

International Psychiatry

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Mission of *International Psychiatry*

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.

The editor's dilemma: assessing papers from low-income countries

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Most scientists are now aware of what has been called the 10:90 divide (Saxena *et al*, 2006): the fact that 90% of the published scientific activity in the world comes from the richest 10% of countries. Many would like to brush off this simple fact as unimportant, but at another level it could be regarded as a scandalous disequilibrium of the planet's resources. One small way of reversing this is for editors to publish more papers from low-income countries and counter what can be described somewhat strongly as editorial racism (Horton, 2003). We have tried to do so in the *British Journal of Psychiatry* (Tyrer, 2005); this paper describes some of the difficulties.

Seven strategies can be identified in the assessment of papers by authors from low-income countries. Not all of them are ones for which we can burst with pride in exposing, but they need to be discussed.

Seven strategies

(1) Positive discrimination

This is a two-edged sword. It allows a sloping playing field to be tilted towards the horizontal but runs the risk of going too far and being unfair to other authors. At its most extreme, it could lead to authors from rich countries who despair of getting any of their work published in good journals recruiting collaborators from low-income ones to improve their political correctness and then get publishing success. So there has to be a balanced form of positive discrimination, one that is seen by all as essentially fair. This is easy to say but difficult to achieve in practice. I will take one example from Ecuador to illustrate this (Incayawar, 2008). Dr Incayawar describes the diagnostic skills of *yachactaitas* (Quichua healers) in the Andes in relation to mental illness. There was an element of positive discrimination in selecting this paper for publication. Our publication rate from Ecuador was previously nil. The country does not have a well-developed mental health service and it is reasonable to look at the ability of *yachactaitas* to buttress any other (rich country) models of service, as it may give some interesting insights into the diagnostic process in psychiatry. However, all editors have also to be aware of the main interests of their readers, and I suspect the ability of *yachactaitas* to diagnose correctly is not especially high on the agendas of most of mine.

(2) Paternalistic rejection

One of the common problems with papers from low-income countries is what is best described as 'lack of savvy', or reduced ability to identify what should be included in a publication emanating from a rich country. Papers representing

this in its most extreme form provoke guffaws and amazement at such naivety and tend to lead to a somewhat patronising response. Although this is couched in language to avoid offence, the response is essentially along the lines of 'It is clear you have no idea of how to write a scientific paper. Your X, Y and Z sections do not conform to journal style, your paper is too long/short, and your references are up the shoot. Go away and come back only when you have learnt how to write a paper properly.' This is a very easy trap to fall into; one of the standard refuges of an editor is to look at the structure without examining the content, and I constantly have to remind myself to do this the other way round.

(3) Capacity building

This is the counter to patronising paternalism. We should be attempting to build research (and publishing) capacity in low-income countries and giving advice that promotes this is the right response. So, if a paper is rejected but is essentially sound, it is often a good idea to invite a resubmission and spell out in much more detail for this group of authors how this should be achieved. This is where our international representatives on the editorial board can be so helpful, as they can provide local knowledge and advice.

(4) Impact factor

The impact factor is measured as the ratio of the number of citations of articles appearing in the 2 years following publication in the relevant journal to the total number of articles published in the relevant year. For 2008, for example, this would be the total number of citations of 2006 and 2007 original papers (not editorials) in 2008 divided by the total paper numbers. Thus, the impact factor of 5.45 for the *British Journal of Psychiatry* in 2007 indicates that the average number of citations in 2007 for each paper published in 2005 and 2006 is just over 5. It is not easy to keep up this level, and the papers published from low-income countries, where journals are few, are much less likely to be cited than papers from rich countries (Patel & Kim, 2007), another form of imbalance, which could be called citation racism.

The paper by Dr Incayawar (2008) is not likely to be cited as often as many others, as it is unlikely that any local journal will be indexed (i.e. be part of the 'inner group' of journals that are recorded for citation purposes) and so many references to it would go unrecorded.

As journal editors are naturally proud of their impact factors, as badges of intellectual virility and success (Howard & Wilkinson, 1998), they do not want to have theirs reduced, and so tend to reject many papers from low-income countries. This is a trend that can be countered by journals becoming more genuinely international in their outlook.

(5) Parochialism

This, the opposite of internationalism, represents the natural, but wrong, tendency to be partial towards familiar and local research. This creates a bias against low-income countries and can be referred to as the 'Chamberlain effect', named after Neville Chamberlain, the British Prime Minister in 1938, who declined to intervene in Hitler's takeover of Czechoslovakia, on the grounds that 'this is a far-away country of which we know little'. We have to realise that no country on this planet can be regarded as too far away.

(6) English language

We are remarkably lucky in the UK that English is now the language of international communication. However, it is a fiendishly difficult language in which to write good scientific papers, and many authors from low-income countries whose main language is not English know this to their peril. It is therefore extremely easy to reject a paper that might otherwise be important on the grounds that it reads badly. Of course, if it is badly written it will not convey the authors' message, but it is right and proper to make some allowance for this in assessing contributions from those who do not have an English ghost writer waiting constantly by their side.

(7) Laziness

This is left to the end because it is linked to all the previous six points. An editor usually has to work harder with authors

from low-income countries than with those from richer ones in order to get their papers to the printed page. If laziness intervenes, it is much easier to press the reject button than to put in the extra effort required. It is always possible to get an editor on a bad day, when the level of work is overwhelming, and under these circumstances the author from a low-income country is at a distinct disadvantage. My advice is to persist despite adversity.

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THEMATIC PAPERS – INTRODUCTION

Child and adolescent psychiatry services in low- and middle-income countries

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The theme in this issue concerns the interface between child psychiatric services in low- and middle-income countries and the availability of such services in higher-income countries. In neither context are such services ideal, and resources are relatively slim when compared with demand. The key issues are discussed in three terms: first, of the need for nations to have a general statement of child and adolescent mental health policy (Shatkin *et al*); second, of the need to establish international child and mental health research networks to foster research in low- and middle-income countries (Erlich & Plener); and third, of the circumstances that exist for providing such support to children in one such country, Pakistan (Khan *et al*).

The major concern of all three sets of contributors is that there are very few countries with policies that address the mental health needs of this client group. Since the Convention on the Rights of the Child was implemented in 1989 by the United Nations, children have had, on paper at least, the opportunity to seek mental health support in all 193 countries that have ratified the agreement. There is a serious lack of resources in many of these countries. We

know from international efforts to investigate the prevalence of mental health problems that they will affect up to one in five children, irrespective of culture. Shatkin *et al* reviewed the provision of services in all participating countries and found that only 35 had any sort of mental health policy for children, and of these only a minority provided good-quality and flexible care. In all cases, child and adolescent psychiatry was subject to the same range of policies as adult psychiatric services, however inappropriate that might be in objective terms. Clearly, the Atlas project, in which they attempted to gain an overview of child mental health provision around the world, is of potentially great value and significance, but it failed to gain adequate relevant information from many countries because there was no statutory authority tasked with collecting or providing it.

There is a need for more epidemiological information about the range and nature of child mental health problems in low- and middle-income countries, and in order to gain such knowledge we need to have more appropriate trained researchers in child psychiatry where those studies are needed. Stefan Ehrlich and Paul Plener describe how they are

aiming to establish websites to assist those working in the field to conduct research, with supervision and advice 'at a distance'. They founded the organisation Young Investigators in Biological Child and Adolescent Psychiatry, in Germany, with the aim of improving communication and collaboration between young psychiatrists starting out in this area of research. They would like to attract child and adolescent psychiatrists from low- and middle-income countries to join their network, although they acknowledge that the priorities of such psychiatrists may be very different to their own. The increasing availability of e-communication offers an exciting and novel way of promoting research in areas of the world where there are few local experts.

Finally, we consider the specific case of Pakistan, where Drs Khan, Shehzad and Chaudhry consider the difficulties in providing child psychiatry services in a country of 169 million people, of whom 40% are under the age of 15 years.

There is no specific allocation of funding in Pakistan to this specialty, and no demarcated pathway by which children can be referred for assessment and intervention. Sadly, children are often admitted to adult psychiatric wards, where there is no particular medical or nursing expertise on how to manage their problems. One hope for the future may be a joint paediatric-psychiatric liaison service, but this has yet to take firm root. They emphasise the urgent need for protocols to assist in the management of children. There is also a potential role for mentoring by 'senior volunteers' from the Royal College of Psychiatrists, in a scheme that is attempting to bring senior professionals in the UK into dialogue with psychiatrists (such as those in Pakistan) who would value a mentor. This application of e-communication has the potential to foster the development of a special interest in managing children's mental health among psychiatrists who have trained in adult psychiatry.

