicate with the College. When I joined the Psychiatric Trainees Committee (PTC), I thought that it was imperative that trainees in the overseas divisions have adequate representation. I remembered the SARS episode and thought that the chaos caused by poor communication should not be repeated. Sherry helped me get in touch with the Hong Kong Trainees Committee through a colleague.

As mentioned in my letter in the April 2007 issue, I was able to set up a meeting with the Hong Kong Trainees Committee in November 2006. They were pleased to meet with me and expressed a long-felt need for a say in training and examination issues. Some of those concerns have since come to pass. The new MRCPsych structure has created anxiety among both Hong Kong trainees and trainers. There was special concern over how the workplace-based assessments were to be implemented. Hong Kong trainees were worried that it would become difficult for them to sit the MRCPsych.

It was fortunate that the College backed my proposal for a Hong Kong trainee representative to sit on the PTC at such a crucial time. Dr Yat Chow was elected by the Hong Kong Trainees Committee to take on that role and attended the PTC residential conference in October. He was able to highlight concerns about the exams and also to inform us of the value Hong Kong trainees place on the MRCPsych. At the conference he had the opportunity to meet with the Dean, Professor Bhugra, who reassured him that the College would be in close contact with the Hong Kong College of Psychiatrists about the issue and that the matter could be resolved. His attendance at that conference was useful in getting Hong Kong trainee voices heard, but it also drove home to the rest of us that the College is an international body: more than 15% of its membership comes from overseas.

The Board of International Affairs has backed the idea of trainee representation in the overseas divisions and a trainee representative has been appointed for the West Pacific Division. More divisions are likely to have trainee representatives. It is hoped that this facilitates better communication and ensures that, as important stakeholders in the College, trainees' voices are heard. The College is listening.

Allen Kharbteng MRCPsych
Trainee Representative to the Board of International Affairs

Correspondence is welcome either on articles published in *International Psychiatry* or on aspects of current policy and practice in psychiatry in different countries. Letters should be sent to: Amit Malik MRCPsych, Consultant Psychiatrist, Hampshire Partnership NHS Trust, UK, email ip@rcpsych.ac.uk.

Forthcoming international events

13–17 April 2008
9th Congress of the European Federation of Sexology
Rome, Italy
Organiser: European Federation of Sexology
Contact: Dr Rosi Romagnolo
Email: r.romagnolo@aimgroup.it
Website: http://www.aimgroup.it/2008/efs

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/

15–17 April 2008
4th International Conference on Psychiatry: Globalization, Psychiatry and Mental Health
Jeddah, Saudi Arabia
Organiser: Saudi Psychiatric Association
Contact: Dr Mohamed Khaled
Email: moh.khaled@gmail.com

16–20 April 2008
Reflections and Ideas for Innovation Psychiatry Conference
Fiuggi, Italy
Organiser: WPA Section on Ecology, Psychiatry and Mental Health
Contact: Dr Giuseppe Spinetti
Email: gspinetti@libero.it

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

3–8 May 2008
APA Annual Meeting
Washington, DC, USA
Organiser: American Psychiatric Association
Website: http://www.psych.org/edu/ann_mtgs/am/08/index.cfm

12–13 May 2008
Conflict, Mental Health and Making the Peace
London, UK
Organiser: London Institute of Psychiatry
Contact: N. D. Minton MD
Email: nd.minton@btopenworld.com

22–25 May 2008
18th Alzheimer Europe Conference
Oslo, Norway
Email: maija.juva@nasjonalforeningen.no
Website: http://www.alzheimer-conference2008.org/

29–31 May 2008
International Congress of Dual Pathology
Madrid, Spain
Organiser: Spanish Society of Dual Pathology
Contact: Carolina Garcia Sicilia
Email: secretariat@cipd2008.com
Website: http://www.cipd2008.com

19–21 June 2008
WPA Thematic Conference on Depression and Other Common Mental Disorders 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

12–15 July 2008
Brain Development and Learning Conference
Vancouver, Canada
Email: devcogneuro@gmail.com, melinda.mackey@gmail.com
Website: http://www.interprofessional.ubc.ca/bdl.html

13–17 July 2008
XXVI CINP Congress 2008
Munich, Germany
Website: http://www.cinp2008.com

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: http://www.wpa-prague2008.cz

26–29 September 2008
11th Congress for Bridging Eastern and Western Psychiatry
Antalya, Turkey
Website: http://www.turkeybipolar.com/

17–19 October 2008
3rd International Conference on Schizophrenia
Chennai, India
Organiser: Schizophrenia Research Foundation (SCARF)
Contact: Dr R. Thara
Email: SCARF@vsnl.com
Website: http://www.icons-scarf.org

28–31 October 2008
International Conference on Priorities in Health Care
Gateshead, UK
Email: eileen.coope@ncl.ac.uk

30 October–2 November 2008
13th Pacific Rim College of Psychiatrists Meeting
Tokyo, Japan
Website: http://www.prcp2008.org/

6–8 November 2008
2nd International Conference on Intellectual Disability/Mental Retardation
Bangkok, Thailand
Organiser: World Health Organization (WHO)
Contact: Dr Shekhar Saxena
Email: bangkokconference2007@ssss.gouv.qc.ca
Website: http://www.bangkok-id-conference.org

Contents of the *African Journal of Psychiatry* (affiliated journal)

Volume 11, Number 1, February 2008

Guest editorial
Sharing mental health research resources in Africa – the place of all inclusive consortia 1
D. M. Ndetei

Newsletter
Board of International Affairs, Pan-African Division, Quarterly newsletter, African International Division 11
Royal College of Psychiatrists

Review articles
Psychiatric disorders and general medical conditions: implications for the clinician 18
P. Oosthuizen, P. Carey and R. A. Emsley

Mental health literacy: focus on developing countries 23
K. A. Ganasen, S. Parker, C. J. Hugo, D. J. Stein, R. A. Emsley and S. Seedat

The neuroendocrinological sequelae of stress during brain development: the impact of child abuse and neglect 29
A. Panzer

Original articles
Depression among Sesotho speakers in Mangaung, South Africa 35
N. L. Mosotho, D. A. Louw, F. J. W. Calitz and K. G. F. Esterhuyse

Level of maternal education and performance of Black, South African infants on the 1996 Griffiths Mental Development Scales 44
K. Cockcroft, Z. Amod and B. Soellaart

Post-traumatic stress disorder symptoms in a psychiatric population not presenting with trauma: a preliminary study 51
D. L. Mkize

Abstracts
Abstracts submitted to Anxiety Disorder Symposium, March 2008 56

Obituary
Olabisi Adebayo Odejide 77

Movie review 80