

International Psychiatry

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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.

Counterfeit medicines and the unregulated market for drugs

Hamid Ghodse

Editor, *International Psychiatry*

The unregulated market for medicines has evolved in different ways and exists in different forms in different parts of the world. Given this wide variation, the phrase 'unregulated market for drugs' is commonly used in a generic sense and encompasses the sale of medicines that have been licitly manufactured but diverted from legitimate sales routes as well as the illicit manufacture and sale of (counterfeit) pharmaceuticals. Also within this unregulated environment, prescription-only drugs are sold (illegally) without prescription.

In countries that can offer only limited access to healthcare professionals, hospitals, clinics or pharmacies, unauthorised or unregulated outlets are more likely to exist, because consumers may be forced to buy drugs of whatever sort, from wherever they can. In low- and middle-income countries, the unregulated market may include makeshift outlets at village fairs or on street markets, where medicines are sold along with commodities such as balms, tonics and creams. There are also more organised systems, operated by unscrupulous manufacturers, importers, retailers, wholesalers and healthcare professionals, driven by the possibility of substantial profits. Medicines are likely to be cheaper on the unregulated market.

In higher-income countries, the internet plays a significant role in the unregulated market. It facilitates contact between suppliers and consumers, and offers almost limitless opportunities to sell drugs; delivery to the buyer is often via postal or courier services. The level of privacy offered by internet pharmacies, combined with the weakness of drug regulatory and enforcement mechanisms, contribute to a thriving unregulated market and it is not surprising that the number of illegally operating internet pharmacies continues to rise and has long surpassed the number of licensed and accredited internet pharmacies. They are major suppliers of counterfeit medicines.

Although selling drugs out of a suitcase in a village market may seem very different to selling drugs over the internet, the consequences and the associated problems are similar. Specifically, they offer opportunities for prescription-only medicines to be bought without a prescription, so that powerful drugs become available and may be used in wholly inappropriate ways. In addition, any type of unregulated market represents a useful sales outlet for counterfeit medicines.

The nature of the problem

Although the existence of counterfeit medicines is not new, their availability was first formally acknowledged as a problem only in the mid-1980s. It has been identified as a growing problem since then, constituting a serious health risk to users. Indeed, the situation has been dramatically worsened by the rapid expansion of unregulated markets,

and the World Health Organization (2006) estimates that counterfeits could account for more than 10% of the global medicines market. The expansion is undoubtedly due to the fact that counterfeiting medicines is a lucrative criminal activity. According to the US Center for Medicines in the Public Interest, counterfeit drug sales will reach US\$75 billion globally in 2010, an increase of more than 90% from 2005 (see World Health Organization, 2006).

While counterfeits can be found in all regions of the world, low- and middle-income countries are disproportionately affected. Indeed, according to the World Health Organization (2006), an estimated 25–50% of the medicines consumed in those countries are counterfeit.

It requires little imagination to appreciate the nature and magnitude of the problem represented by counterfeit medicines, which are specifically manufactured to maximise profits. The products are of doubtful quality, safety and efficacy, and their sources are not guaranteed. In addition to violating intellectual property rights, they undermine healthcare systems through their frequent lack of therapeutic efficacy and safety. Above all, they pose serious health risks to their users because their constituents may be at best ineffective and, at worst, positively harmful (even resulting in death). The problem is compounded by the fact that counterfeit drugs often closely resemble the genuine products in their appearance and packaging. This lulls consumers into believing that they are buying the 'real' drug.

The true criminality of counterfeit medicines is illustrated by the use in Africa of counterfeit vaccines, which, in 1995, resulted in some 2500 deaths (World Health Organization, 2006). It is therefore not an exaggeration to consider trafficking in counterfeit drugs as a potentially life-threatening crime.

Psychotropic medicines

A wide range of psychotropic medicines, including anti-depressants, anxiolytics, stimulants and even narcotic analgesics, are available from unregulated markets in both high-income and low- and middle-income countries. The manufacture and trade of these drugs, which are frequently subject to misuse, are strictly controlled under international conventions and they should be dispensed only on prescription. Their wide availability without prescription via the unregulated market is dangerous for those who may consume them inappropriately and also has public health implications because of the increased risk of misuse and dependence.

Internet pharmacies appear to play a particularly important role in the unregulated market for psychotropic drugs. For example, a recent US survey of 185 internet pharmacies found that 85% of them sold benzodiazepines, 68% sold

opioid analgesics, 8% sold stimulants and 1% sold barbiturates; 89% of them did not require a prescription and only 3% indicated that, before they dispensed a medicine, a prescription would be required (National Center on Addiction and Substance Abuse, 2006). In 2006, 34 illegal internet pharmacies dispensed more than 98 million dosage units of hydrocodone products (International Narcotics Control Board, 2008). In the USA, the law enforcement authorities examined 1153 imported parcels containing medicinal products during a 3-day operation in 2003. The overwhelming majority of the products (88%) were illegally imported drugs, including more than 25 different controlled psychotropic medicines, such as diazepam and codeine (Food and Drug Administration, 2003).

Law enforcement and cooperation

According to a study conducted by the World Health Organization (2003), in 30% of countries drug regulation is either non-existent or very limited. Clandestine manufacture and trafficking are facilitated by weak drug regulations, weak enforcement of existing regulations and lenient penal sanctions for counterfeiters. If sanctions are not commensurate with the enormous profits that are made, they do not serve as a sufficient deterrent.

Effective action requires the existence of competent national drug regulatory authorities, with a sustained resource base, to ensure control and regular inspection of those involved in the manufacture, trade and distribution of pharmaceuticals.

To regulate the medicines market effectively, national drug regulatory authorities require political will, relevant legislation, appropriate organisational capacity and skilled professionals. The training of healthcare professionals should include guidance on how to promote the rational use of medicines in general and psychotropic medications in particular. Codes of conduct for associations of healthcare professionals, industry and chambers of commerce should address the issue of incorrect or improper handling of drugs. Drug regulatory authorities, law enforcement agencies, manufacturers of pharmaceuticals, professional associations of medical practitioners and pharmacists, as well as consumer protection groups, need to work in concert to identify counterfeit medicines that are in national distribution channels and their

sources, so that adequate preventive measures can be undertaken. Without the cooperation of all concerned, there will be little chance to overcome this problem.

These actions at national level need to be complemented by strengthened, concerted international preventive and investigative efforts. National drug regulatory authorities should cooperate effectively in eliminating counterfeit medicines from international commerce. Cooperation and intelligence sharing among national drug regulatory and law enforcement authorities would help to stop shipments of counterfeit medicines and would facilitate the arrest of persons engaged in counterfeiting. Furthermore, national drug regulatory authorities should cooperate with the International Medical Products Anti-Counterfeiting Taskforce, set up with the Declaration of Rome of 18 February 2006. Governments need to be appropriately sensitised to the health and economic risks associated with the counterfeiting of medicines, so that appropriate laws against counterfeiting are enacted, and resources and infrastructure are provided for effective law enforcement at national level.

Apart from governments, the pharmaceutical industry, professional organisations, consumer associations and healthcare professionals, mass media and particularly the health and medical journals all have an important role to play in public education. Psychiatrists, particularly through psychiatric and mental health societies and associations, have a pivotal role to play in relation to the appropriate use of psychotropic medicines, which should include education of both patients and their carers in the risks associated with the use and misuse of medicines, especially those from unregulated sources.

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THEMATIC PAPERS – INTRODUCTION

Migration and psychiatric adjustment

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With the extraordinarily large movements of populations from some of the former Soviet Union states into Western Europe, since their recent membership of the European Union, attention has been focused in recent years

on how easy or otherwise it has been for these people to adjust to life in very different economic and social circumstances. It has been estimated that the UK has absorbed up to a million immigrants from Eastern European states

since 2004, and an equivalent picture is seen elsewhere; for example, in Switzerland immigrants now comprise nearly a quarter of the population. We consider here the mental health issues faced by those moving to work in other countries, some of whom aim to become citizens, others to gain temporary economic advantage, and yet others to escape persecution and threats to their personal safety in their countries of origin.

Solvig Ekblad considers the situation in Sweden, where the immigrant population now comprises about 12% of the total: as she indicates, there have in recent years been several waves of immigration from the 15 republics of the former Soviet Union, and from Eastern Europe, with many women coming in the hope or expectation of marrying Swedish men. Perhaps surprisingly, those from Poland and other Eastern European states are at far higher risk of psychiatric disorder than immigrants from countries that had been Soviet republics, although all are at risk of poorer physical health than the native Swedes. The Swedish system of immigrant management has been criticised by the United Nations for failing to provide adequate support for the physical and mental well-being of vulnerable groups.

In the Canadian immigrant population, there is an over-representation of those living below the poverty line, as discussed by Stephen Kisely. He, like Dr Ekblad, emphasises the importance of providing adequate support. This includes mental and physical healthcare. As in Sweden, some Canadian provinces do not automatically provide levels of care that are similar to those accessible by the native population. This may be motivated by a desire to discourage those whose reason for coming is to obtain specific treatments for an existing condition. Mental health seems to be better

among those who settle in urban areas, for reasons that are at present speculative. There are significant differences in the approach to the management of immigrant health across the Canadian provinces, which have a degree of autonomy in this respect. Manitoba seems to set a high standard, in the opinion of Dr Kisely, to which other provinces might aspire.

Finally, we have an interesting review of research into the psychological adjustment of young refugees, which summarises the findings from a report on the well-being of young asylum seekers, prepared by Winnie Lau and Trang Thomas from Australia. They point out the important fact that nearly half the world's refugees are children and adolescents. Here we have a very different situation to that facing economic migrants, for these people are escaping situations replete with threat and often overt trauma. Drs Lau and Thomas argue that we ought to be aware that many such children may have symptoms that are indicative of post-traumatic stress disorder, although these may not at first be obvious, even to their parents. Fortunately, over time they do seem to adapt to life in their new country, but even so the prevalence of mental health problems in the children of refugees and asylum seekers is much higher than in the indigenous population. We should not only be aware of this situation but, as concerned psychiatrists, we should be pressing for services to be made available to such children in order to facilitate their adjustment and acculturation. There is naturally a greatly enhanced risk to those who migrate unaccompanied by parents, especially boys who were former child soldiers. It seems there are still considerable gaps in our knowledge about the practical solutions to these pressing problems, although we do know that certain governmental policies, such as mandatory detention, are likely to exacerbate them.

THEMATIC PAPER – MIGRATION AND PSYCHIATRIC ADJUSTMENT

Mental health among recent immigrants to Sweden from Eastern Europe and the former Soviet Union

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Several European states such as Sweden have become transit countries for migrants, as well as reception countries for an increasing number of young migrants, not only asylum seekers and refugees from beyond Europe but also from the European Union's new members, after the dissolution of the Soviet bloc in 1989 and then the Soviet Union itself in 1991. Over 110 000 immigrants from Eastern Europe and the former Soviet Union resided in Sweden in 2002, although the exact figure is difficult to estimate because of the varied legal status of the migrants. International migration is not a new phenomenon in this part of the world, of course: people have

always moved in the search of greater personal safety, among other reasons. However, new groups with new psychosocial needs and demands on the healthcare systems of the host countries will be a challenge. The aim of this article is to give an overview of three sets of empirical data:

- the prevalence of mental disorders among recent immigrants to Sweden from Eastern Europe and the former Soviet Union
- their access to mental health and social care facilities arising from their legal status
- their utilisation of health and social services.

East–west migration

Earlier waves of migration from east to west were directly connected to political events and human rights issues (for reviews see Fassmann, 1994; Blomstedt *et al*, 2007). The decision of the Swedish government to allow immigration through the recruitment of workers from Hungary in 1947 and Poland in the mid-1970s has had an impact on immigration from these areas. In addition, there are new waves of immigrants applying for asylum or family union coming from the 15 republics of the former Soviet Union, especially Kazakhstan, Kyrgyzstan, Georgia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan and Belarus (<http://www.scb.se>).