THEMATIC PAPERS – CHILD AND ADOLESCENT PSYCHIATRY SERVICES

Child and adolescent mental health policy worldwide: an update

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Few countries worldwide maintain policies specifically designed to address the mental health needs of children and adolescents. Yet policies are essential to guide the development of systems of care, training programmes for practitioners, and research endeavours. Without policy, there is no clear pathway for programme development, no specific commitment from government, no expression of governance, no guide to support funding, and no clarification of who exactly is responsible for providing services to children and adolescents. In 2004, we published a report aimed at identifying child and adolescent mental health policies worldwide (Shatkin & Belfer, 2004). The present review expands upon that report and provides an up-to-date assessment of these policies.

As in our prior study, we define a policy as a guide that dictates actions, such as programme development, financing, and access to care. Policy can be formally enacted by law or adopted by decree. Regardless of the level of detail, in all cases policy provides a recognisable document with the presumed force of law. Although there is great discrepancy in the way various countries execute mental health policy in general, the near absence of policies designed specifically to address the mental healthcare needs of children and adolescents, combined with poor execution of those few policies that are currently in existence, is an ever-growing concern. Given that children and adolescents have no political power, policies must be designed to ensure that they are able to access even the most basic mental healthcare.

Background

The United Nations' 1989 Convention on the Rights of the Child outlines the basic rights to which children are entitled. The right to mental healthcare is a key tenant of the document, and the absence of policies designed to address the mental healthcare needs of children and adolescents stands in direct opposition to the rights established by the Convention. Despite the Convention's ratification by 193 countries, there has been no international enforcement or movement to create mental health policies, leaving most children and adolescents without adequate care.

When considering the lack of child and adolescent mental health policies, one of the most troubling findings is the enormous discrepancy between needed and available resources. Certainly, the mental healthcare available to children and adolescents is far from commensurate with the burden of need. One-half of all lifetime cases of mental illness are now recognised to begin by the age of 14, and three-quarters by the age of 24, thereby rendering children and adolescents an extremely vulnerable group but with little protection (Kessler *et al*, 2005). Worldwide prevalence rates of child and adolescent mental health disorders approximate 20% (one in every five young people), with little variation found among the types of disorders seen across various cultures (US Department of Health and Human Services, 1999; Belfer & Saxena, 2006). Despite effective treatments, there are long delays, sometimes decades, between the first onset of symptoms and the

time at which individuals seek and receive treatment, and untreated mental disorders are now recognised commonly to lead to more severe and difficult-to-treat illnesses, along with the development of comorbid disorders (Kessler *et al*, 2005). Globally, five of the top ten leading causes of disability for children aged 5 years and over are diagnosable mental psychopathologies (Murray & Lopez, 1996). These findings provide evidence of the large gap that exists between the needed and available services for this extremely vulnerable population.

Clearly, the costs of ignoring the mental healthcare needs of children and adolescents affect both individuals and the whole of society. Children and adolescents who suffer from mental illness are unlikely to reach their full potential when healthcare resources are sparse or unavailable, and sick children are unable to learn and grow to become effective workers. The creation of government policies addressing child and adolescent mental illness is crucial in helping countries first to recognise the burden of illness and then to begin programme development to identify and treat these individuals in a systematic manner.

Method of review

In an attempt to identify existing mental health policies on a global scale, we performed an extensive review in 2002 (Shatkin & Belfer, 2004). Given the virtual impossibility of surveying every country worldwide, we employed a literature review methodology, supplemented by contact with consultants and experts in the field at the World Health Organization (WHO) and internationally. Of the 191 countries recognised by the United Nations at that time, we were able to identify only 35 with a mental health policy that might affect children and adolescents. In an effort to categorise each of the policies, we created a four-point classification scheme (Table 1).

The findings from our study provided solid evidence of the gap in child and adolescent mental healthcare policies. Of the 35 countries found to have identifiable mental health policies that may have an effect on children and adolescents, only 14 countries (11 of which are European) qualified for an 'A' ranking. Consequently, only 7% of countries worldwide (14 of 191) had any type of clearly articulated policy for dealing with the mental healthcare needs of children and adolescents. Of greatest interest is the fact that the mental health policies

for youths within these countries were all embedded within policies for adults. No single country, out of all we were able to assess, had a stand-alone policy for children and adolescents.

Following up on this research, the WHO aimed to assess further the gap in mental health policies for children and adolescents at an international level. In collaboration with the World Psychiatric Association Presidential Global Program on Child Mental Health and the International Association for Child and Adolescent Psychiatry and Allied Professions, the WHO published the Atlas on child and adolescent mental health resources in 2005 (WHO, 2005). The Atlas project represented a more systematic attempt to identify the gap in resources within child and adolescent mental health policies by employing a more interactive methodology than our prior study (Shatkin & Belfer, 2004). Data for the Atlas was obtained from countries through the use of a key informant method. Questionnaires requesting both quantitative and qualitative measures of policy performance were sent to select individuals from all WHO member states who were uniquely positioned to provide the relevant information.

Findings

The Atlas project succeeded in collecting data from 66 nations. While providing relevant and useful information, the Atlas suffered from a low response rate, in large part due to the lack of an identifiable focal point for child and adolescent mental health services, the fragmentation of child and adolescent mental health service systems, and the absence of appropriate mechanisms for gathering data. The inability to gather such valuable data makes policy and service efficacy virtually impossible to calculate.

The findings from the WHO Atlas confirm the absence of adequate epidemiological data relating to child and adolescent mental health disorders in low- and middle-income countries (Belfer & Nurcombe, 2007). The dearth of such data leads to a poor understanding of the disorders that are most prevalent in these areas and an even more limited understanding of how these disorders are viewed within different cultures. In the vast majority of countries outside of Europe and the Americas, service systems for child and adolescent mental health simply do not exist. Many of these countries rely on hospital or custodial settings for managing mental illness in their youth. As suspected, the Atlas documented that those countries with higher proportions of children in their population (typically poor countries) are also the most lacking in mental health policy for children and adolescents. These findings demonstrate that the gap in mental healthcare resources is greatest in areas that are most deserving of such services.

The number of policies identified by the Atlas project among responders to the survey varies greatly by WHO region. Even these numbers, however, are likely inflated, as identified national policies often were integrated into human rights, social welfare, child protection and education legislation or doctrines. Furthermore, the existence of national health programmes designed to address child and adolescent mental illness was considerably less frequent than the policies themselves, ranging from 6% in Africa to 83% in the Western Pacific Region. Consequently, the Atlas data demonstrate that simply having a child and adolescent mental health policy

Table 1 Criteria for categorising child and adolescent mental health policies (from Shatkin & Belfer, 2004)

Category	Criteria
A	National policies and/or programme plans that recognise the unique mental health and developmental problems of children and adolescents and clearly enumerate a unifying plan of action
B	National policies and/or programme plans that recognise the unique mental health and developmental problems of children and adolescents but do not enumerate a unifying plan of action
C	National policies and/or programme plans that recognise the mental health problems of adults and are likely to have some direct or indirect beneficial effect on the mental health of children and adolescents
D	No clearly identifiable national policies or programme plans for mental health

in place does not necessarily translate into an identifiable service programme; nor does ratification of the Convention on the Rights of the Child appear to make it more likely that a given country will have a national policy for the provision of child and adolescent mental health services. Lastly, the Atlas project was able to identify an institution or government entity with overall responsibility for child and adolescent mental health services in fewer than one-third of all countries. It is presumed that such services are often supported to varying degrees by ministries of education, social services, and health, but with little communication and coordination.

There are numerous barriers to child and adolescent mental healthcare which remain a significant concern worldwide. Those barriers identified most frequently by the WHO Atlas include lack of resources, transportation difficulties and stigma surrounding mental illness. Of note, stigma associated with the disorders themselves or stigmatisation from one's community was found to be a greater barrier in high-income than in low-income countries. It is suggested that this finding may be due to greater public knowledge of the implications of mental illness in high-income countries, which leads to increased stigma for those diagnosed. By contrast, low-income countries identified transportation difficulties and a lack of available treatment resources as the most significant barriers to receiving care. Additional barriers to care include lack of financial resources and an inability to communicate effectively in the patient's native language.

The Atlas project, coupled with observation of service systems in both higher- and lower-income countries, suggests that a continuum of care is absent. The establishment of such clinical and administrative continuity requires a strong mental health policy. In countries throughout the world, legislatures are far more willing to build buildings than to support home visits or preventive services. The illusion persists that supporting more medicalised care, including the use of pharmaceuticals, will yield greater accountability. However, the evidence suggests that reliance upon in-patient care is not cost-effective and may be counterproductive (Grimes & Mullin, 2007).

Finally, the WHO Atlas addressed the lack of adequate training programmes and standards for practitioners who provide mental health treatment for children and adolescents (Levav *et al*, 2004). The Atlas estimates that one-half to two-thirds of mental health needs go unmet in most countries. Even in the USA, the world's wealthiest country, child and adolescent psychiatrists are the most under-represented of all medical sub-specialists, with an estimated 6300 practitioners serving a population whose estimated need is over 30000 practitioners (Kim, 2003). As imagined, the situation is far worse in low- and middle-income countries, where, for example, the Atlas was able to identify only ten psychiatrists trained to work with children in the entirety of sub-Saharan Africa outside of South Africa. The Atlas suggests that the lack of trained professionals and stand-alone policies addressing child and adolescent mental illness may be due to a lack of political power, brought about by the absence of children in the political sphere.

The Atlas notes that much of the funding for child and adolescent mental healthcare emanates from temporary and unstable sources rather than from existing government funding. This funding trend was observed in both high- and low-income countries, suggesting that the needs of children

and adolescents are often ignored in policy development and financial allotment, due to their invisibility in the political arena. These findings act as further evidence of the need for unique policies to deal with this extremely under-represented population.

Discussion

Child and adolescent mental health policy discussions are taking place worldwide. Recognising the limited pool of funds allocated to healthcare, professionals involved in the mental health of children and adolescents are becoming stronger advocates and more attuned to the need to compete for funding.

Perhaps the greatest causes of morbidity and mortality among children and adolescents worldwide remain the infectious diseases, yet people who are mentally ill often receive treatment late and do not adhere well to treatments such as antibiotics and other necessary medications. Children and adolescents are no exception. By treating co-existing child and adolescent mental illness and by taking other measures to increase general emotional wellness, the physical health of children and adolescents will also improve. Furthermore, although treatments for children and adolescents with mental illness are continually refined, some of these treatments, primarily medications, carry a significant risk of side-effects, and this evident risk has led to increasing policy discussions. Finally, recent media attention directed to child and adolescent mental health has focused on disease-specific initiatives, such as autism and bipolar disorder, with consequences for national policy – witness the major allocation of money for autism research in the USA brought about through national legislation.

The focus on privatisation of child and adolescent mental health services, along with simultaneous implementation of various forms of managed care and insurance, has led to a troubling trend in policy discussions worldwide. Understandably, yet mistakenly, policies that seek to promote privatised and managed care are being driven, at least in part, by the antipathy of governments to support the presumed unknown or unknowable costs associated with child and adolescent mental health services. These concerns, however, are based on earlier reports of uncontrollable costs. In fact, the available data suggest that improved access to child and adolescent mental health services will be ensured by strong policies in this domain (Grimes & Mullin, 2007).

As evidenced by our earlier study and the WHO Atlas, no single country worldwide is meeting the documented need for child and adolescent mental health services. Although child and adolescent mental health policies are frequently imperfect and do not necessarily translate into mental health programmes, we continue to suggest that policies are a logical first step towards the recognition of need and subsequent programme development (Belfer, 2007; Belfer *et al*, 2007).

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THEMATIC PAPERS – CHILD AND ADOLESCENT PSYCHIATRY SERVICES

Helping each other help children – worldwide research networks in child and adolescent mental health

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The International Congress of the International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP) takes place every other year. It is an opportunity for specialists from around the world to meet, exchange ideas and plan new projects. Since 2006, the Donald J. Cohen (DJC) Travel Fellowship has been an integral part of the Congress. It aims to foster the professional development of 'emerging leaders' in child and adolescent mental health (Adler et al, 2007).

At first glance, child and adolescent psychiatrists from high-income countries would be expected to have very different interests, and very different resources, from those from low-income countries. Many young German child and adolescent psychiatrists, for example, do biological research using multi-channel electroencephalography (EEG), magnetic resonance imaging (MRI), and genetic or cell biology assays. Those from low-income countries might be more interested in such things as the epidemiology of certain disorders in their region, the prevalence of particular conditions, such as child abuse, or the efficacy of community-based mental health programmes.

In Germany, the profession of child and adolescent psychiatry is rather young but well established, the treatment is covered by health insurance, advanced technological tools are accessible, and the medical research infrastructure is complex enough to support some highly specialised projects. In a low-income country there may be only a handful of child and adolescent psychiatrists nationally, the field is often not held in high esteem either by the public or by government, and funding and legislative support for child mental health are

correspondingly weak. Health systems generally suffer from low funding and are focused on essential medical needs. Technology such as MRI devices is seldom available. Public health and clinical care take priority over basic research.

When child and adolescent psychiatrists from higher- and lower-income countries meet at a scientific conference, as we and others have under the auspices of the DJC Fellowship, the obvious question therefore is 'Can we help each other?' Which is to say, 'How can we help each other help children?' While forming personal and professional relationships is a good first step, the next is to consider carefully the opportunities for cooperation, and the obstacles.

Tools of research

If we think not about the specific substance of our research but rather about the tools we use, we see that researchers in higher- and lower-income countries face some similar challenges. Questions arise out of our daily clinical work. We must reframe those into more precise research questions, and devise an adequate research design. This requires access to the existing research literature, as well as resources such as reports from the World Health Organization (WHO). The relatively new journal *Child and Adolescent Psychiatry and Mental Health* offers free access to peer-reviewed, high-quality, worldwide information on all topics relevant to child and adolescent mental health (Fegert & Vitiello, 2007). Web forums such as Medscape offer free access to some scientific journals

and congress reports (<http://www.medscape.com/welcome/journals>). In addition for scientists in low- and middle-income countries, the *Journal of the American Academy of Child and Adolescent Psychiatry* (JAACAP; <http://www.jaacap.com>) is now free.

We need to find good assessment tools, learn the methods and conduct the study. This requires that researchers understand validity, reliability and specificity, and also consider cultural appropriateness and cost-effectiveness. Some questionnaires are available free of charge. The library website of the University of Adelaide gives a detailed list of all psychiatric rating scales and diagnostic aids available online (<http://www.adelaide.edu.au/library/guide/med/menthealth/scales.html>).

Young researchers face financial constraints in both higher- and lower-income countries, and these constraints oblige us all to acquire expertise in raising funds, and especially in writing grant applications. Last but not least, we have to analyse and interpret the data, and present our conclusions to the research community. Generating publishable research demands in-depth knowledge of higher-level statistics, and many child and adolescent psychiatrists lack such knowledge. Researchers who are not native-speakers of English may face the added obstacle of language, and so struggle both with writing articles and with choosing an appropriate journal to submit their articles to. These are all areas where skills and information can be usefully shared between child and adolescent psychiatrists from any part of the world.

A group of German biological researchers has formed an organisation called Young Investigators in Biological Child and Adolescent Psychiatry (YIBcap), as a means of encouraging such sharing. Although our research priorities are not the same, our knowledge of research tools and our experience in creating the 'social capital' (Shortt, 2004) of a research network are things we feel can be useful to researchers in lower-income nations. The skills of doing research, and of organising researchers into productive work teams, are not, in general, capital intensive or unique to biological research. Here, we present a brief history of our creation of YIBcap, and invite suggestions for further cooperation.

Origins and purpose of YIBcap

In 2005 we founded YIBcap with the goal of intensifying collaboration between all professions conducting biological research in child and adolescent psychiatry, and to increase both the quality and the efficiency of our research (Ehrlich & Stegemann, 2007). Currently the group comprises 40 members from more than 10 different German university hospitals and different specialties – physicians, psychologists, biologists and nutritionists. All members communicate via web-based group software and our own homepage (<http://www.yibcap.de>). We share new clinical and scientific knowledge, get quick advice on open questions (e.g. statistical matters) and collaborate on scientific projects. In addition, we rely on an expert panel of ten internationally renowned senior advisors – all senior faculty members in child and adolescent or adult psychiatry – who help young researchers with their methodological knowledge, writing skills, fund-raising techniques and contacts. Eventually, some of our senior faculty members will go beyond advice and instruction and engage in a trusting and caring mentor–mentee relationship (Martin,

2005). In the context of existing scientific congresses, we organise meetings where experts give workshops on research methods such as statistical multivariate analysis, gene linkage analysis, neurophysiology or diffusion tensor imaging.