During the 1990s the number of marriages between Swedish-born men and women from Baltic countries and Russia increased. Indeed, over recent years there has been an overall increase in immigration via marriage to Swedish men (i.e. marriage migration) but the social conditions of these migrant wives in the reception country has received scant attention. In contrast, the Swedish media have, in different ways, paid attention to trafficking from Russia and other Eastern European countries. Skarpsvärd & Yenidogan (2005), in a qualitative study, interviewed ten Russian women aged from 25 to 50 years who had moved to Norrbotten, in the northern part of Sweden, after marrying Swedish men. They showed that the main motives for migration were economic and social security, a wish to attain the cultural female ideal that the women were unable to realise in their life in Russia, and a vision of a better world in the West. Their self-identity changed as they became more familiar with Swedish society. Further, these women rethought their ideas regarding a woman's position in the family and in society.

Prevalence

There is a fundamental lack of representative data on the mental health of different groups of migrants (e.g. asylum seekers, refugees, those who migrate for family reasons, undocumented migrants) from Eastern Europe and the former Soviet Union. Non-participation in health surveys is common among these groups. Results from an investigation of a representative postal questionnaire survey performed in Sweden in 1999–2000 showed that immigrants were under-represented; those born in the former Yugoslavia, Arabic-speaking countries and Poland were especially so (Carlsson *et al*, 2006). In a review (Sungurova *et al*, 2006), immigrants from Eastern Europe and the former Soviet Union in Sweden were reported to run an increased risk of psychiatric illness, to take psychotropic drugs, to attempt suicide and to complete suicide.

Blomstedt *et al* (2007) studied a cross-sectional national sample comprising 35 459 Swedish-born persons aged 25–84 years as well as immigrants from Poland ($n = 16$), other Eastern European countries ($n = 164$) and the former Soviet Union ($n = 60$) who arrived in Sweden after 1944 and were interviewed during 1994–2001. They found that the country of birth had a strong influence on self-reported mental health. Polish and other East European immigrants in general had a twofold higher odds ratio of reporting psychiatric illness and psychosomatic complaints. This result was not accounted for by demographic and socio-economic variables. Immigrants from the former Soviet Union, however, had odds similar to

those of the Swedish-born reference group. The conclusion was that adjustments for acculturation variables (e.g. language spoken at home and number of years in Sweden) changed the relationship between the country of birth and the outcomes only to a small amount.

In another cross-sectional study, Sungurova *et al* (2006) during 1993–2000 interviewed 373 immigrants from Poland and other European countries (Hungary, Bulgaria, Czech Republic, Slovakia and Romania) and from the former Soviet Union (all 15 former republics), aged 25–84 years, who arrived in Sweden after 1944, and compared them with 35 711 Swedish counterparts. Age- and gender-adjusted unconditional logistic regression showed in general a 92% higher risk of reporting poor health among immigrants than among Swedish-born respondents. The risk remained after adjustment for several potential confounders (living singly, having a poor social network, low socio-economic status and smoking) and after an additional adjustment for acculturation (language at home and years in Sweden).

Utilisation of healthcare

Sweden is one of the few member states of the European Union in which adult asylum seekers and undocumented foreign nationals do not have access to the same healthcare as adults domiciled in Sweden (Nørredam *et al*, 2006). All asylum seekers who come to Sweden are offered a medical examination free of charge. During last year, only 45% of the newcomers chose to undergo such an examination (Wintzer, 2008). After a mission to Sweden, Paul Hunt, a special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, expressed the opinion that such differential treatment constitutes discrimination under international human rights law (Hunt, 2007).

Conclusion

The results from studies that have been performed in Sweden on the immigrant population are broadly in line with those from other West European countries. In particular, it is possible to identify inequality in health by country of birth. Immigrants are significantly under-represented in such studies (Carlsson *et al*, 2006). Until now, there have been no causal pathways identified between migration and health among the populations studied. Being born in Eastern Europe or the former Soviet Union is an independent risk factor for reporting poor health. Further, studies have shown that self-reported health is poorer among those from Eastern European countries than it is among those from the former Soviet Union. However, this may largely be explained in terms of differential access to resources and different exposures to risk.

The 'migration import' hypothesis assumes that rates of illness among immigrants correspond more closely to those of their country of origin than to those of their adopted country (Ponizovsky *et al*, 1999). This effect tends to reduce over time and the rates become more like those of the host population (the 'migration convergence' hypothesis).

There is a consensus that living conditions are related to health in the population. It is important for the primary

and public healthcare services to pay attention to the health status and needs of immigrants. Kastrup (2008) proposes a competent treatment of patients with multicultural backgrounds, which demands that mental health professionals be aware of alternative traditional approaches and show an interest and an ability to bridge the more traditional and the Western approaches to treatment. Transcultural psychiatry today is recommended to facilitate 'an understanding about basic mental functions and disease categories, while paying specific attention to culturally influenced constellations of stress factors, psychosocial variables that influence treatment outcome and the individual understanding and interpretation of disease symptoms' (Schouler-Ocak *et al*, 2008, p. S1).

Healthcare and healthcare systems should be seen and understood in their sociocultural context (Kastrup, 2008). Access barriers remain, as does discrimination. As poor mental health may block the process of acculturation, the mental health of immigrants from East European countries should be paid more attention, particularly with the recent enlargement of the European Union.

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THEMATIC PAPER – MIGRATION AND PSYCHIATRIC ADJUSTMENT

Migration and mental health in Canada: can government policy help?

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Canada admits more than 220 000 immigrants every year and this is reflected in the statistic that 18% of the population was born abroad (Beiser, 2005). However, government policy emphasises the admission of healthy immigrants rather than their subsequent health. Immigrants do not show a consistently elevated rate of psychiatric illness, and morbidity is related to an interaction between predisposition and socio-environmental factors, rather than immigration *per se*. These factors include forced migration and circumstances after arrival, such as poverty, limited recognition of qualifications, discrimination and isolation from the immigrant's own community. For instance, in Canada more than 30% of immigrant families live below the official poverty line in the first 10 years of settlement (Beiser, 2005).

Some groups are at higher risk of psychiatric morbidity, such as asylum seekers. In this population, symptoms of depression and anxiety, panic attacks or agoraphobia are

common and are often reactions to past experiences and current social circumstances (Kisely *et al*, 2002). More than 20% of asylum seekers in Australia reported previous torture, a third reported imprisonment for political reasons, and a similar proportion the murder of family or friends (Silove *et al*, 2000; Steel & Silove, 2001; Sultan & O'Sullivan, 2001). In one British study, 65% of Iraqi refugees had a history of systematic torture during detention (Gorst-Unsworth & Goldenburg, 1998). These experiences are compounded by the rigours of reaching safety, social isolation, poverty, hostility and racism (Kisely *et al*, 2002).

Acculturation

Although resettlement countries can do little to address pre-settlement experiences, governments can address issues of unemployment, discrimination and acculturation following

arrival (Beiser, 2005). Acculturation refers to culture change that results from continuous, direct contact between two independent cultures. This process is known to influence, for example, biological, physical, social, cultural and psychological factors. Aspects include:

- enculturation, which is defined as the degree to which an immigrant adopts the new culture or values relationships with the larger society (and which can be associated with 'culture shock')
- biculturalisation, which is defined as the degree to which immigrants maintain their cultural identity but also adopt the new culture and larger society (usually in association with access to multiple resources).

Immigrants' responses to acculturation include the following (Beiser, 2005):

- assimilation, where the culture of origin is abandoned in favour of the new
- integration, where there is a creative blending of the two
- rejection, where the new culture is rejected
- marginalisation, where neither the old nor the new are accepted.

Marginalisation is associated with the greatest risk of psychological morbidity, integration the least.

Government policy and immigrant health

Government policies can directly compromise health. Some Canadian provinces insist on a waiting period before newly arrived immigrants can have access to public health services. Concerns about uncontrolled migration have encouraged some destination countries to adopt policies of deterrence, in which increasingly restrictive measures are being imposed on asylum seekers (Kisely *et al*, 2002). In Australia these include confinement in detention centres, restriction of the right to appeal, and temporary rather than permanent asylum. These policies may be counter-productive, in that they can aggravate pre-existing medical problems and may actually compromise public health.

Some asylum seekers are held in detention facilities for considerable periods of time. An Australian report identified more than 80 detainees who had been held in detention for between 2 and 5 years (Human Rights and Equal Opportunity Commission, 1998). Housing refugees in crowded conditions can facilitate the spread of infectious disease. In America, 90 asylum seekers contracted tuberculosis from a fellow detainee. Detention may also harm the mental health of asylum seekers. Asylum seekers in detention have high rates of attempted suicides and hunger strikes. They also show significantly higher levels of depression, suicidal ideation, post-traumatic stress, anxiety and panic attacks than asylum seekers, refugees and immigrants from the same country living in the community (Silove *et al*, 2000). In Australia, the Human Rights and Equal Opportunity Commission (1998) has suggested that the boredom and frustration of prolonged detention together with social isolation may be responsible for outbreaks of violence, including domestic violence, among detainees and between detainees and officials. Single women and children may be at increased risk of abuse and exploitation when confined in mixed-gender detention facilities (Silove *et al*, 2000).

Where do immigrants settle in Canada?

Most immigrants settle in Toronto, Vancouver or Montreal, and they have lower suicide rates than those who go elsewhere in Canada. This is confirmed in studies that show reduced rates of mental illness where there is a like-ethnic critical mass. Immigrants prefer to settle in these urban centres for three reasons:

- increased closeness to family or similar ethnic groups
- enhanced employment opportunities
- improved access to support services that help with integration into Canadian society.

The challenge for smaller provinces

The dilemma for smaller provinces is evident in the statistics presented in Fig. 1. When immigration trends by province are examined, 90% of newcomers go to three provinces: Ontario, Quebec and British Columbia. Smaller provinces must find a way to attract and retain immigrants in ways that maximise their physical and mental health. Policies that direct newly arrived entrants to low-density areas where there are few immigrants run counter to research evidence of the health benefits of like-ethnic communities (Beiser, 2005). Such policies also ignore the association between dispersion and compromised mental health (Beiser, 2005).

Manitoba's approach has been of particular interest. In spite of its relatively small population (1 million), Manitoba has consistently ranked fifth among provinces in attracting immigrants and is seeing increasing success in retention (Fig. 1).

Manitoba's government set an annual target of 10 000 arrivals, with strategies both to attract newcomers to the province and to keep them there (Manitoba Labour and Immigration, 2005). One component is the Manitoba Provincial Nominee Program (MPNP), which is an economic programme that nominates skilled workers for permanent resident status in Canada. It also assists with adult language training and the recognition of qualifications. Manitoba's immigration programme is run by the Immigration and Multiculturalism Division, which comprises:

- adult language training services
- settlement and labour market services
- immigration promotion and recruitment
- a multiculturalism secretariat
- a strategic planning and programme support
- an executive administration.

Another component of the strategy is the creation of the Manitoba Immigration Council, an appointed 12-member body with representation from business, labour, multicultural organisations and educational institutions. The Council provides advice in three key areas: attracting immigrants; provision and development of settlement services; and complementing the development of crucial supports to retain immigrants in Manitoba.

Having arrived in Manitoba, provincial policy seeks to maximise retention by providing:

- employment opportunities, through awareness of labour market needs and willingness on the part of employers to hire immigrants
- affordable and available housing (including temporary accommodation)

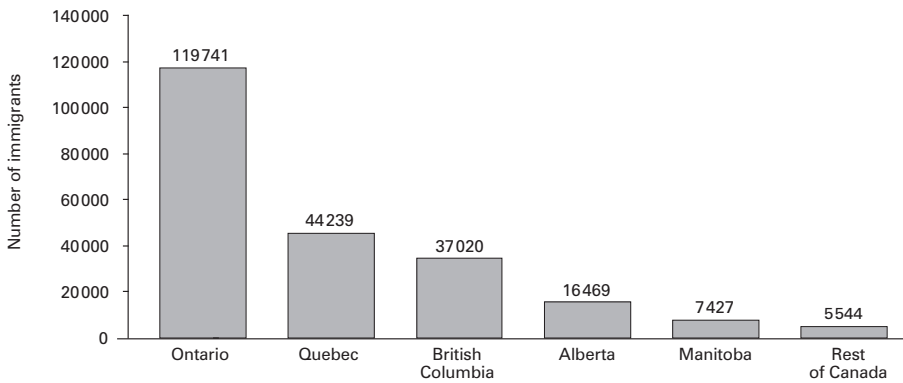


Fig. 1 Immigration by Canadian province or territory, 2004.