Present state and future challenges

The network has had many successes in its first 3 years of existence. We have contributed to the translation and adaptation of questionnaires regarding self-harm, to a study of diagnostic issues in attention-deficit hyperactivity disorder, to the genotyping of patients with eating disorders, to the sharing of neuronal cell lines and to the transfer of EEG methodology. We were able to hold our own symposia at the IACAPAP conferences in 2006 and 2008, the 2007 conference of the European Society for Child and Adolescent Psychiatry (ESCAP) and have received official recognition and support from the German Association of Child and Adolescent Psychiatry and Psychotherapy. Currently, our first collaborative multicentre study on substance misuse is about to start.

Despite these achievements, we find that there are still many challenges. Funding for travel is hard to find. Mailing lists need to be moderated and protected to prevent misuse. Maintaining a website is labour intensive, as is organising meetings. One has to be cautious not to dissipate one's energies in administrative work.

Belonging to a rather small specialty within medicine, we feel that there is a great need for child and adolescent psychiatrists around the world to get to know each other, stay in touch, discuss recent advances in clinical care and research, as well as help each other with resources, methodology and contacts. E-communication and web logs are an efficient and affordable way to make use of this form of social capital. Web-based group software (e.g. Google groups, Yahoo groups) is free, and offers the distribution of emails to all group members, archiving of messages, file sharing, and polls. We also invite interested researchers to join YIBcap as guest members. We are especially interested in fostering dialogue with researchers in low- and middle-income countries.

Young researchers benefit in any context if they agree to share their knowledge and cooperate on research tasks. Time-efficient and cost-efficient means to communicate as a group are available through the internet. In order to benefit from external resources and to foster the seriousness of such networks, a board of senior researchers as advisors is highly recommended. In the midst of all our specialised research – the tracing of a specific receptor, the function of a subtle brain structure or gene – we should not forget that our primary goal is to serve the needs of children and adolescents, and to improve the mental health of the general population. Dialogue between child and adolescent psychiatrists from all over the world reminds us of this most important aim of our work, whether in biological research, epidemiology or community-based psychiatry.

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are founding members of YIBcap and former D. J. Cohen Fellows, but have no financial or other conflicts of interest that might bias their work.

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THEMATIC PAPERS – CHILD AND ADOLESCENT PSYCHIATRY SERVICES

Child and adolescent mental health services in Pakistan: current situation, future directions and possible solutions

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Worldwide, mental disorders are on the increase (Gadit, 2007) and an estimated 10–20% of children have one or more mental or behavioural problems (Park, 2002). There is an urgent and serious need to pay attention to the mental health needs of children in low- and middle-income countries (Rahman *et al*, 2000). The initial survey for the World Health Organization's Atlas project (Sherer, 2002) showed that 41% of countries surveyed had no mental health policy and 28% had no separate budget for mental health.

In Pakistan, with a population of 169 million, the allocation to adult mental health is hardly 1% of the annual health budget, and there is no specific allocation for children and adolescents. The provision of child and adolescent mental health services is very fragmented nationally.

This paper highlights the status of child and adolescent psychiatry services in Pakistan and makes some suggestions on how to develop them within the available resources.

Current situation

The current situation in Pakistan is that there is no formal referral pathway to psychiatric services for children. Children with mental and behavioural problems present to general practitioners in the community or to psychiatric out-patient departments, where they are seen by general adult psychiatrists, most of whom have little if any formal training in child psychiatry. However, it would not be improper to hypothesise that children reach these services after attending spiritual and faith healers.

The more common referrals involve neuropsychiatric and neurodevelopmental disorders, including behavioural sequelae of epilepsy and brain injury, pervasive developmental

disorders, attention-deficit hyperactivity disorder, Tourette syndrome, early-onset psychosis, other psychoses, psychosomatic/dissociative disorders, eating disorders, depression, anxiety and obsessive-compulsive disorders.

If children require admission, they stay on general adult psychiatric wards with adults who are acutely mentally unwell. The staff have very little formal training in managing children. Hence, the burden falls on the parents and carers to look after and manage them, leading to further anxiety and distress, especially if a parent has to take time off work.

Future directions and possible solutions

Developing paediatric-psychiatric liaison services

In Pakistan, in order to make use of scarce resources and still provide an appropriate in-patient setting, a suitable model could be for admissions to be to the paediatric ward, but with full support from the psychiatric team. Each adult psychiatry department could set up a paediatric liaison facility. Where the child is acutely disturbed and is difficult to manage in the paediatric ward, there could be a designated area on the psychiatric ward, preferably away from adult patients.

Lack of communication among existing paediatric and psychiatric specialties needs to be addressed through integration. One way to establish services would be to hold joint departmental meetings once a month, to which ward nurses, psychologists and local general practitioners should also be invited, to increase their awareness of psychiatric disorders in children. Attendance at paediatric ward rounds and joint teaching sessions, journal clubs, case presentations and so on would allow a clearer understanding of the issues faced by all involved.

Establishing multidisciplinary teams

In child psychiatry, an ideal team consists of professionals from different disciplines, including psychiatrists, psychologists, occupational therapists, nursing staff, family therapists, teachers and psychotherapists. There are usually close links with paediatricians and local social services.

In Pakistan, it is difficult but not impossible to develop a multidisciplinary team. Currently, teams consist mainly of psychiatrists, psychologists and nurses. Many units have occupational therapy as part of the in-patient experience and this is an area that could be developed in a more structured way. Psychiatrists working in adult psychiatric units attached to a general hospital (which is now the usual arrangement) often have good links with teams in the rest of the hospital and frequently receive and send referrals to them. Similar links could be developed with local paediatricians, where a child psychiatry service is to be developed.

Foreign aid

Given the shortage of specialist child psychiatry services, one way forward could be for child and adolescent psychiatrists trained abroad to join with local psychiatrists. Working as a team, they could develop culture-specific guidelines. This would be especially helpful if there were clear protocols for the management of various mental health problems in children. Currently this is happening in an *ad hoc* way (Rahman *et al*, 2000). The help of other organisations could be enlisted in achieving this; for example, the Royal College of Psychiatrists has its Volunteer Programme for Senior Psychiatrists and Specialist Registrars, which aims to match senior professionals working in the UK with departments in different parts of the world looking to develop expertise in particular areas (see <http://www.rcpsych.ac.uk>). The South Asian Forum for Psychiatry provides training in various countries; this will also prove to be a useful resource in providing training in child and adolescent mental health services.

Similarly, the Higher Education Commission of Pakistan welcomes foreign-trained professionals who are willing to contribute to service development in the country.

Another example worth mentioning is DRIP – Disaster Relief by Irish and Pakistani doctors (see <http://www.dripireland.org>). A voluntary organisation of Pakistani-origin doctors living in Ireland, DRIP is developing emergency medical services in Pakistan and extending its input to all branches of medicine with a view to introducing culturally appropriate protocols and guidelines in all the fields of medicine. Local and foreign experts will provide a platform for future developments in the field. DRIP has recently established an adult and child psychiatry branch.

Training of health professionals

Medical training at undergraduate and postgraduate levels needs both to create awareness and to stress the importance of child and adolescent psychiatry.

Joint problem-based training sessions with paediatricians and psychiatrists needs to be rolled out in teaching set-ups, with a view to developing liaison services.

Nurses need to be trained in the management of children with psychiatric disorders. They should develop counselling skills and be able to run structured and unstructured groups. These skills can be imparted to them during their training years by psychologists and psychiatrists.

There is also a question of training general practitioners (GPs). The aim would be to increase their awareness of protocols and referral pathways. It should be made mandatory for GPs to do 6 months of psychiatry to obtain their licence. Currently, 1-week programmes in psychiatry for GPs are conducted at Fountain House, Lahore, which is affiliated with the World Psychiatric Association's section on education (these contribute to the GPs' programme of continuing medical education).

In Pakistan mental health professionals need first to identify their area of special interest in treatment modalities, such as cognitive-behavioural therapy, family therapy, psychotherapy, education or occupational therapy. They then need to develop their interests by pursuing the appropriate training. The Royal College of Psychiatrists is looking to offer short periods of training to appropriately qualified individuals.

In hospitals, heads of departments have been organising training programmes and inviting local and foreign speakers, in this way keeping staff abreast of innovative and exciting developments in the field. Overseas Pakistani psychiatrists can be a useful source of training. At the Institute of Psychiatry at Rawalpindi General Hospital, email consultation and supervision with child psychiatrists in the UK has proved to be a very useful resource (Rahman *et al*, 2006). Similar set-ups could be developed in other parts of the country.

Involvement of the community

Discharge plans need careful consideration to ensure that all supports and follow-up plans are in place. In Pakistan the family and carers take on this role. Family psychoeducation for the early identification of symptoms of relapse is desirable, especially when families live in areas where they cannot easily come for regular follow-up. This information needs to be provided by the treating mental health professionals. Training/psychoeducation of the community is being carried out by mental health professionals in a number of areas; for instance, a programme in Lahore involving mothers, Imams (religious leaders) and teachers is running an awareness campaign on psychiatric disorders.

Given the importance of school in the lives of children, teacher training is another area to focus on. Several voluntary organisations, such as Amin Maktab and the National Society for Emotionally and Behaviourally Handicapped Children, have been running outreach programmes, training parents and local community volunteers.

Research and audit

There is a need to develop robust research projects to identify the prevalence of childhood mental illness. (Currently the lead author is conducting one such project in a teaching hospital in Lahore.) A summary of significant international epidemiological studies concluded that the rate and range of psychiatric symptoms in children is similar in lower- and higher-income countries (Fayyad *et al*, 2001). However, the prevalence of child mental health problems in Pakistan is higher than has been reported in studies from other countries (Syed *et al*, 2007a). Research in the area of understanding the psychopathology of mental disorders in children in our cultural context needs to be explored (Nikapota, 1991). Furthermore, 'needs assessment' of the target population is another area worth exploring.

Conclusion

In Pakistan, the national annual budget for mental health is far below what would be necessary to meet the needs of the population. There are very few child mental health facilities in the country (Syed *et al*, 2007b).

Collaborative working between professionals managing children needs to be strengthened. Management guidelines have to be developed, as this will enable good clinical care and also facilitate research and audit. Research is needed to identify the prevalence, psychopathology and needs of mental health problems in children and priorities for management. Psychiatrists trained abroad could be a source of support and training, preferably on a longer-term basis, through email consultation and supervision. The transfer of skills through workshops and short training courses also is effective.

Children lacking in mental health have an adverse effect on the country's productivity, economic stability and viability. Recent research from Karachi, Pakistan, has highlighted effective models of utilisation of scarce child mental health resources within the current health and educational set-up (Syed *et al*, 2007b). Policy-makers in the face of lack of finances and resources need to make decisions based on the efficacy of proposed and evaluated interventions which are not only beneficial to the population in question but also cost-effective.

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COUNTRY PROFILE

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

Psychiatry in Belgium

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The Kingdom of Belgium is a high-income country in northern Europe with an approximate area of 33 000 km² and a population of 10.5 million. The proportion of the population under the age of 15 years is 17% and the proportion of the population above the age of 60 years is 22%. Life expectancy at birth is 75.2 years for males and 81.5 years for females. As a founding member of what is now the European Union, it hosts the headquarters of the European Commission and the European Parliament, as well as other major organisations, including NATO.

Belgium is divided into the Flemish-speaking region of Flanders, in the north, with 58% of the population, the French-speaking southern region of Wallonia, inhabited by 32%, and the Brussels capital region, officially bilingual, inhabited by 10% of the population. A small German-speaking community exists in eastern Wallonia. Belgium's linguistic

diversity is reflected in the organisation of its psychiatric institutions and legislation.

Mental health policy

In Belgium, as both federal government and communities are in charge of different parts of the mental health service, there is both a national mental health policy, formulated in 1988, and a community mental health policy. A substance misuse policy is present which was initially formulated in 1921 and a national mental health programme was formulated in 1990 and updated in 1999.

Belgium has a suicide prevention policy, implemented by the Mental Health Centre in Brussels. It focuses on the quality of help offered and on the efficacy of the services from the

network of providers in mental health and social care. The goals of the policy are: to optimise the care offered to clients at risk of suicidal behaviour; to develop networks to enable follow-up with at-risk patients; to lend support to and to share relevant knowledge with other carers; and to advocate for suicide prevention within local networks.

Belgium has a nationwide data-collection system or epidemiological study on mental health, known as the Minimum Psychiatric Dataset. There are specific programmes for mental health for minorities, refugees, disaster-affected populations, indigenous populations, the elderly and children.

Different organisations subsidised by public authorities exist in Wallonia, Brussels and Flanders. In the not-for-profit sector, organisations include the Wallonia Institute for Mental Health and the Brussels Francophone League for Mental Health. Their objectives are to join the representatives in the field of mental health (via their organisations) with stakeholders, including service users and carers, to regularly evaluate social mental health issues, to encourage critique of mental health practice, to participate in mental health promotion and to work on ethical questions.

There exist 'platforms' of dialogue which group together psychiatric care structures for each region. Their objective is to highlight the study of health service research needs and to open dialogue between the stakeholders in mental health to improve the availability of care.

Belgium has disability benefits for persons with mental disorders. Factors such as degree of autonomy in daily activities, ability to work and degree of handicap are assessed.

Mental health services

Belgium spends 6% of the total health budget on mental health. There are some 69 psychiatric hospitals in Belgium, with 22.1 psychiatric beds per 10 000 population. There are around 18 psychiatrists per 100 000 population. The primary sources of mental health financing are social insurance, private insurance, out-of-pocket expenditure by the patient or family, and tax-based revenue. The Flemish-speaking and French-speaking communities are in charge of all non-hospital mental healthcare, such as sheltered housing and centres for mental health. The federal government is in charge of hospitals, location of psychiatric care and quality of hospital care. Mental health is a part of the primary health-care system and so the treatment of severe mental disorders is available at the primary care level. There is regular training in mental health for primary care professionals. Emergency facilities are geographically sectorised across the country, which offers immediate care at low rates, through subsidisation by the local centres.

Patients may also use regional ambulatory centres for a consultation or receive a home visit. Care is offered by a multidisciplinary team able to address the medical, psychiatric, psychological and social aspects of a health problem. The remit of mental healthcare centres is both curative and preventive.

Belgium has a long history of community care. The city of Geel is known for the early adoption of deinstitutionalisation. The earliest Geel infirmary and the model where patients go into town, interact with the community during the day, and return to the hospital at night date from the

13th century. This practice is based on the positive effects that placement in a host family gives. The model continues today, where patients participate in family life and sleep in the family house, but are still considered the responsibility of the hospital; they spend part of the day or all day in hospital doing various activities and can go back to the hospital for observation or in case of crisis. In 2003, there were 770 family accommodation places available in the Flemish region and 192 in the Walloon region.

Mental health legislation

The royal decision of May 2000 changing the previous one of 1976 fixed a maximum number of beds in psychiatric services. There are specific child and adolescent psychiatric beds in general, paediatric and psychiatric hospitals in Belgium. Since 2002 there have been specific legislative guidelines for child and adolescent psychiatric disorders. The latest legislation was enacted in 2000 and a new piece of legislation regarding the detention of those with a mental disorder was adopted in April 2007. Mental health legislation is uniform across both the Flemish and Wallonia regions.

Research

Belgium is cited as being in the top ten leading countries for psychiatric research, in terms of both the number of papers and impact. Funding has come primarily from the federal government and European Union framework programmes.

The Department of Psychiatry at Université Libre de Bruxelles, Erasme Hospital, has been involved in initiating and implementing large European consortia (e.g. the GENDEP Consortium) on the genetics of mood disorders and schizophrenia. A European network of clinical and research centres for genetic studies in mood disorders (Biomed I and Biomed II programmes) has been established. The department is now coordinating a European multicentre study on treatment-resistant depression, including prospective work on pharmacogenetics.

Other major research centres include: the Psychoneuro-endocrinology Unit, University of Liege, which specialises in affective disorders; the Universitair Centrum Kinder- en Jeugdpsychiatrie, University Hospital, Antwerp, which specialises in child psychiatry; and the University Hospital Brugman, Brussels, which specialises in sleep medicine. The Unit for Suicide Research, University of Gent, studies the epidemiology of suicidal behaviour, the biological and psychological characteristics of suicidal behaviour and prevention strategies.

Pharmaceutical research in Belgium has been led by Janssen and Janssen-Cilag, and resulted in the development of both haloperidol in 1958 and risperidone in 1984.

Education and training

Belgium has nine medical schools; the oldest, the University of Leuven, dates from the 14th century. Most Belgian undergraduate training takes the form of a 3-year bachelor's degree, encompassing basic sciences, followed by a 4-year masters degree, which includes clinical disciplines. Psychiatry,

medical psychology and child and adolescent psychiatry are included during the medical curriculum in the 7 years of study by Belgian medical graduates. They are also trained in aspects of the patient–doctor relationship during small-group sessions.

Postgraduate training and specialisation last 5 years, during which trainees work under the supervision of a 'maître de stage' in adult psychiatry, as well as child and adolescent psychiatry, and they also spend 1 year in neurology, paediatrics or internal medicine.