- settlement and integration support (information, orientation, referral, counselling, accessible programmes)
- language training (full time, part time, community, workplace, specific purposes, accessible programmes)
- access to health, education and social programmes (interpretation, cross-cultural awareness)
- community support and appreciation of diversity
- cultural and recreational opportunities.

Does it work?

One way of assessing efficacy is to compare Manitoba, which has a population of approximately 1 million, to a similar jurisdiction of roughly the same population, such as Nova Scotia. While Manitoba has its well-established MPNP and Immigration Council, to make it easier for highly skilled immigrants to find employment in occupations for which they have training and experience, such innovation has been absent until recently in Nova Scotia. In 1995, 3500 immigrants settled in each province. Ten years later this had increased to 7427 in Manitoba and fallen to 1770 in Nova Scotia. This difference was statistically significant. Retention rates also differed.

The Manitoban programme has informed the development of a similar strategy in Nova Scotia (Immigration Office, 2005). The province has now established an Immigration Office, consolidating all provincial immigration activities into one location, and set 5-year targets for both doubling the number of immigrants and increasing the retention rate from 40% to 70%.

Conclusions

Government policy can have direct effects on the attraction and retention of immigrants, as well as on their subsequent mental health. Ill-considered initiatives such as denying access to healthcare and not recognising qualifications, or encouraging dispersion, can worsen outcomes. Restrictive policies towards certain groups, such as asylum seekers, can be particularly harmful. On the other hand, policies that recognise the importance both of maximising employment

opportunities and of the support of like-ethnic communities can benefit both immigrants and the host country.

Physicians can contribute constructively to the debate in several ways at an individual and collective level. We need to ensure sufficient medical support for detention centres, as well as continuity of treatment programmes on discharge to the community. There is a fine balance between ensuring that asylum seekers receive appropriate healthcare and collusion with a system of detention that is potentially harmful to health. As a profession, we should also be lobbying for migrants' access to healthcare and other government services, to break the cycle of poverty, ill-health and limited access to health services. Lastly, doctors should set an example within their own profession by streamlining the recognition of qualifications for international medical graduates.

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Research into the psychological well-being of young refugees

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Interest in the psychological well-being of refugees and asylum seekers has steadily grown in recent years. Latest estimates indicate there are 32.9 million people of concern to the United Nations High Commissioner for Refugees (2006). A refugee is defined as being in that position because of a well-founded fear of persecution due to race, religion, nationality, social group or political opinion, and who is consequently outside and unable to return to his or her country. The status of 'refugee' is contrasted with that of a person seeking asylum, whose experiences may be similar but who is not formally determined in the same way.

The literature reporting mental health research concerning young refugees and asylum seekers is less comprehensive than that concerning adults. This is remarkable, given that almost half the world's refugees are children and adolescents (United Nations High Commissioner for Refugees, 2006). This paper summarises key research findings about the psychological well-being of child and adolescent refugees and asylum seekers. A full review has been presented by the Australian Human Rights and Equal Opportunity Commission (2002). For brevity, the term 'refugee' will be used hereafter to encompass those also seeking asylum.

Symptoms of post-traumatic stress

Many young refugees migrate with histories of exposure to trauma. Such trauma may include the violent death of a parent, injury to or torture of a family member, separation from parents, witness of murder or even massacre, exposure to bombardments, shelling or terrorist attack, forcible eviction from home, detention, physical injury and disability inflicted by violence, sexual assault, disappearance of loved ones, enduring political oppression, deprivation of human rights and education, and subjection to child-soldier activities. Children and adolescents are especially vulnerable to these effects because of their incomplete biopsychosocial and cognitive development, dependence, and underdeveloped coping skills. This vulnerability is increased owing to potential under-reporting of symptoms by parents (Almqvist & Broberg, 1999).

In the main, investigations have considered the impact of traumatic events upon psychological well-being, predominantly in terms of post-traumatic stress disorder (PTSD) or related symptoms. Included within this broader set of symptoms may be presentations of physical discomfort,

trauma-themed repetitive play, personality changes, regressive or violent behaviour, high anxiety, social withdrawal, conduct problems or survivor guilt.

Despite controversy surrounding the application of the term PTSD to populations affected by war (arguably, this diagnostic approach 'pathologises' normal reactions to abnormal situations), many studies have shown that trauma symptoms are common among young refugees. The studies by Kinzie *et al* (1986) and Sack *et al* (1999) are frequently cited to attest to the persistence of post-traumatic stress and poor adaptation in young refugees exposed to trauma as children. Others have successfully used interviews with children to identify a large, otherwise hidden, proportion who were not known by their parents to have symptoms, yet who had a diagnosis of PTSD (Almqvist & Brandell Forsberg, 1997).

While the nature of traumatic exposure varies, from direct to indirect and from single to repeated events, post-traumatic stress is well established in young refugees from many different regions, including, for example, Bosnia (Papageorgiou *et al*, 2000), Central America (Rousseau *et al*, 1997), Iran (Almqvist & Broberg, 1999) and Somalia (Ellis *et al*, 2008). Although prevalence rates of PTSD are highly variable (from 2% up to 50%; Howard & Hodes, 2000), there is general support for the validity of the diagnosis as a useful construct in children, cross-culturally.

Studies have also examined the impact of trauma before immigration, in relation to its type, amount and duration. Review of such studies indicates that the greater the severity, number and extent of exposures, the poorer the psychological outcome in terms of onset and severity of PTSD symptoms (Papageorgiou *et al*, 2000). For example, children directly exposed to violence (e.g. an assault on parents) or multiple trauma (e.g. shelling, combat) have a greater risk of developing chronic or severe PTSD (Almqvist & Brandell Forsberg, 1997).

Although it is not yet established whether the legacy of exposure to traumatic stress is carried into adulthood, longitudinal studies do show that while the severity of these symptoms may lessen, they nevertheless persist over time in up to a third of young refugees, causing continued distress (Sack *et al*, 1999). Another consistent finding is that disorders cluster in families, with the risk of PTSD increasing when a parent or other family member exhibits PTSD (Sack *et al*, 1996). Young refugees are also susceptible to vicarious trauma; in such cases a parent's own traumatic experience can influence the symptoms experienced by the children (Hodes, 2000).

Although consistent outcomes are reported in the literature for young refugees regardless of the type of traumatic experiences and cultures, the specific impact of trauma within a cultural context has rarely been examined. There is, though, increasing evidence that trauma symptoms are influenced by culture (Rousseau *et al*, 1997).

Comorbidity and other psychological outcomes

Adverse psychological outcomes are exacerbated by problems of malnutrition, disease, physical injuries, brain damage and sexual abuse. These should not be overlooked when making psychological enquiries of young refugees.

Disorders that are commonly associated with PTSD include high rates of anxiety and depression, with the latter being more closely associated with ongoing adversity during resettlement (Sack *et al*, 1996). Somatic complaints include sweating, headaches, respiratory and gastric problems. Cognitive problems include negative beliefs, expectations and suicidal thoughts. In displaced children, eating and sleep disorders are reported to accompany uncertainty regarding current status and fears about the future (Kocijan-Hercigonja *et al*, 1998). Among adolescents, a small number experience psychoses (Hodes & Tolmac, 2005). In terms of psychosocial outcomes, young refugees experience learning difficulties, isolation and social disadvantage (Howard & Hodes, 2000).

It should be noted that there is inconsistency in reports, with some studies documenting equivocal findings concerning the prevalence of mental health disorder among refugee children. Rather than suggesting an absence of distress, this may indicate that symptoms can be transient. Alternatively, psychopathological outcomes may form only part of the short- and long-term trauma response, which includes not only PTSD, anxiety and depression, but also other negative outcomes, such as loss and grief (Howard & Hodes, 2000).

Moreover, there is good evidence that, despite multiple traumas and elevated prevalence rates in young refugees, adaptation does occur (Punamaki *et al*, 2001). That there is resilience and recovery, after multiple loss and hardship, is reassuring. None the less, when compared with non-refugees, there is significantly greater psychological disturbance in young refugees. For example, psychological disturbance is three times greater among refugee children in Britain than among children in the general population (Fazel & Stein, 2003).

Risk and protective factors

This discussion has highlighted the fact that specific pre-migration risk factors, including trauma exposure and forced migration, are the most detrimental. Previous research also identifies dispositional and environmental factors as predictors of mental health. An ability to respond to new situations, positive self-esteem, good temperament and positive support through strong peer relationships are protective factors (Almqvist & Broberg, 1999).

The risk and protective factors during the post-migration period are equally important. This is because ongoing resettlement stressors can significantly undermine well-being. As is the case before migration, existing mental health

problems, family dysfunction, parental incapacity and unavailability (especially maternal in origin) are critical post-migration risk factors (Almqvist & Broberg, 1999). Furthermore, stressors that occur during resettlement can exacerbate or reactivate memories and emotions of past trauma.

It has been consistently shown that young refugees who are unaccompanied or who have been separated from their families have a greater risk of mental health problems than those who are accompanied or who later re-establish contact with their family (Sourander, 1998). Because of their heightened vulnerability to being forced to undertake child-soldier activity as well as their greater potential to support a family financially at resettlement, boys are highly represented in this unaccompanied group (Rousseau *et al*, 1997). The risk to unaccompanied minors is exacerbated following a history of multiple separations (Rousseau *et al*, 1997) and when caregivers other than the natural parents are substituted at resettlement (Kinzie & Sack, 1991).

Displacement and the processes associated with seeking asylum pose risks to young refugees for many reasons. These include the compounding stressors of camp life, enforced supervision and communal living outside the family and/or cultural group. The risk of mental health problems is also increased by delays in processing immigration status, dealing with officials, racism and discrimination, uncertainty about asylum status, loneliness and boredom (Silove *et al*, 1997). In Australia, mandatory detention has now been abandoned as a government policy: while in operation it increased the risks of hopelessness, despair and self-harm among those seeking asylum (Fazel & Silove, 2006). Negative outcomes associated with displacement and detention may also be attributable to the loss of traditional parent roles, perceived control and learned helplessness.

Acculturative stressors, including low socio-economic status, problems in language and school adjustment also predict poor adaptation. By contrast, good academic achievement, as influenced by language acquisition and good peer relations, is predictive of adaptation (Rousseau *et al*, 1997). Importantly, discrimination and financial hardship have been shown to predict depression in the resettlement period (Ellis *et al*, 2008), supporting the strong association between depression and acculturative stress (Sack *et al*, 1996). Conflict in adolescent identity formation is related to poor psychological adjustment. The process of adapting to a new culture can further increase vulnerability through high parental expectations and intergenerational conflict (Rousseau *et al*, 1997).

There are contradictory findings regarding the influence of age and gender on risk of mental health problems among immigrant children. While some suggest cognitive immaturity in younger children is protective (Papageorgiou *et al*, 2000), others have suggested that an inability to articulate and express distress on the part of younger children may increase risk (Berman, 2001). Girls and boys are more vulnerable at different ages and in rather different conditions (Papageorgiou *et al*, 2000). Of course, differences in gender may reflect cultural expectations for the display of emotions.

The availability of social support and positive peer relationships can facilitate successful adaptation in the resettlement period despite a history of extreme trauma (Almqvist & Broberg, 1999). The maintenance of close ethnic community ties is also protective, alongside cultural and religious traditions, which assist in restoring a sense of continuity

(Rousseau *et al*, 1997). Despite low rates of help-seeking, early intervention and appropriate psychosocial assistance have been reported as crucial protective factors (Howard & Hodes, 2000; Punamaki *et al*, 2001).

Conclusions

Unfortunately, the major risk factor is traumatic war exposure, and that cannot be eliminated. Let us remember, though, that with knowledge of the factors that are significant, especially those that enhance resilience, we can help to minimise the burdensome effects of trauma and give strength to this vulnerable and growing population.

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COUNTRY PROFILE

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Estonia

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Estonia is a small country (45 000 km²) with a population of 1.3 million people. It has undergone rapid change since it gained independence from the Soviet Union in 1991. It has achieved some economic success, although there is a suggestion that this has been at the expense of the mental health and general emotional well-being of the people. In the Estonian Health Interview Survey, depressive symptoms were observed in 11.1% of respondents and their presence was strongly correlated with socio-economic status (Aluoja *et al*, 2004).

Health system

The Estonian health system is funded via a national social insurance scheme. The Health Insurance Fund is provided from taxes on incomes of the working population, but it also covers those who have no income from employment. It is a universal scheme, under which medical institutions are reimbursed for treatments provided to all patients.