One year of training can be done in research. At the end of the specialisation, the candidate must publish one paper in an international journal or present at an international conference. Training includes mandatory academic courses and an examination during the third year. Since 2002, specific training in child and adolescent psychiatry has been available. Following specialisation, trainees will have a specific registration number from the Institut National d'Assurance Maladie-Invalidité (National Institute of Illness and Disability Insurance).

Psychiatric associations

Psychiatric associations in Belgium are divided between adult and child disciplines, and French-speaking and Flemish-speaking organisations. The primary association is the Société Royale de Médecine Mentale de Belgique (Royal Society of Mental Medicine of Belgium), which was founded in 1869. It is responsible for the primary Belgian psychiatric journal, the *Acta Psychiatrica Belgica*. The Vlaamse Vereniging Voor Psychiatrie (Flemish Association of Psychiatry) represents the Flemish-speaking community of adult psychiatrists. The Société Belge Francophone de Psychiatrie et des Disciplines Associées de l'Enfance et de l'Adolescence (French Belgian Society of Psychiatry and Associated Disciplines of Childhood and Adolescence) represents the French-speaking child and adolescent mental health professionals and the De Vlaamse Vereniging voor Kinder- en Jeugdpsychiatrie is the Flemish equivalent.

These professional societies are responsible for specialist professional standards, education and providing advice on

policy. They are responsible for mental health promotion and the organisation of scientific events and congresses each year.

The Belgian College of Neuropsychopharmacology and Biological Psychiatry (BCNBP) was founded in 1974 and represents the scientific body of psychiatrists in Belgium.

Conclusion

As a high-income European country, Belgium has a modern psychiatric infrastructure comprising policy, legislation, community care, education, training and research. The integration of policy and services may be limited by its linguistic and cultural diversity, and future care programmes and pathways may benefit from a more unified strategy. Community care has historically been seen as a priority and the legislation in 2000 supports this continuing trend.

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COUNTRY PROFILE

Mental health in Yemen: obstacles and challenges

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The Republic of Yemen, on the south-western coast of the Arabian Peninsula, was formed in 1990 when North and South Yemen united. Yemen covers 527 970 km². The capital is Sana'a. The country is divided into 20 governorates and one municipality. It has an elected president, an elected House of Representatives, and an appointed Shura Council. The president is head of state, and the prime minister is head of government. Suffrage is universal for

people aged 18 and older. The population of Yemen according to the 2004 census is about 20 million, but recent years have seen the arrival of many refugees.

Mental health in Yemen has been fortunate to receive government support, albeit modest, and benefits from human resource development projects. These projects have enabled Yemeni students to study psychiatry, psychology, psychiatric nursing and social work abroad. Mental health in

Yemen has developed within a context of social development against wars, internal struggles, poverty, high rates of reproduction and illiteracy. Mental health disorders are closely connected to myth, superstition, witchcraft and jinns. There continues to be stigma associated with mental health and, by extension, with psychology and psychiatry.

Human resources

A survey conducted by the Yemeni Mental Health Association (YMHA) in 2006 gave a figure of 3580 professionals with at least a BA in psychology. These include 139 people working in higher academic institutions. There are 198 psychiatric nurses and 45 psychiatrists and neurologists, giving one psychiatrist or neurologist per 500 000 population. There are only three child psychiatrists in the country and they work between hospitals and universities.

Educational and training institutions

Two types of institution provide education and training.

First, within the undergraduate programme, four departments of psychiatry, housed in university faculties of medicine, serve the national educational and accreditation professional development needs. The training programme in general medicine lasts 6 years. Medical students spend one semester in psychiatry and two in the behavioural sciences or medical psychology. Activities in psychiatry departments are limited to teaching, lecturing and examination, and do not include research or service activities to the community. Reasons for this include scarce resources and consequent limitations and loss of motivation, social stigma associated with mental health issues, newness of the discipline, and a critical shortage of experienced specialists.

Second, since 2003 the Yemeni Council for Medical Specialisation under the Ministry of Health has run local academic qualification programmes in psychiatry and clinical psychology. The qualification for this specialisation is dependent on the Arab Board System (a 4-year course). Unfortunately, there is little interest in psychiatry and to date there have been only three graduates of the diploma programme.

In 2003, a national academic qualification programme was established that provides 1 year of post-baccalaureate training in clinical psychology. By 2007, 30 individuals from the Sana'a and Aden governorates had graduated.

Mental health services

Psychiatric hospitals

There are only four psychiatric hospitals treating mental illness in Yemen; the one in Aden, built in 1966, is the oldest on the Arabian peninsula. The total number of beds in the country is nearly 850 (YMHA, 2006) and these are available in only four governorates. These hospitals are for adults and have no special sections for children. Patients who have a mental illness wander the streets of cities and towns. Others, in their thousands, are detained in family homes in oppressive conditions, which is especially difficult for women, for whom the oppression is twofold.

Psychiatric clinics in general hospitals

In response to the World Health Organization's direction concerning the provision of mental health services in governorate hospitals, a number of mental health out-patient clinics have been developed at public hospitals, to which psychiatrists are appointed. However, these services are not provided by all public hospitals, and are subject to suspension or termination due to staff shortages and budget constraints.

Psychiatric clinics in prisons

Patients who are mentally ill and who have a criminal record can be detained in correctional facilities. The second National Conference for Mental Health held in Sana'a in 2004, organised with the International Committee of the Red Cross, recommended that patients with a mental illness be separated from prisoners and placed in mental health hospitals.

Private nursing homes

There are estimated to be only five private nursing clinics, in four governorates, with a capacity of approximately 100 beds (YMHA, 2006). Some have no beds and function as out-patient clinics.

Private clinics

There are about 45 private mental health clinics in Yemen run by psychiatrists (YMHA, 2006). Psychologists work in some of these clinics, supervised by psychiatrists. Drugs and electroconvulsive therapy (ECT) are typical treatments in these settings. Some work within a collective therapeutic team model. There are no designated clinics for children.

Patient management and treatment

Successfully treating mental illness often involves using drugs prescribed by psychiatrists and, in rural areas, by psychologists. Although effective, medication is of limited use, as drugs are unaffordable for most. The use of ECT remains widespread. Few evidence-based treatment programmes are considered appropriate for this culture. There are individual settings where institutional or individual initiatives have led to the establishment of models that demonstrate the potential and effectiveness of mental health services in the Yemeni context.

Psychiatric hospital data in Yemen

Statistical data obtained from Yemeni psychiatric hospitals gave a patient population of 29 519 (YMHA, 2006). Paranoia with schizophrenia was the most common diagnosis, followed by emotional disturbances (depression and anxiety), while epilepsy, still classed as a mental illness, was in third place.

Epidemiology of suicide

Suicide is a problem of great sensitivity, and much stigma and shame are connected to the act. According to available official data, suicides in Yemen totalled 243 in 2006 (YMHA, 2006), with the use of a firearm being the most common means.

National Mental Health Programme

The National Mental Health Programme was established in the late 1980s with help from the World Health Organization and the Ministries of Health from North and South Yemeni

governments of the time. The project concentrated on treatment in mental hospitals and care of patients with a mental illness by qualified psychiatrists. The National Mental Health Programme responded to recommendations put forward by the first National Workshop on Mental Health in Yemen, in October 2002, organised with the International Committee of the Red Cross. The Mental Health Programme was established by ministerial resolution and administered within the primary care division of the Ministry of Health.

The Programme is still being developed and requires support in both human and material resources as well as the development of a database of resources, statistics and epidemiological information.

Non-governmental organisations

In Yemen, non-governmental organisations (NGOs) focusing on mental health have increased in quantity and quality since the Associations Law of 2001 permitted the formation of professional organisations. By 2006, there were seven associations in the country, with a membership of 1280 (Saleh, 2008).

The Yemeni Psychiatric and Neurological Association (YPNA) was established in 1989, while the YMHA was established in 1998. In general, most associations are new and struggling but continue to advocate for and provide services. These associations play influential roles in campaigning against physical, mental and sexual violence towards women and children. They organise celebrations for International Mental Health Day, conferences, workshops, seminars, publishing endeavours, radio and television programmes, and contributions to journals and magazines in mental health. Finally, they advocate for the establishment of a formal code of ethics and a Mental Health Act, often at great personal and emotional expense, which is rarely acknowledged.

Publications

There are two bi-annual journals published by the Yemen Psychological Association (YPA) (20 volumes), another by the Doctor and Clinical Psychologists' Association (DCPA) (3 volumes) and two newsletters published periodically by both the YMHA (30 volumes) and the Aden Central Psychiatric Hospital (10 volumes) (YMHA, 2006). The main obstacles are a lack of financial resources and technical facilities for printing and dissemination.