The first point of contact for the patient is the family doctor. Where necessary, the family doctor can refer the

patient to a specialist for consultation or can transfer the patient to hospital. Emergency medical cover is provided to all persons staying in the territory of the Republic of Estonia, regardless of nationality, citizenship or possession of a health insurance card. Psychiatry belongs to the sphere of specialist medical care.

Mental health policy

There is no mental health policy in Estonia, although attempts have been made to draft one. The first of these was made as early as 2001, when the Ministry of Social Affairs ordered the compilation of a source document of mental health policy from the Praxis foundation. The project was ended in December 2002. The intention had been to gather together all the important organisations and different interest groups in the mental health area, and to draft a well-balanced mental health policy centred on the client's perspective. The policy document was to have included a hierarchical listing of the most important mental health problems in Estonia, together with their possible solutions. Options for the development of mental health services for Estonia were described, alongside the existing plans for their development. This document was never adopted. There is, though, a Mental Health Act that regulates the provision of mental health services, and this is described below.

While no substantive national progress has been made in the area of mental health policy, the Estonian government, under the supervision of Commission of the European Communities, made a valuable contribution to the European Green Paper (2005) entitled *Improving the Mental Health of the Population. Towards a Strategy on Mental Health for the European Union*. Furthermore, Estonia has signed the Helsinki Declaration of the World Health Organization.

Mental health services

Estonia's mental health services have improved considerably over the past 10–15 years. The old system had been modelled on Soviet psychiatry; services are now more centred on the patient and are essentially targeted at improving clients' quality of life.

The Mental Health Act regulates the organisation of psychiatric care and defines the financial obligations of the state and local government in that respect. Under the Act, only those healthcare institutions, physicians and other specialists with appropriate licences may provide psychiatric care. Local governments must guarantee access to social services for people with mental disorders. The law also provides that in order to get psychiatric care the patient may turn directly to a specialist for out-patient consultation, that is, without referral from a family doctor.

Mental illness prevention is the responsibility of the Ministry of Social Affairs. Other legislation relevant to mental health includes the Social Welfare Act.

Psychiatric care is mainly provided on an out-patient basis in Estonia. In-patient psychiatric care is mainly used to help patients through a short-term crisis or for solving complex differential diagnostic and treatment problems. Hospital admission is resorted to only where a period of continuous

monitoring is necessary for diagnosis, medical treatment or rehabilitation, or when patients are deemed to be a danger to themselves or others, or are unable to cope without assistance outside hospital. People can be admitted to the psychiatric department of a hospital for emergency psychiatric care or otherwise treated without their consent (or that of their legal representative) only if all of the following circumstances exist:

- they have a severe mental disorder which restricts their ability to understand or control their behaviour
- without in-patient treatment, they endanger the life, health or safety of themselves or others as a result of the mental disorder
- other psychiatric care is not sufficient.

Persons in involuntary treatment may not be subject to clinical trials, or the testing of new medicinal products or treatment methods. The Healthcare Board supervises involuntary treatment.

Biological treatment methods predominate in comparison with psychotherapy. Indeed, the availability of psychotherapy and counselling or emergency help services – for example emergency counselling for family crisis or school violence – is limited. Emergency help on the basis of in-patient hospitalisation is guaranteed. There was little in the way of community-based services during the Soviet period, but these have been expanded year on year. As this process is ongoing, it is difficult to give actual figures.

The provision of rehabilitation services is ensured by the Social Insurance Board.

Training and numbers of specialists

Psychiatric training is available to graduates of Tartu University's Faculty of Medicine who have spent 1 year in training as a general doctor and who have passed an examination to become a specialist trainee. Training starts at Tartu University Psychiatric Clinic. After 4 years of 'common trunk' training and a final examination in psychiatry, doctors will have the specialty of psychiatry accredited to them by the Healthcare Board. A psychiatrist can apply for the sub-specialty status of child and adolescent psychiatrist or psychotherapist from the Estonian Psychiatric Association.

As of 1 January 2002, the structure and quality of the healthcare professions have been governed by specialty and professional associations, such as the Estonian Nurses' Union. For example, these bodies carry out periodic assessment of the competency of their members, although these assessments are voluntary for the professionals. The certification system of the Estonian Psychiatric Association was established in 2004.

Based on workload standards and training requirements, the Ministry of Social Affairs has suggested that the optimal number of psychiatrists in 2015 will be 260. The model takes into account working hours, training sessions, vacations, the numbers of patients and the numbers of episodes of illness, as well as the age and potential migration of doctors currently working in the system. Based on this estimate, the Ministry has submitted a government order for employment contracts for at least eight additional psychiatry residents (including one resident in children's psychiatry) each year.

Table 1 Estonia's national requirements for psychiatrists

Area of work	Basis for estimate	Numbers required
Out-patient psychiatrists	1 psychiatrist per 10 000 inhabitants	130
Child psychiatrists	1 child psychiatrist per 40 000 inhabitants	30+
In-patient psychiatrists	Dependent on the number of beds and shifts	90–100
Other fields – education and research, forensic psychiatry, prison psychiatry		5–10 total

The Estonian Psychiatric Association broadly concurs with these Ministry estimates, on the basis of the numbers shown in Table 1.

Professional association

The Estonian Psychiatric Association was established in 1989. It has three specialist sections – child and adolescent psychiatry, biological psychiatry and eating disorders – and a section for young psychiatrists and trainees.

In recent years the members of the Association have been increasingly active. Some important campaigns have related to:

- price rises in connection with mental health services
- the need for a mental health policy
- the need to re-establish child and adolescent psychiatry as a specialty, and in particular the need for more child and adolescent psychiatry centres.

Research

The main areas of research in Estonian psychiatry are the epidemiology of depression and biological markers of anxiety disorders. In recent years there has been increasing interest in research on the part of psychiatric trainees and young doctors. One obstacle is a national lack of research supervisors, but consequently there has been a trend to work with foreign colleagues.

Stigma and human rights

A pre-conference meeting on mental health at the World Health Organization's European Ministerial Conference took place in Estonia in October 2004. The matters raised included mental health issues in the workplace, especially stigma and the need of those with a mental disability to find appropriate employment. Stigma was also discussed in the document on mental health policy (see above).

Institutions which mainly deal with human rights in relation to mental health include the Estonian Chamber of Disabled People, the Estonian Mentally Disabled People Support Organisation, the Estonian Patients' Advocacy Association, the Estonian Psychosocial Rehabilitation Association and the Estonian Psychiatric Association.

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COUNTRY PROFILE

Mental health in the Syrian Arab Republic

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The following view was espoused in a 1903 *Lancet* editorial describing psychiatric services in the East: 'The treatment of lunatics in the East has not yet fully emerged from the clouds of ignorance and barbarism which have surrounded it for ages.' One of the first reformers was 'Mr. Theophilus Waldmeier, a gentleman resident in Syria, who commenced in the spring of 1896 the work of helping and

providing for the numerous sufferers from mental disease in Syria and Palestine.' He attempted to introduce the methods of humanity and science in this field. In 1939 Bernstein described his visit to the Maristan Arghoum, a psychiatric hospital, in the city of Aleppo. He observed the complete lack of medical supervision, 'bad' patients being chained and the despotic rule of the 'keeper' of the hospital.

Demographics

The Syrian Arab Republic has a total area of 185 180 km², of which approximately 80 000 km² is cultivable land; the remainder is desert and rocky mountains. The country's population in 2006 was estimated at 18.717 million. The population growth rate was 2.45%; 39.4% of the population were below 15 years of age and 3.3% above 65 years. In 2006, the crude death rate was estimated to be 4 per 1000 population per annum and the crude birth rate 30 per 1000 per annum. In the same year, life expectancy at birth was estimated at 72 years.

The socio-demographic correlates of psychiatric morbidity among low-income women in Aleppo, Syria, were studied by Maziak *et al* (2002), who concluded that the prevalence of 'psychiatric distress' was 55.6%, but there was no categorisation of these psychiatric disorders. The study used a special questionnaire based on items not relating to psychosis from the 20-item Self-Reporting Questionnaire (SRQ-20), as well as questions about background information considered relevant to the mental health of women in the population studied. (The SRQ-20 was developed primarily as a psychiatric screening tool to suit primary care settings in low- and middle-income countries.) 'Psychiatric distress' was related to a number of factors, including women's illiteracy, polygamy and physical abuse, most of which are amenable to intervention. It is the authors' opinion that women's education is a very important factor for the mental health of this population. In 2006, mental illnesses contributed 0.2% of the total mortality, according to the Ministry of Health (no further details were given).

General health services

In 2005 the health expenditure per capita was US\$58. This is very low in comparison with the UK (where the health expenditure per capita was US\$2900 in 2005). The Ministry of Health budget was 1.4% of the government budget in 2005.

With respect to human resources, in 2006 there were 78 196 physicians, 27 636 dentists and 54 855 qualified nurses and midwives. The overall provision per 10 000 population of physicians, dentists and nursing and midwifery personnel was 14.8, 7.4 and 18.8, respectively.

The health system is based on primary care and is delivered at three levels: village, district and provincial.

Mental health services

Currently there are 65 psychiatrists and 40 psychiatric residents in the whole country.

Public sector

General adult psychiatry is the main specialty in Syria. Three different government ministries – Health, Defence and Higher Education (Damascus University) – provide this service.

The Ministry of Health runs the two main psychiatric hospitals:

- There are 800 beds at Ibn Sina Hospital, in Damascus, distributed over 18 wards, of which 600 are for male patients and 200 for female patients. Approximately 100 of these patients are under legal confinement.

- Ibn Khaldoun Hospital, in Aleppo, has 400 beds, 250 of which are for male patients and 150 for female patients.

In addition, there is a 30-bed addiction treatment centre in Damascus, with three psychiatrists, three psychotherapists and two social workers, who provide the service and supervise trainees. The Ministry of Health also runs community psychiatric out-patient clinics, which operate in nearly every big city in Syria; there are four such clinics in Damascus. They are run by trained psychiatrists and offer consultations and medical interventions but no psychological input.

The Ministry of Defence service includes two military general hospitals that have mental health departments. The biggest is Tishreen Hospital, with a 40-bed department.

The Ministry of Higher Education runs Damascus University Hospital (Al-Moassat Hospital), which has a psychiatric ward with 12 beds for the purpose of undergraduate and post-graduate training.

Specialist services

There are special foundations attached to the Ministry of Work and Social Affairs that provide treatment and rehabilitation for patients with intellectual disability. Child and adolescent psychiatric services are provided through non-governmental organisations and the above foundations. They deal with patients suffering from intellectual disability, autistic spectrum and other behavioural disorders. These foundations have clinical freedom and a lot of government support. They offer treatment and support to patients and their families under supervision of licensed psychiatrists and psychologists.

The private sector

While there is a private health system, there is currently limited private health insurance and so most patients who choose to be treated privately pay for their healthcare out of their own funds.

Private hospitals

There are only two private hospitals and both are in Damascus. They offer acute admission, as well as long-stay and out-patient clinics. Medical treatment and some psychotherapy are available. The larger is Al-Basheer Hospital, with 50 beds; the other is a recently established day hospital for adults, which also incorporates a special centre for autistic children.

A hot-line has been set up with the help of the private sector to offer free consultations and advice to people with mental health issues.

Private clinics

There are 65 private clinics in Syria; most (45 clinics) are in Damascus, and 10 are in Aleppo; the other 10 clinics are located in the other big cities, for instance Homs. The main specialty of these clinics is general adult psychiatry. There are only two child and adolescent psychiatrists in Syria.

Mental health policies and legislation

The rules governing mental health and psychiatric treatment in the Syrian Arab Republic are derived from the health legislation issued in 1981 by the Ministry of Health. Currently, a draft Mental Health Act is under discussion.

In 2001 the Ministry of Health established a Psychiatric Directorate to improve and develop services.

Admitting a patient to a psychiatric hospital is done either informally or under a court order.

A responsible psychiatrist or a family member can raise concern about a patient's mental state. Following a referral, a committee of three psychiatrists will decide whether an informal admission is appropriate. After the patient has been in hospital for 1 week, another assessment by the same committee is done to validate the decision and the management plan.

If a patient refuses informal admission, she or he must be assessed by a psychiatrist in the community, who will then submit a report to a court. The judge may order an assessment by a general forensic doctor (there are no forensic psychiatrists in Syria). If the doctor decides to admit the patient, the committee of three psychiatrists decides the management plan.

If a patient commits an offence, a court may order an assessment by a special committee and if the patient is found to be mentally ill she or he will be detained in a high-security unit.

Professional bodies

Most of the 65 Syrian psychiatrists are members of the Syrian Psychiatric Association, which was established in 1996. Psychiatric residents can have honorary membership. The Association has an important role in medical education and training, by arranging conferences and lectures.

Training

Undergraduate training

Medical students have formal training in psychiatry as part of the syllabus for internal medicine. It includes lectures and clinical training during the fourth and fifth year (4 weeks each).

Psychiatrists

There are three different training schemes attached to the three ministries that provide the services (see above), with a total of 40 psychiatric residents.

Each scheme is a 4-year programme and at the end of it the doctor is granted either a masters degree in general adult psychiatry (Damascus University scheme) or a certificate to practise general adult psychiatry. The curriculum includes general adult psychiatry, addiction treatment and a compulsory 6 months in neurology.

There is a proposal for a temporary, instead of permanent, licence for psychiatrists, to be renewed every year, to ensure that high standards are maintained in clinical practice.

Psychiatric nurses

There are no psychiatric nurses in Syria, but instead general nurses with psychiatric experience. The Ministry of Health has acknowledged this problem and now psychiatric nursing is part of the nursing curriculum.

Psychology and psychotherapy

The Faculty of Education and Psychology in Damascus University is currently running 4-year courses to train students in social and psychological specialties. Students obtain a diploma in social counselling or a diploma in psychological counselling. Students can take a higher degree in clinical psychology and get a masters degree in cognitive-behavioural therapy.

Syria has very few psychodynamic psychotherapists; most of those there are have trained abroad. Other forms of psychotherapy (solution focus therapy, cognitive-behavioural therapy, behavioural therapy, art therapy, music therapy and so on) are not practised.

Research in psychiatry

Despite the existence of a few research projects, it is very rare for any of the results to be published. Every masters student in psychiatry is expected to conduct and produce a research thesis.

The future

The government is trying to develop modern psychiatric care by encouraging the establishment of more community-based services and smaller centres, and in addition involving the private sector more in the delivery of services. Syria is opening its market to some private insurance companies, and this may have a beneficial effect on service development.

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European Psychiatric Association – new name for the Association of European Psychiatrists (AEP)

The Extraordinary General Assembly held in Nice on 7 April 2008, during the 16th European Congress of Psychiatry, brought about important changes to the Association's statutes and future, notably the new name: the European Psychiatric Association (EPA) (Arbeitsgemeinschaft Europäischer Psychiater, Association Européenne de Psychiatrie). This change is motivated by the wish to be in harmony with the name of European and international partners and with the title of the European Congress. The EPA still represents individual members and corporate bodies, while highlighting the European level of the Association.

Slovenia

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Slovenia, with an area of 20 000 km² and a population of 2 million, is one of the smallest members of the European Union. It gained its independence from Yugoslavia in 1991. The country has a gross domestic product (GDP) of US\$27 300 per capita. (Largely because of its historical links with Western Europe, Slovenia has a higher GDP compared with other countries in transition in Central Europe.) The health budget represents 8.4% of GDP. Slovenia has a low birth rate and an ageing population. It is divided into 210 municipalities; however, the reorganisation of government into several separate regions with more administrative and economic autonomy is in progress. The prevalence of mental illness is comparable to that in other European countries, although there are high levels of alcoholism and suicide.

Mental health policy and legislation

Slovenia is a democratic country with a parliamentary form of government. The government must generally endorse all healthcare reforms before they are implemented. The Law of Healthcare and Health Insurance presents the basis for compulsory and voluntary health insurance and also allows for the privatisation of healthcare. The Health Insurance Institute of Slovenia is a public non-profit institution, which is overseen by the state and is bound by the Law on Compulsory Health Insurance. Ministries, government agencies and offices have an administrative and regulatory function and are also responsible for the development of health policy, preventive programmes and health promotion. The state is also the owner and director of public health institutions, such as hospitals and clinics.

Currently the National Programme for Mental Health is in the process of being passed in parliament, as is the new Law on Mental Health. Until now, the provisions of the Non-contentious Procedure Act from 1999 have been used, but these are not in accordance with the constitution. The new Law on Mental Health establishes a network of implementers of mental health programmes and services, defines the rights of people in the network (including the right to a representative or lawyer), establishes the conditions and manner of the appointment of representatives, coordinators of supervisory proceedings and coordinators of services, and regulates the procedure for voluntary or involuntary admission to a psychiatric hospital or social welfare institution. It also contains an innovation, the supervision of patients with psychiatric disturbances in their local

community. This would mainly hold true for patients with severe psychiatric disturbances.

Mental health service delivery

The healthcare system and mental health service delivery are both defined by the Law on Medical Services. Mental health institutions are part of the public health network; there are no private psychiatric hospitals or centres for long-term care in the country. Only community care is private, with the majority of providers having contracts with the Health Insurance Institute. Access to psychiatric services is available to everyone and it is paid for by the Health Insurance Institute with funds from compulsory health insurance.

Real deinstitutionalisation of psychiatry has never been achieved in Slovenia. There are four general psychiatric hospitals, one psychiatric clinic and one department of a university clinical centre. This provision amounts to 0.85 beds/1000 inhabitants, which includes beds occupied by patients under compulsory and forensic care. There are 5.4 psychiatrists per 100 000 inhabitants and 5.8 psychiatric nurses per 100 000 inhabitants, who are mainly employed in psychiatric hospitals. Within the Psychiatric Clinic and the University Clinical Centre there are two departments of child and adolescent psychiatry, while another department of child psychiatry is located at the Children's Hospital. In Slovenia there are 24 specialists in child and adolescent psychiatry.

Adults with special needs or those with severe and chronic mental disorders are treated in five institutions, which are partly financed by health insurance funds and partly from social welfare.

Community psychiatric treatment is provided by psychiatrists who are otherwise employed in psychiatric hospitals, by those in health centres and by private psychiatrists who have contracts with the Health Insurance Institute. There are community care facilities for patients with mental disorders, but a broader system of community mental health has not yet been developed. Psychiatric hospitals and clinics provide professional support and education for those employed in non-government organisations, which are active in rehabilitation, the integration of patients into society, counselling and other forms of assistance, and also play an active role in anti-stigma programmes. Within their framework there are 44 residential groups, 22 day centres and 14 information offices.

Slovenia also has specific programmes for the mental health of minorities, refugees, the elderly and children. Educational programmes are run for general practitioners, and teachers, school counsellors and others for the recognition of suicidal tendencies.

Psychiatric training

In Slovenia there are two medical faculties. Medical studies last 6 years. One faculty is linked to the Psychiatric Clinic in Ljubljana, the other to the Psychiatric Department of the University Clinical Centre in Maribor. After completion of studies and a 1-year internship it is possible to specialise in psychiatry.

The Medical Chamber of Slovenia is responsible for specialisation, licensing, issuing a code of medical ethics and supervising clinical practice. Membership of the Medical Chamber is compulsory for all professionals. A call for applications for specialisation in all fields is made by the Medical Chamber twice a year, according to national needs. Annually there are on average advertisements for 15 vacant positions for specialisation in psychiatry, but the positions remain unfilled because of the severe shortage of doctors throughout the country. Training for specialisation in psychiatry lasts 5 years, as does training in child and adolescent psychiatry. Both specialisations have a common 2-year programme, after which they differ.

Psychiatric sub-specialties and allied professions

Psychotherapy is only partly included in the specialisation programme (4 months); a longer period of psychotherapy training is not compulsory. The specialisation in clinical psychology lasts 4 years, and is advertised by the Ministry of Health. There is no special specialisation for psychiatric nurses, but only additional education, which is run by the two university psychiatric institutions with the assistance of the Nursing Chamber of Slovenia.

Main areas of research

Slovenian psychiatry is rather underdeveloped in the area of research. Only one professional psychiatric journal is published, and this does not have an impact factor. There is no research institute in the field of psychiatry in the country; hence research is left to interested and highly motivated professionals.

The Institute of Public Health of the Republic of Slovenia has carried out research in the field of suicide. Slovenia has one of the highest suicide rates in the world, with 22.7 suicides per 100 000 inhabitants per year. The suicide rate has, though, declined since 1992, when it was 28.9 per 100 000 population. There is a higher suicide rate among

men (38.2 per 100 000 population) than among women (9.19 per 100 000 population). Most alarming is the extremely high suicide rate in the over-65 age group, of 48.45 per 100 000, with the rate in males reaching 94.85/100 000 population. This places Slovenia foremost globally for suicides among the elderly.

Other research is being carried out in the field of pharmacogenetics, in collaboration with faculty institutions, and into cognitive functions in some severe physical illnesses.

Workforce issues, resources

There is still too little employment in the field of psychiatry. There is a shortage of doctors in Slovenia and despite increased enrolment in the medical faculties no increase in the number of doctors or psychiatrists can be expected until 2015. The employment of psychologists, psychiatric nurses, occupational therapists and social workers is dependent on the budget of each institution. Perhaps part of the problem will be solved by increased privatisation in health, especially in community care. Private psychiatrists can choose between patients, as they have long waiting lists; this places a heavy burden of patient management onto hospital psychiatrists, who run a 24-hour emergency service. The new national health programme envisages larger work obligations for private psychiatrists.

Human rights issues

Slovenia has a human rights ombudsman, whose office intensively oversees human rights, especially in psychiatric hospitals and prisons. In parliament, a new law on patients' rights was approved in April this year. This introduces more ombudsmen for patients' rights throughout the country (previously there had been only one). Also in parliament, a new Mental Health Act is awaiting approval. This will introduce a national plan on mental healthcare, and reform psychiatric services towards a more community-oriented approach.

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UN Convention on the Rights of Persons with Disabilities

The UN Convention on the Rights of Persons with Disabilities came into force on 3 May 2008. The Convention was adopted by the UN General Assembly on 13 December 2006, and was opened for signature and ratification on 30 March 2007. It has been signed by 127 countries and ratified by 25. The Convention asserts the rights of an estimated 650 million people with disabilities to education, health, work, adequate living conditions, freedom of movement and freedom from violence and exploitation. Of particular significance for people with intellectual disabilities and people with mental health disabilities is that the Convention provides the right to equal recognition before the law and obliges governments to establish support mechanisms for people who need assistance in making decisions. It also provides the right to live in the community and the right to vote, without exceptions. The Convention's Optional Protocol, which has been binding since 3 May, allows individuals to petition an international expert body with grievances.

The Mental Disability Advocacy Center (MDAC) has been campaigning for ratification of the Convention and calls on national authorities in European member states to do so as soon as possible. For further details on how you can contribute to this effort please visit the MDAC website, <http://www.mdac.info>, and join the 'Ratify Now' campaign.

What factors are associated with the presence of mental health legislation? A cross-national study

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The *World Health Report 2001*, dedicated to mental health, identified several important factors for improving mental health services (World Health Organization, 2001): the policy and legislative framework; community mental health services; provision of mental healthcare within primary care; human resources; public education; links with other sectors; and monitoring and research. Moreover, national mental health policies and national implementation programmes for these policies are vital for the improvement of mental health services (World Health Organization, 2004; Jacob *et al*, 2007).

Mental health legislation is an important driver in facilitating implementation of national mental health policies (Saxena *et al*, 2007). It is also important for the protection of basic human and civil rights of vulnerable people with mental disorders, particularly those who receive involuntary treatment (Saxena *et al*, 2007). People with mental disorders not infrequently experience abuse of their human rights and many countries have reported violation of the human rights of such individuals (Jacob *et al*, 2007).

Between 70% and 78% of all countries are thought to have formal mental health legislation (Saxena *et al*, 2007; Jacob *et al*, 2007), but low- and middle-income countries are significantly less likely to do so (Jacob *et al*, 2007). Therefore, this cross-national study was designed to examine two unidirectional hypotheses:

- socio-economic status, healthcare and mental healthcare expenditure and national mental health policy will be associated with the presence of mental health legislation
- measures of mental health service delivery will be associated with the presence of mental health legislation.