Research

Research in mental health is not well developed, because of a lack of capacity and the absence of research institutions. Graduate (PhD and MA) students and teaching faculty conduct most mental health research in universities. The YPA and the YMHA take an active role in launching research initiatives and community surveys related to a variety of mental health issues, including violence against women and children, qat addiction, female genital mutilation and suicide. A lack of sustainable funding remains the biggest obstacle to research.

Mental health and leadership

In November 1989, the President of the YPNA, Dr A. Khleadi, also became President of the Arab Psychiatric Association. In 1997 and in 2001, two professors from the Department of Behavioural Sciences, Faculty of Medicine Aden University, became vice presidents of the World Federation of Mental Health for the Middle East Region (Dr Hassen Khan and Dr Maan Saleh). In 2002, Dr Ahmed Makki became a member of the Shura Consultative Council and reporter for its Health Committee. In 2003, Dr Dugysh, from the Aden governorate, became the first neuropsychiatrist to be elected as a Yemeni member of parliament.

Future challenges and goals

Until Yemen develops its own research base, addressing the population's mental health needs will require creativity and commitment. Developing short- and long-term programmes requires adapting research knowledge and both regional and international experiences appropriately to the Yemeni landscape while accelerating Yemeni progress in the field.

Goals for the future include:

- fostering qualitative and quantitative improvements in graduate and postgraduate higher education and training in mental health (doing so will enable Yemen to train specialists with culturally appropriate skills who can respond to the needs of society)
- offering annual scholarships abroad, for at least 5 years, across the different fields of mental health, with sensitivity to issues of gender
- broadening the faculty role so that university professors can engage in research while being supported by a clear administrative and legislative mandate
- increasing the number of educational campaigns to reduce the stigma of mental illness
- mandating a political and national strategy for mental health that includes the participation of the Ministry of Health, Yemeni universities (faculties of medicine) and related mental health NGOs
- improving and developing services in all the governorates
- getting the Ministry of Health, specialised associations, and concerned scientific departments of Yemeni universities to prepare laws to protect those who are mentally ill and to promote and develop the field as a priority
- strengthening communications with regional and international institutions with respect to mental health and its financing
- joining efforts to establish an accurate database that is methodical and up to date, and that uses contemporary techniques in data collection and manipulation.

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Mental and neurological health profile of Ecuador

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We assessed the mental and neurological health (MNH) situation of Ecuador in 2006–8, using the Mental and Neurological Health Country Profile (MNHCP) (Gulbinat *et al*, 2004; Jenkins, 2004; Jenkins *et al*, 2004), an instrument which helps to develop evidence-based MNH policy and services (Townsend *et al*, 2004). An extensive review of the literature was undertaken and consultations and consensus meetings (Schilder *et al*, 2004) were conducted with key mental and neurological health stakeholders, including consumers, carers and clinicians from the government and non-government sectors.

Context

Ecuador, in the north-west of South America, has an area of 256370 km² and a population of around 13400000. The population distribution has become younger in recent decades, with 61.9% aged 15–64 years. Nearly two-thirds (63.4%) of the population live in urban areas. The national fertility rate is 22.9 births per 1000. Life expectancy is 78 years for women and 72 years for men. The major ethnic groups are Mestizo (65%), Native Indigenous (25%), White (7%) and Black (3%). Official languages are Spanish and Quechua. Most of the population (95%) is Roman Catholic.

Other significant data are presented in Table 1.

Internal and external migration is significant. Over one million Ecuadorians emigrated to the USA and Europe following economic problems in 2000. The Colombian guerilla

movement has forced the displacement of half a million Colombians into Ecuador and rural migration continues to increase the size of the slum areas in major cities.

Positive mental health and well-being is understood as emotional health; mental disorder and mental illness as loss of reason; neurological illness is described in terms of the associated disability; and personality disorder is understood as antisocial or delinquent behaviour. Discrimination against people with mental or neurological illnesses exists owing to cultural influences and ignorance. Mental and neurological disorders are considered physical and cultural ailments, and approximately 30% of the population (particularly those in the rural sector) regard mental and neurological conditions as punishments of nature.

Women primarily bear the burden of caring for people with mental and neurological disorders. There are significant levels of stigma and discrimination shown to people with MNH problems and to other vulnerable groups, including those who experience physical or intellectual disability, poverty, disease, the young and the aged. There is no recognition of the rights of people with disabilities, resulting in government failure to address the physical and MNH needs of these groups, until a start was made by the 2006 Organic Health Law.

Violence against women, associated with male jealousy and macho attitudes, is common. Alcohol misuse is high and commonly associated with unemployment, lack of close family, marital problems and debt. Drug misuse among children and young people is rising. This is frequently associated with parental migration, as it often causes young people to come under the care of grandparents. Homicide rates have tripled in the last 19 years, going from 6.5 per 100000 people in 1985 to 19 per 100000 in 2004. Drug- and alcohol-related criminal violence resulted in 2315 deaths in 2004.

Social policy, health policy, legislation and human rights

Ecuador experienced social spending restrictions, economic reforms and economic restructuring in the 1980s, followed by the introduction of welfare legislation in 1992 and compulsory education in 2000. However, school non-attendance remains high. Alcohol is available only to those above 18 years of age; public tobacco advertising is restricted; and tobacco and alcohol are taxed. There is regulation of drink-driving and firearms.

Free maternity services are provided and there are childhood immunisation programmes. There are, however, no

Table 1 Select national data, 2006

Measures	
Gross national product	US\$44 billion
National debt	US\$11 billion
Economic aid	US\$22 billion
Proportion of budget spent on health	6%
Proportion of budget spent on mental health	0.00006%
Annual income per capita	US\$3216
Proportion of population living below poverty line	30%
Proportion of homeless people	31%
Proportion of population with access to safe drinking water	15%
Proportion of population with access to adequate sanitation	43%
Unemployment rate	8.8%
Inflation rate	3.1%
Child immunisation coverage	93%
Prison population	14400 male, 1600 female

Source: Inec, *Indicadores Basicos de Salud* (2006).

programmes aimed at: reducing substance misuse, tobacco or alcohol consumption; detecting and preventing high blood pressure; or promoting life skills in schools.

There is no national MNH policy in Ecuador. The Ministry of Public Health is the main body responsible for the regulation of MNH care. The 2006 Organic Health Law legislates for human rights in the field of MNH, and regulates the way in which involuntary admission is decided by family members, physicians, police officers and the justice system. The law guarantees patients access to their case-notes, but there is no tradition of enforcing constitutional rights.

Estimates of need

Small-scale neuroepidemiological surveys were carried out in Ecuador in the 1980s, using a World Health Organization protocol (Cruz *et al*, 1985). Epilepsy prevalence figures (10–17/1000) are generally higher than those found in industrialised countries. Migraine headache has been found to affect 68 people per 1000 (Cruz *et al*, 1995). The prevalence of established cerebrovascular disease was 3.5 per 1000 and of peripheral neuropathies 15 per 1000. There are no community-level epidemiological data on mental disorders.

Financial and human resources

The main obstacle to the purchasing and delivery of specialist care in Ecuador is lack of financial resources. Central government spending accounts for only a small proportion of national expenditure for mental and neurological illnesses. In 2008, 6% of the national budget (US\$700 million) was allocated to general health. Of this, US\$3200000 was allocated to MNH. MNH services are also financed through social security insurance, private insurance, fee for service, community financing, charity and donor funds (loans and grants). The cost of medicines is high, public health services are limited and private sector services are expensive. The approximate financial burden experienced by a family when a member is mentally or neurologically ill is approximately US\$500 per month.

Ecuador has 4658 primary care doctors, 338 psychiatrists (or 2.3 per 100000), 333 neurologists, 22 community psychiatric nurses and 1 psychiatric social worker.

Medical students receive 36 hours of training in psychiatry and 36 hours in neurology, spread over the 18 weeks of the internal medicine module. Psychiatric postgraduate training has been in place for the past 25 years, sponsored by the Central University of Ecuador, in Quito. It is a 3-year course, with eight students per year. A similar programme has been established recently by the University of Cuenca. There are no training programmes in psychiatric nursing.

Services

Initial treatment is generally in the form of home-made medicines, products from local pharmacies or friends' advice. There are 721 primary care centres (169 in the state sector, 12 in the non-government sector and 540 private facilities). Specialist care is also available.

There are 1635 psychiatric beds in state-funded general and teaching hospitals. No information is available on the non-governmental and private provision of psychiatric beds.

It is a legal provision that psychotropic substances are available only through prescription. In Ecuador the financial expenditure on antidepressants and anticonvulsants alone is about US\$120 million per year.