Methods

Data on the presence of mental health legislation and parameters of national policy on mental health (items A1–5 in Table 1), mental healthcare funding (item B4 in Table 1) and mental health service provision (items C1–10 in Table 1) were ascertained from the *Mental Health Atlas 2005*, published by the World Health Organization (http://www.who.int/mental_health/evidence/mhatlas05/en/index.html). The World Health Organization's website (<http://www.who.int/countries/en/>) also provided data on the gross domestic product (GDP), the proportion of GDP spent on health and

per capita expenditure on health (items B1–3 in Table 1) for the year 2002. Gross domestic product was used as a measure of socio-economic status.

The relationships between the presence of mental health legislation and measures of national policy on mental health, socio-economic status, healthcare and mental healthcare funding, and mental health service provision were examined with the Mann–Whitney *U*-test (for continuous variables) and the chi-square test (for categorical variables).

Results

A total of 192 countries were listed on the website. Mental health legislation was present for 147 (81%) of the 181 countries with available data. Data on the different measured parameters were available for a median (range) of 178 (97–181) countries. Except for percentage of the total health budget spent on mental health ($n=97$), data on all other parameters were available for at least 158 countries (87%).

Table 1 shows the relationship between the presence of mental health legislation and measures of national policy on mental health, socio-economic status, healthcare and mental healthcare funding, and mental health service provision. The presence of mental health legislation was *not* associated with any measure of national mental health policy, nor with some measures of mental health service provision, including mental health being part of primary care system and the availability of mental health training to professionals in primary care. The presence of mental health legislation was significantly associated with higher GDP, a higher proportion of GDP spent on health, higher per capita health expenditure, a higher proportion of the total health budget spent on mental health, the availability of acute treatment for severe mental illness in primary care, the availability of community care for mental health, involvement of non-governmental organisations in mental health, and higher total numbers of psychiatric beds, psychiatrists, psychiatric nurses, psychologists and social workers per 10 000 population.

Discussion

Some methodological issues need consideration. Data on the presence of mental health legislation and measures of

Table 1 The relationship between the presence of mental health legislation and mental health policy, socio-economic status (GDP), health funding and markers of service provision

Variable	Statistic ^a	Sample size
A. National policy on mental health		
1. Presence of a national mental health policy	NS	181
2. Presence of a national mental health programme	NS	181
3. Presence of mental health information-gathering system	NS	177
4. Presence of substance misuse policy	NS	178
5. Presence of national therapeutic drug policy and essential list of drugs	NS	180
B. Socio-economic status and health funding		
1. GDP	$Z = -2.17, P = 0.03$	181
2. Proportion of GDP spent on health	$Z = -2.9, P = 0.04$	181
3. Per capita health expenditure	$Z = -2.8, P = 0.005$	181
4. Percentage of the total health budget spent on mental health	$Z = -3.19, P = 0.001$	97
C. Mental health service provision		
1. Mental health being part of primary care system	NS	179
2. Availability of acute treatment for severe mental disorders in primary care	$\chi^2 = 4.46, 1 \text{ d.f.}, P = 0.035$	178
3. Availability of mental health training to professionals in primary care	NS	179
4. Availability of community care for mental health	$\chi^2 = 10.5, 1 \text{ d.f.}, P = 0.001$	180
5. Involvement of non-governmental organisations in mental health	$\chi^2 = 4.09, 1 \text{ d.f.}, P = 0.043$	178
6. Total number of psychiatric beds per 10 000 population	$Z = -3.6, P < 0.0001$	177
7. Number of psychiatrists per 10 000 population	$Z = -2.7, P = 0.007$	178
8. Number of psychiatric nurses per 10 000 population	$Z = -2.9, P = 0.004$	170
9. Number of psychologists per 10 000 population	$Z = -2.8, P = 0.005$	168
10. Number of social workers per 10 000 population	$Z = -2.8, P = 0.005$	158

Items A1–5, and C1–5 were categorical variables. Items B1–4 and C6–10 were continuous variables.

^aMann–Whitney *U*-test *Z* and *P* values and chi-square values are given.

national policy on mental health, socio-economic status, healthcare and mental healthcare funding, and mental health service provision should be viewed cautiously because: data were not available from some countries; the validity of the data is unclear; some countries may have poor registration facilities for data on health-related measures; some countries may have poor infrastructure for providing accurate financial data; and the mere presence of mental health legislation is likely to be less important than the content and quality of the legislation and its actual implementation. However, the entire data-set was the best and the latest available from the World Health Organization, and there is other evidence confirming the validity of the data (Shah & Bhat, 2008). Caution should also be exercised in drawing conclusions about the direction of the causal relationship between the presence of mental health legislation and any of the measured variables from this cross-sectional ecological study. Nevertheless, both the study hypotheses were confirmed.

The finding that countries with mental health legislation had higher GDP is consistent with previous reports of an association between absence of such legislation and low- and middle-income countries (Jacob *et al*, 2007; Saxena *et al*, 2007). Wealthier countries have been reported to spend a higher proportion of GDP on healthcare, have higher per capita health expenditure, and spend a higher percentage of the healthcare budget on mental health (Shah, 2007; Jacob *et al*, 2007). Countries with higher healthcare and mental healthcare budgets are more likely to have national mental health policies and implementation programmes for these policies (Jacob *et al*, 2007; Shah & Bhat, 2008). In turn, countries with national mental health policies and implementation programmes for these policies may be more likely to have mental health legislation.

Mental health legislation can be successful only if the content and quality of the legislation are appropriate (Saxena *et al*, 2007), legislation is actually implemented and enforced (Saxena *et al*, 2007; Jacob *et al*, 2007) and the implementation of legislation is supported by an adequate mental health service infrastructure. In a lot of countries, mental health legislation is many years old and may not be appropriate for contemporary use (Saxena *et al*, 2007). There are examples of countries where mental health legislation is not implemented in a systematic manner, and consequently the legislation is ineffective and inefficient (Jacob *et al*, 2007). In the current study, countries with mental health legislation, compared with those without, were more likely to have acute treatment for severe mental illness in primary care, community care for mental health, involvement of non-governmental organisations in mental health, and higher total numbers of psychiatric beds, psychiatrists, psychiatric nurses, psychologists and social workers per 10 000 population. This suggests that countries with mental health legislation, compared with those without, were more likely to have better resourced mental health services. Moreover, this is more likely to occur in wealthier countries because high-income countries spend more on healthcare and mental healthcare, and they are more likely to have national mental health policies and implementation programmes for these policies (Shah, 2007; Saxena *et al*, 2007; Jacob *et al*, 2007). A positive correlation between mental health service provision and healthcare expenditure and presence of national mental health policies has previously been observed (Shah, 2007; Saxena *et al*, 2007; Jacob *et al*, 2007).

The challenge for international organisations, including the World Health Organization, the World Psychiatric Association and the World Bank, and for national governments is

to encourage fair and equitable mental healthcare budgetary provision and the development of national mental health policies, including mental health legislation, with effective national implementation programmes in low- and middle-income countries. Otherwise, vulnerable patients with mental disorders will continue to suffer in silence, without the protection of their human and civil rights to receive mental healthcare free of discrimination, ill-treatment and abuse. This challenge has recently been taken up by the *Lancet*, which launched a new movement for mental health (Horton, 2007), supported by a series of outstanding articles (e.g. Jacob *et al*, 2007; Saxena *et al*, 2007; Patel *et al*, 2007; Saraceno *et al*, 2007).

The current findings also suggest further avenues for research. Does the mere presence of mental health legislation ensure protection of the rights of patients? Is mental health legislation implemented correctly? Is the legislation followed and monitored adequately? Evidence gathered by the Mental Health Act Commission in England and Wales suggests that without constant vigilance by the state, mental health service providers fail to implement legislation appropriately (Mental Health Act Commission, 2006, 2008). This may also be true in other countries; clearer understanding of the way legislation is implemented would be of assistance to countries with and without adequate legislation.

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ORIGINAL ARTICLE

Comparison of risperidone, olanzapine and quetiapine: effects on body weight, serum blood glucose and prolactin

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Schizophrenia is a chronic illness with a lifetime prevalence of 1% and with serious physical, social and economic consequences. Over the past decade, atypical antipsychotic medications have become the first-line treatment for schizophrenia (Breier *et al*, 2005).

The extensive use of atypical antipsychotics is based on their clinical efficacy (for both positive and negative symptoms) and lesser side-effects (e.g. extrapyramidal symptoms) compared with conventional antipsychotics. However, the unique pharmacodynamic profiles and accumulating evidence suggest that these agents, particularly olanzapine and risperidone, do have certain side-effects, including weight gain and elevated blood glucose and serum

prolactin levels. These side-effects are a burden to patients and may affect adherence to treatment. The prescribing clinician has to weigh up the risks and benefits of a particular antipsychotic in an individual case.

There is a growing concern about the metabolic syndrome and its complications with the long-term use of at least some of the atypical drugs (American Diabetes Association, 2004). Weight gain, high levels of cholesterol and high blood glucose concentrations are part of the metabolic syndrome. These factors increase the risk for diabetes mellitus and are a risk factor for coronary heart disease (Straker *et al*, 2005). Before the introduction of atypical antipsychotics, prolactin elevation was an inevitable risk of treatment with antipsychotics.

Prolactin elevation is less of a concern with some of the atypical agents. The exception is risperidone, which results in prolactin elevations that are similar to those associated with first-generation antipsychotics (Allison *et al*, 1999).

The present study was designed to determine whether three atypical antipsychotics, risperidone, olanzapine and quetiapine, differ from each other in their effects on body weight and blood glucose and serum prolactin levels.

Methods

This randomised clinical trial was conducted at the out-patient Department of Psychiatry, Sir Ganga Ram Hospital and the Free Psychiatric Clinic at Ahbab Hospital, Ravi Road, Lahore, Pakistan. The study protocol was carried out in accordance with the Declaration of Helsinki.

One hundred and twenty drug-naïve patients aged between 18 and 58 years who had schizophrenia, diagnosed according to DSM-IV-TR criteria, were eligible after they had given their informed consent. Patients with a total score on the Positive and Negative Symptoms Scale (PANSS) of 60 or more were included. Those with serious physical or neurological illnesses were excluded.

Patients were randomly allocated to receive risperidone ($n = 40$), olanzapine ($n = 40$) or quetiapine ($n = 40$). Dosing was flexible: risperidone, 1–6 mg/day; olanzapine, 5–20 mg/day; and quetiapine, 100–600 mg/day. Doses were adjusted for each patient to achieve maximum efficacy with minimum adverse effects. Each drug was administered twice daily for up to 90 days. The only concomitant medication allowed during the study period was lorazepam (≤ 4 mg/day).

Age, gender, marital status, education and family history of psychiatric disorder were recorded for each patient. Duration of illness ranged from 6 months to 4 years. Patients' body weight, blood glucose and serum prolactin levels were recorded at baseline, and at 15, 30, 60 and 90 days of taking antipsychotic medication. Blood was obtained approximately 12 hours after the last dose. Assessments based on the PANSS were conducted at baseline and 90 days after random assignment to treatment.

Results

The sample comprised 83 men (69%) and 37 women (31%). Their mean (s.d.) age was 35.4 (9.6) years and their mean (s.d.) duration of illness was 24.9 (11.3) months. Sixty-one patients (51%) reported a family history of psychiatric illness. Mean (s.d.) doses of drugs were: 4.2 (1.1) mg risperidone, 16.9 (3.7) mg olanzapine and 342.8 (135.9) mg quetiapine. There were seven drop-outs in the risperidone group, three in the olanzapine group and one in the quetiapine group.

Olanzapine-treated patients had a significant increase in body weight and blood glucose level compared with those on risperidone or quetiapine. Risperidone-treated patients had a raised serum prolactin level compared with those on olanzapine or quetiapine. The results are given in Table 1.

The groups were matched at baseline. After 90 days, a significant decrease in PANSS score was observed in the risperidone group, to a mean of 35.7 (6.4), followed by the

Table 1 Side-effect profiles of the three atypical drugs

	Stage	Mean	s.d.
Risperidone ($n = 33$)			
Body weight (kg)	Baseline	69.0	9.5
	90 days	70.7*	9.5
Blood glucose (mg/dl)	Baseline	114.9	27.2
	90 days	118.0	19.1
Serum prolactin (ng/dl)	Baseline	16.6	8.3
	90 days	49.3*	24.5
Olanzapine ($n = 37$)			
Body weight (kg)	Baseline	70.1	8.5
	90 days	72.4*	8.6
Blood glucose (mg/dl)	Baseline	123.3	29.9
	90 days	166.6*	53.2
Serum prolactin (ng/dl)	Baseline	14.0	6.0
	90 days	14.9*	6.0
Quetiapine ($n = 39$)			
Body weight (kg)	Baseline	64.7	8.7
	90 days	65.4*	8.7
Blood glucose (mg/dl)	Baseline	114.4	19.3
	90 days	115.0	18.6
Serum prolactin (ng/dl)	Baseline	12.6	6.4
	90 days	13.5*	6.6

* $P < 0.05$ for inter-group comparisons (see text).

olanzapine group, to a mean of 41.5 (6.3), and quetiapine group, to a mean of 41.9 (5.7) (Table 2).

Discussion

In a systematic review (Taylor & McAskil, 2000), it was found that the risk of increase in body weight associated with olanzapine, quetiapine and risperidone was 14–27% at 6–8 weeks and as high as 40% by 3.5 years. But there was a lack of direct long-term comparisons. However, Bryden & Kopala (1999) suggest that the risk of weight gain is greatest with olanzapine, probably intermediate with risperidone and low with quetiapine, which is similar to the current study.

In a study by Gupta *et al* (2004) it was notable that weight declined when patients were switched from olanzapine to quetiapine after they had gained more than 20% of their weight during olanzapine treatment. In that 10-week study, 12 patients lost a mean of 2.25 kg.

A trial comparing clozapine, olanzapine, risperidone and haloperidol found similar results as the current study for olanzapine and risperidone regarding elevation of blood glucose levels. Clozapine and haloperidol were associated with significantly elevated mean glucose levels after 8 weeks of treatment compared with risperidone. Changes in glucose levels were independent of weight increase in all four treatment groups; significant weight gain was observed in olanzapine-treated patients, followed by clozapine- and risperidone-treated patients (Gupta *et al*, 2004).

Table 2 PANSS scores in the three groups

Groups	Baseline		90 days	
	Mean	s.d.	Mean	s.d.
Quetiapine ($n = 39$)	61.0	4.1	41.9	5.7
Risperidone ($n = 33$)	66.2	5.3	35.7	6.5
Olanzapine ($n = 37$)	64.6	4.8	41.5	6.3

$P < 0.05$ for both the decrease over time in all three groups.

The current study found that risperidone gave a greater overall reduction of scores on PANSS at 90 days than did either olanzapine or quetiapine (see also Lindenmayer *et al*, 2003).

A double-blind comparison of olanzapine and quetiapine in the treatment of patients with schizophrenia and schizoaffective disorder showed that both medications improved symptoms, with similar response rates. Olanzapine appeared to be better than quetiapine on overall PANSS response, while quetiapine was significantly better than olanzapine on the disorientation scale only. In terms of side-effects, quetiapine appeared to have a lesser effect on prolactin levels. Both medications caused weight gain (Svesta *et al*, 2003).

Another study has compared olanzapine with risperidone in relation to serum prolactin levels. A significantly lower proportion of patients receiving olanzapine experienced an elevation above standard reference ranges in prolactin concentration (51.2% v. 94.4%) (Tran *et al*, 1997). The present study found a similar trend.

One study showed that both olanzapine and risperidone were effective, but with olanzapine apparently significantly more effective. Both medications were associated with a 2 kg weight gain during the course of the study (Svesta *et al*, 2003). These results are in line with those of the current study.

The current study also found at 90 days a 46% reduction in PANSS score with risperidone, compared with 36% with olanzapine. An 8-week study randomly allocated patients to quetiapine (400–800 mg/day), olanzapine (10–20 mg/day) or risperidone (4–8 mg/day). The quetiapine group had a 31% improvement in PANSS score, while the olanzapine group had a 25% improvement and the risperidone group a 21% improvement. Weight gain was more prominent with olanzapine: 36% of the patients had a weight gain of > 5% from baseline, compared with 17% of the risperidone patients and

13% of the quetiapine patients (Sachetti *et al*, 2003). The present study had similar results.

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ORIGINAL PAPER

Use of herbal medications among out-patients in a psychiatry clinic in Sri Lanka

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The use of complementary and alternative medicine is increasing among psychiatric populations. Herbal medications are a form of alternative and complementary medicine whose use has increased over the last decade. Two studies done among Western out-patient groups have reported rates of use of herbal medicine at 15% ('current use'; Matthews *et al*, 2003) and 24% (Knaudt *et al*, 1999).

Eastern cultures have a long tradition of using herbal medicines for a variety of conditions and people on the Indian subcontinent, for example, seem to be very familiar with

them. Concomitant use of herbal and Western medications is commonly observed even in the West. Herbal preparations contain biologically active components, with unique side-effect profiles (Matthews *et al*, 2003). There have been reports of clinically significant interactions between herbs and Western medications (Fugh-Berman, 2000). In a US study of patients who used alternative therapies, only 38.5% had discussed this with their physician (Eisenberg *et al*, 1998).

However, there is limited information available on the prevalence of use of herbal medications, the types of plants

Table 1 Prevalence of use of herbal medications by diagnosis

Diagnosis	Total number of patients	Number who had previously used herbal medications	Number currently using herbal medications
Depressive disorder	29	14	5
Bipolar affective disorder	13	4	1
Schizophrenia	18	3	1
Neurotic/stress related	3	2	1
Dementia	5	2	1
Delusional disorder/acute psychotic disorder	7	2	1
Substance use disorders	33	3	1
Totals	108	30	11

used or the reasons for their use, especially in low- and middle-income countries. We have carried out a preliminary study among psychiatric out-patients in Sri Lanka.

Methods

The objectives were to determine:

- the prevalence of the use of herbal medicines among psychiatric out-patients
- patients' awareness of possible interactions between herbal and psychotropic medications
- the reasons for the use of such medications
- whether the use of herbal medications had been elicited by medical officers in their assessment of the patients.

We carried out a cross-sectional descriptive preliminary study using a pre-tested interviewer-administered questionnaire. The study participants were 108 consecutive patients who attended the out-patient psychiatric clinic, during 1 week, at the North Colombo Teaching Hospital, Ragama, Sri Lanka.

Patients were interviewed after they had given their written informed consent and after diagnosis according to ICD-10 criteria (World Health Organization, 1992).

Results

Of the 108 out-patients in the sample, 30 (28%) had previously used herbal medicines and 11 (10%) were currently using them. Table 1 gives a breakdown of prevalence by diagnosis.

Of those patients who used herbal medications, 63% were female. Sixty-two per cent had used an oral form of herbal medication, while the rest had used it topically. Seventy-one per cent of these patients did not know the contents or the type of herbal medicine they were using or used, and 68% were not aware that there could be interactions between herbal and psychotropic medications. Table 2 shows the reasons given by the patients for the use of herbal medicine.

Table 2 Reasons for the use of herbal medicine

Reason given by the patient	Percentage
As an adjunct to Western medication	53
Herbal medicines reduce the side-effects of Western medications	62
Accepted by relatives/peers	41
Herbal medications are natural	32
There is a better understanding how herbal medicines act	25
No response to Western medications	11

Fifty-nine per cent of this patient group had not told their psychiatrist about the use of herbal medication, and 69% indicated that their psychiatrist had not asked them about the use of herbal medications.

Discussion

In our study, 28% of the out-patient sample had used herbal medicines at some point during their experience of mental disorder, while 10% were currently using them. The figures are somewhat lower than the proportions reported in studies among psychiatric out-patients in the West, although the general assumption is that in Eastern cultures people tend to use more complementary medicine than in the West. In our survey about a fifth of patients with affective disorders had used herbal medications. A study done in the USA demonstrated that the majority of patients with self-defined anxiety or severe depression used some form of complementary or alternative therapy (Kessler *et al*, 2001). However, our sample size was too small for any firm conclusion to be drawn regarding type of diagnosis and use of herbal medications.

The herbal medications used typically include St John's Wort for depression (Kessler *et al*, 2001), kava kava (Kessler *et al*, 2001) for mild anxiety, valerian (Werneke *et al*, 2006) as a sedative and *Gingko biloba* (Werneke *et al*, 2006) as a cognitive enhancer.

In our study, a majority of the patients did not know that there can be interactions between herbal and psychotropic medications. Of those taking herbal medicines, 53% had used them as an adjunct to Western medication and 62% to reduce the side-effects of Western medications. Lack of awareness of the nature of the herbal medications can have deleterious consequences; for instance, some ingredients such as cannabis can precipitate or induce psychiatric problems. There are reports that Sri Lankan Ayurvedic preparations contain cannabis (Liyanage, 2004) and other psychoactive compounds, such as opioids (Government of Sri Lanka, 2007). The traditional Ayurveda and Unani-Tibbi medicine systems have used opium and cannabis as therapeutic agents for centuries (Dwarakanth, 1965).

Fifty-nine per cent of the patients had not told their psychiatrist about the use of herbal medication, and 69% indicated that their psychiatrist had not asked them about their use.

Conclusion

A significant proportion of out-patients with mental disorders had used or were currently using herbal medications. It is important for psychiatrists to ask all patients about the

use of herbal medications and to provide their patients with information about the potentially dangerous interactions between herbal and psychotropic medications. More research is needed into the prevalence of use of herbal medicines, the types of medicine used and drug-herb interactions. Patients' use of alternative therapies, including herbs, should be emphasised more in medical curricula, to increase awareness among medical professionals.

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NEWS AND NOTES

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

RCPsych at the APA meeting in Washington – May 2008

The College held its annual reception, organised by the Pan-American Division, at the meeting of the American Psychiatric Association (APA), on 5 May 2008 at the Marriott Hotel. The President of the College, Sheila Hollins, updated the nearly 100 attendees on the College and psychiatric issues in Britain and Ireland; she went on to introduce her successor, Dinesh Bhugra, as well as Rachel Jenkins, Director of International Affairs, who spoke of the success of College educational efforts in Kenya and Iraq, despite severe poverty and major political problems, and Peter Tyrer, Editor of the *British Journal of Psychiatry*, who spoke of its increased scope and recognition and who ended with a Shakespearean epilogue!

The President of the APA, Carolyn Robinowitz, spoke of her shared passion for advocacy with Sheila Hollins and of the joint presidential symposium on this subject. There was also a joint symposium on education and the Pan-American Division held its seventh annual symposium, with six speakers from the International Divisions of the College, on poverty and mental illness around the world. There were members at the reception from all over the USA, Canada, Jamaica and Venezuela. It was also attended by the President-Elect of the Latin American Psychiatric Association, the Chairs of at least two other International Divisions, the Secretary of the Japanese Psychiatric Association, and many officers, trustees and former Presidents of the APA. It was a great social occasion and an important opportunity for networking and cooperation, which continued with other shared activities.

Anyone interested in next year's symposium at the APA or the Pan-American Division session at the College annual meeting should contact Nigel Bark, Chair, Pan-American Division, on panamericandivision@rcpsych.ac.uk.

Dr Nigel Bark
Chair, Pan-American Division, Royal College of Psychiatrists

Report on the Asian disasters in Myanmar and China

The Cyclone Nargis disaster in Myanmar

Cyclone Nargis (an Urdu word meaning daffodil) developed on 27 April 2008 in the central area of the Bay of Bengal. On 2 May 2008, with peak wind speeds of 215 km/h (135 mph), it moved ashore, leaving a trail of death and massive destruction. The death toll has now reached 100 000, with 56 000 missing, and appears to be increasing. Responding to the disaster, the Asian Federation of Psychiatric Associations (AFPA) and South Asian Forum International joined forces with the Burmese Medical Association of Australia to bring relief and care. We have set up a crisis committee:

- to assist and support the immediate medical care and treatment for all victims
- to support and enhance possible avenues to prevent infectious diseases
- to provide physical and psychological support for the relief workers who are engaged in active disaster relief work
- to facilitate capacity building and resilience promotion, including training of professionals in psychological assessment and mental health issues in recovery from disasters.

On 30 and 31 May 2008 the Asian Disaster Mental Health Network ran a training workshop for Burmese doctors and other professionals and volunteers who will be going to Myanmar to implement phases 2 and 3 of the recovery programme. On 29 August 2008 the Asian Disaster Network will run a symposium on recent Asian disasters at the 13th Psychiatric Congress of the Association of South East Asian Nations (ASAEN) in Bangkok. The Burmese Medical Association of Myanmar is sending a team of experts from the Asian Disaster Network to Myanmar for a series capacity-building activities.

Details for donations to the Burmese Doctors' Relief Fund are as follows:

Bank: CBA Martin Place Sydney Australia
 BSB: 062 000
 Account No: 1164 5054

Earthquake disaster in the Sichuan province of China

More than 50 000 people are estimated to have died in the earthquake which struck Sichuan province on 12 May 2008, China's deadliest natural disaster in a generation. China disclosed that at least 4 million apartments and homes had been damaged or destroyed, leaving almost 5 million people homeless. The Chinese Society of Psychiatry (CSP) and the Asian Disaster Mental Health Network are joining forces to raise funds. The Section on Disaster Intervention of the World Psychiatric Association sent its guidelines on disaster management and minimum standards in mental health management in disasters. Further plans for phased mental health disaster recovery are being developed by the Chinese Society of Psychiatry and the Asian Federation of Psychiatric Associations will participate in this work.

Dr Russell D'Souza
 Chair, Asian Disaster Mental Health Network, AFPA

BPPA Awards 2008

The British Pakistani Psychiatric Association (BPPA) offers a number of awards each year. The Young Researcher of

the Year Award aims to promote an interest in psychiatric research among young Pakistani health professionals and students whose research work, in any sub-specialty or psychiatric field, has been published in any peer-reviewed scientific journal. There are two categories – one for research carried out in Pakistan and the other for research carried out in the UK or Ireland. The winners and runners-up will be entitled to memorial shields and cash rewards equivalent of £250 and £150, respectively.

The Clinical Audit Award offers memorial shields and cash awards of £100 and £50 to the winner and runner-up, respectively. An independent evaluation committee will short-list the six best projects and the short-listed candidates will be invited to present their projects at the 7th Annual Conference of the BPPA on 1–2 November 2008.

The Public Education Award is a new prize for promoting an interest in public education in mental health issues among Pakistani media professionals, artists, health professionals and students.

Further information and nomination forms for any of the above awards may be obtained by emailing secretary@bppauk.org or visiting www.bppauk.org. All nominations must be received by 31 August 2008. The results will be announced by 30 September 2008.

Dr S. H. Jawed
 Chairman, BPPA

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Ethno-psychopharmacology

Sir: We read the article by Pi & Zhu (2007) with interest, as this topic is particularly important to psychiatrists practising in countries like Sri Lanka, where, because of the lack of local prescribing guidelines, the dosing of medication is generally determined by guidelines developed for patients in the West, such as those from the National Institute for Health and Clinical Excellence (NICE) and the *British National Formulary*.

There are reports that Asian people generally require lower doses of psychotropic medications than White people and also that they have a lower threshold for extrapyramidal side-effects (Lin & Finder, 1983). This may be because of genetic and biological variations in pharmacokinetics and pharmacodynamics. Therefore it seems prudent to observe the rule of thumb 'start low and go slow' when prescribing psychotropics, in order to achieve a clinical improvement while avoiding adverse effects.

Self-adjustment of doses of medications is commonly seen among our patients, and that can lead to suboptimal therapeutic responses and more side-effects. Hence it is important to explain treatment decisions and the adjustment of doses.

Another factor which has to be kept in mind is that these patients may also be on concomitant herbal medication. There have been reports that some herbal medications

(particularly Asian herbal mixtures) are contaminated with heavy metals (Ernst & Thompson Coon, 2001). Herbal medications may also be adulterated with prescription drugs or contain misidentified herbal ingredients. The presence of these constituents may alter the pharmacokinetic and pharmacodynamics of psychotropics, leading to toxic effects as well as suboptimal clinical improvement. Patients should be asked about the use of herbal medications, and be educated and cautioned with regard to the possible interactions between herbs and psychotropics.

Therefore, it is important to consider the inter-racial pharmacokinetic and pharmacodynamic differences as well as environmental and cultural factors when determining the dosage of psychotropics for our patients.

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Psychiatry for the person – the view from Asia

Sir: The editorial by George Christodoulou *et al* (2008) on 'Psychiatry for the person' and the response by Jeremy Holmes (2008) have been read with avid interest on this side of the globe. Listening to previous presentations on this topic at Asian meetings of the World Psychiatric Association (WPA), we were often left with a sinking feeling that they resonate well with our work but could be better. For the Institutional Programme on Psychiatry for the Person (IPPP) to succeed, there should be more participation from developing countries. The marketplace of ideas should not be confined to academics in Europe and North America and ignoring the rich experience of clinicians in Chennai, Singapore or Batu Pahat.

Professor Holmes understands that the practice of psychological therapy is different in Asia – the philosophies of Confucius and Lao Tze have immense influence on East Asian psychological therapy. The challenge is how to translate an erudite document in the IPPP into clinical practice, not just for psychiatrists but also for other doctors and medical students. Psychiatry for the person should also be practised at the primary care level; in Singapore two family physicians have crafted an innovative narrative approach in psychological therapy for primary care doctors, focusing on the centrality of personhood (Cheong & Goh, 2008). Psychiatry for the person should not be a hollow catchword and future psychiatrists should not merely be pharmacotherapists, with psychological therapy outsourced to social workers, counsellors and psychologists.

Fortuitously, some of these issues will be discussed in a forthcoming meeting in Singapore on 23–24 February 2009. The TOP (Teachers Of Psychiatry) Conference has the support of the Royal College of Psychiatrists (UK, Western Pacific Division), Pacific Rim College of Psychiatrists and Asian Federation of Psychiatric Associations. This is an open letter to welcome the WPA to participate. Further information on this conference can be obtained from pcmkeh@nus.edu.sg.

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Competency-based training schemes in psychiatry

Sir: At its 2006 annual forum in Riga, the European Federation for Psychiatric Trainees (EFPT) issued its first statement on competency-based training and assessment in psychiatry. The EFPT, which represents national associations of psychiatric trainees from across Europe, is broadly in favour of competency-based training if it improves the standard of psychiatric education and is not overly bureaucratic.

Competency-based training schemes in psychiatry are currently being introduced in Denmark, the Netherlands,

Sweden and the UK, and there are plans for similar changes to training in a number of other European countries. The EFPT believes there are significant opportunities for cross-European collaboration and mutual learning between the countries introducing these changes. The EFPT also very warmly welcomes the decision of the Board of Psychiatry of the Union Européenne des Médecines Spécialistes (UEMS) to set up a working group to look at common competencies in psychiatry required for all specialists working within the European Union (EU), based on the UEMS document 'A profile of a psychiatrist'.

We, as European trainees, believe that well designed, properly funded and wisely implemented reforms that have the potential to improve training will also improve the mental health of Europe. The fact that many EU countries are taking a similar approach and implementing similar changes at the same time also provides a unique opportunity to agree some common standards, to share and develop common assessment tools, and to strengthen the specialty. The adoption of more similar approaches in training and assessment may also facilitate greater cross-EU collaboration and exchange, for example making it far easier for a trainee from one country to spend a period of training in another country if the competencies and means of assessing them are similar.

Ian Soosay

Chairperson, Working Group on Competency-Based Training,
European Federation of Psychiatric Trainees, email r.soosay@ucl.ac.uk

Association of European Psychiatrists (AEP)

Sir: Your readers may be interested to know that the Association of European Psychiatrists (AEP) held its 16th Annual Congress in Nice, France, 5–9 April 2008. There were almost 3000 delegates from 57 countries. The theme was 'Pathways to Integrative Care.'

The AEP Young Psychiatrists Committee also organised a parallel series of high-quality lectures and informal sessions aimed specifically at trainees and young psychiatrists. Among these, Povl Munk-Jørgensen, editor of *Acta Psychiatrica Scandinavica*, provided an informative lecture on getting research published. There were also informal discussions with Professor Wolfgang Fleischhacker on how to embark upon a career in research and Professor Norman Sartorius on mental health issues across Europe. The Committee awarded 15 scholarships to trainees and young psychiatrists from across Europe. These awards enabled enthusiastic trainees and young psychiatrists to attend the conference by providing financial assistance with travel and accommodation. Scholarship winners also received 1 year's free AEP membership and admission to a course for continuing medical education at the Congress.

We look forward to the 17th AEP European Congress of Psychiatry, entitled 'New Diagnostic Approaches in Psychiatry: Relevance for Research and Practice in Europe', which will take place in Lisbon, Portugal, 24–28 January 2009 (see <http://www.kenes.com/aep2009>).

Iris Calliess,¹ Kai Treichel¹ and Alexis Bowers²

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Forthcoming international events

18–23 August 2008

International Mental Health Short Course – Methods & Applications
Institute of Psychiatry, London
Contact: IMH Research Coordinator
Tel: 02078480177
Email: imh@iop.kcl.ac.uk

21–23 August 2008

8th Pan-Arab Conference of Psychiatry: Psychological Consequences of Violence – Evidence-Based Mental Health
Damascus, Syria
Organiser: Syrian Arab Association of Psychiatrists
Contact: Dr. Adib Essali
Email: adib-essali@hotmail.com
Website: <http://www.ebm-syria.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>

26–28 August 2008

4th International Mental Health Conference
Institute of Psychiatry, London
Email: imh@iop.kcl.ac.uk

27–30 August 2008

12th European Symposium on Suicide and Suicidal Behaviour
Glasgow, Scotland
Email: organising@esssb12.org

28–29 August 2008

World Federation for Mental Health International Provider's Forum: Mental Health and Psychosocial Support in Disasters
Institute of Psychiatry, London
Email: imh@iop.kcl.ac.uk

29–31 August 2008

XX Congreso Peruano de Psiquiatria
Lima, Peru
Organiser: Peruvian Psiquiatria Association
Contact: Dr Julio Acha
Email: jacha@terra.com.pe

20–25 September 2008

14th World Congress of Psychiatry
Prague, Czech Republic
Contact: Dr Jiri Raboch
Email: jiri.raboch@lf1.cuni.cz
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/>

29 September– 2 October 2008

XV International Congress of Psychiatry
Buenos Aires, Argentina
Organiser: Argentinean Association of Psychiatrists (AAP)
Contact: Dr Nestor F. Marchant
Email: lcechin@aap.org.ar
Website: <http://www.aap.org.ar>

16–17 October 2008

International Pathways of Investigation in Psychiatry: Psychotherapies, Pharmacotherapies, Combined Treatment
Rome, Italy
Organiser: Psychiatric Sciences Academy & Italian Psychiatric Association
Contact: Deborah Finamore
Email: info@mgacongressi.it

16–19 October 2008

Third Dual Congress on Psychiatry and Neurosciences
Athens, Greece
Organiser: Hellenic Society for the Advancement of Psychiatry and Related Sciences
Contact: Dr Constantine Soldatos
Email: egslelabath@hol.gr

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>

19–22 October 2008

Psychiatry for the Person and Social Transition
Belgrade, Serbia
Organiser: Serbian Psychiatric Association
Contact: Prof. Miroslava Jasovic Gasic; Prof. Dusica Lecic Tosevski
Email: profmjg@eunet.yu; dusica.lecictosevski@eunet.yu
Website: <http://www.application.ups-spa.org>

20–22 October 2008

IEPA 6th International Conference on Early Psychosis
Melbourne, Australia
Contact: IEPA 2008 Conference Secretariat
Email: info@iepa2008.com
Website: <http://www.iepa2008.com>

27–29 October 2008

GCMHP 5th International Conference 'Siege and Mental Health ... Bridges vs. Walls'
Gaza City and Ramallah, Palestine
Organiser: Gaza Community Mental Health Programme (GCMHP)
Contact: Mahmoud Abu Aisha
Email: mahmoud@gcmhp.net
Website: http://www.gcmhp.net/File_files/conference2008/index-conf2k8.htm

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/>

23–24 February 2009

Teachers of Psychiatry (TOP) Conference
Department of Psychological Medicine, National University of Singapore
Supported by the Royal College of Psychiatrists (Western Pacific Division), Pacific Rim College of Psychiatrists and the Asian Federation of Psychiatric Associations.
Contact: Ms Jasmine Tan
Email: pcmnglk@nus.edu.sg

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