The 2006 Organic Health Law integrates traditional medicine within the national health system. Traditional healers include 'cleansers' (who clean the body of bad spirits), midwives, healers, shamans and witches. Other alternative/complementary medicine includes homeopathy, acupuncture and bioenergetics.

There are no programmes for MNH promotion or plans for training workers in this field. There are no policies for reducing mortality from physical illnesses in people with a mental or neurological illness, or initiatives to address suicide reduction or epilepsy and stroke prevention. There are no programmes for addressing the needs of children, older people or disadvantaged minorities, and initiatives are limited in areas such as incest, child abuse, domestic violence, trauma and rape.

The prison population totals 16000, of whom 80% fulfil ICD-10 criteria for mental disorders and 10% deserve specialist attention. Medical services and therapeutic communities exist within prisons. Prisoners have access to primary care and psychiatric and psychological evaluation and in an emergency may be referred to specialist psychiatric services. There are protocols within the prisons for prevention of violence and crisis intervention. Two psychiatrists and 60 psychologists work in the prisons.

Discussion

Key problems for MNH in Ecuador include limited resources and services. The main challenge is to establish a national MNH policy with widespread ownership by the key stakeholders. MNH policy needs to address stigma and discrimination, health promotion and illness prevention, and improved supply of and access to clinical and non-clinical services. MNH needs to be integrated into primary care, with supervision and support from specialist services which are decentralised to all districts, more specialised multidisciplinary personnel, and better access to low-cost medicines. Funding strategies are needed to address resource generation, allocation and audit. Access to care is restricted owing to scarce financial resources, cultural and religious beliefs, a weak primary care system, long distances from the main hospitals, concentration of specialist services in the main cities, discrimination and a lack of inter-sectoral liaison at local and national levels, including within public policy. Of particular concern is the total lack of research in this area or plans for training separate cadres of specialist care staff.

Conclusion

Ecuador has significant MNH needs, aggravated by rising levels of emigration, and high levels of alcohol misuse and violence. Mental health services are mainly delivered by specialists, concentrated in the cities. There is a pressing need for decentralisation of services, for systematic support to primary care, and for inter-sectoral liaison in order to enhance access to mental health promotion, prevention and treatment.

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ORIGINAL PAPER

First-episode psychosis: factors associated with delayed access to care in a rural Egyptian setting

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Over the past few decades there has been a growing interest in first-episode psychosis (FEP), help-seeking behaviour and pathways to care. Treating psychotic disorders in their earliest stages has become a key focus for research and clinical care (Yung & McGorry, 2007). FEP studies show that the average time between onset of symptoms and first effective treatment is often 1 year or more (McGlashan, 1987). This long duration of untreated psychosis (DUP) is undesirable. Early treatment helps minimise the risk of the serious consequences of untreated psychosis, in terms of changes in mental state and behaviour (Larsen *et al*, 1998; Wyatt *et al*, 1998) and can reduce suffering (Ho *et al*, 2003). Some early results suggested that an 'early intervention in psychosis' (EIP) service is more cost-effective than generic services (Mihalopoulos *et al*, 1999).

Most FEP studies have been conducted in high-income countries. The study reported here addressed the question of delayed access to care for an FEP in a rural Egyptian setting.

Method

The study was approved by Al-Azhar University research and ethics committee. Consent was taken from patients and their families before they took part in the study.

All patients with an FEP (meeting ICD-10 criteria) presenting consecutively to the psychiatric department at Mansoura General Hospital (MGH) between January and June 2004 were interviewed. Patients and relevant others (family or friends) were interviewed either separately or together at first contact or after improvement of the acute stage.

The interview protocol consisted of a semi-structured, user-friendly interview which included seven main sections that required only the ticking of various options. In every section there was an additional space under '(Other)' to allow more flexibility and to allow the inclusion of any additional

information. The seven sections were: patient's details; mode of referral; referred to out-patient or in-patient department; DUP; family history of mental illness; diagnosis and treatment; and causes for delayed contact with the psychiatric service.

The study was carried out in Mansoura city, the capital of Eldakahlia province; it is surrounded by a large rural area which includes about 15 towns. The population of Eldakahlia is about 8 million, some 2 million of whom live in Mansoura. In Egypt, primary care is still underdeveloped. Therefore, access to secondary care is mainly not through primary care. Individuals who need specialist care are likely to present to the specialist clinic (state or private) based on their own perception of the nature of the problem or as advised by family or a friend. Two main medical centres cover healthcare in Eldakahlia: Mansoura University Hospital (MUH) and MGH. Each has a psychiatric department. The smaller hospitals (called central hospitals, of which there is one in each town or big village) have no psychiatric department. Therefore, the mental health service in Egypt is essentially hospital based, and there is no well developed community mental health service.

The psychiatric department at MGH has a catchment of about 1 million. It contains an eight-bed ward and an out-patient clinic attended by about 100 patients per day. The medical staff includes two senior house officers, eight specialists and two consultant psychiatrists, and the nursing and non-medical staff comprises eight psychiatric nurses, a psychologist and one social worker.

Results

Of the 43 patients referred to the study, 40 agreed to take part (2 refused admission and decided to seek treatment privately and 1 refused to take part in the study). Out of the 40 patients, 22 needed admission (6 under section and 16 informal) and 18 were treated as out-patients.

The diagnostic categories of the cases were: schizophrenia, 14; affective disorder, 15 (9 depression with psychotic symptoms, 5 manic episode and 1 mixed affective state); postpartum disorders, 5; and others, 6 (1 persistent delusional disorder and 5 mental and behavioural disorders due to cannabis and amphetamine misuse).

Table 1 shows the age of the participants and the classification of their geographical areas of residence, by gender.

On average, these patients undergoing their FEP had their first contact with psychiatric services about 7 months after onset: within 11 months for schizophrenia and within 3 months for affective disorders. In this respect there was no significant difference between males and females.

The main factors associated with delayed access to care were classified as cultural factors (36%), which included jinn/spirit (16%), a preference for traditional healers (10%) and female gender (10%) (Table 2).

The family was the main source of referral (18 of the 40 cases) followed by friends (8) and general practitioners (8). Five patients were referred by specialists, and the remaining patient by a sheikh.

Discussion

Interest in both FEP and DUP has increased greatly over the past few decades. This interest has influenced service models and development mostly in high-income countries; comparatively little has been achieved in low- and middle-income countries. Although it is logical to assume that intervention in the early stage of any illness is beneficial, evidence from economic evaluations is still limited (McCrone & Knapp, 2007). Such economic evidence is especially important for low- and middle-income countries.

In this study, DUP averaged 7 months for all types of FEP and 11 months in schizophrenia. This is shorter than that found in Western countries. Beiser *et al* (1993) found that

average DUP for schizophrenia was more than 1 year. The shorter duration in our study may be due to sample size and a high proportion of mood disorder cases. It is also possible that not recognising the early stage of illness by the public (probably owing to lack of knowledge of early symptoms of psychosis) may cause a spurious shortening of DUP. In the present study, patients with affective disorder accessed psychiatric services earlier than individuals with schizophrenia. This agrees with the findings of Lincoln & McGorry (2000).

In high-income countries, DUP may be influenced by a combined effect of help-seeking behaviour, delayed referral from primary care and delay within the psychiatric service due to waiting lists. In a British study, Brunet *et al* (2007) highlighted the effect of barriers within specialist services as highly significant. In the present study, DUP was mainly influenced by help-seeking behaviour rather than delayed referral from primary care or delay within the specialist service; this was because of the very limited role of primary care in Egypt and the absence of waiting lists in the specialist service. Thus, patients and carers decided for themselves about when and which medical specialist to consult.

Cultural factors and lack of knowledge seem to play an important role in delaying access to care on the part of those with an FEP. Interestingly, believing that mental illness is due to possession with jinn/spirits was the second most important factor identified (after lack of knowledge). A preference for seeing traditional healers (rather than healthcare professionals) in rural Egypt is a complex area; financial, geographical, cultural and religious factors may contribute. Ignorance about mental illness and mental health services was found to be the single most important factor (28%) associated with delayed access to care. Thus, public education may help reduce DUP.

Family members indicated that female gender of the patient discouraged them from seeking help, owing to concern about the effect of stigma of mental illness on their daughter and family reputation in a rural community. In a public survey conducted in the United Arab Emirates, 38% of respondents believed that stigma is worse and 60% believed that the family suffers more if the patient is a female (El-Adl & Balhaj, 2008). This indicates that female gender may be considered as a risk factor for delayed access to care. Loebel *et al* (1992) found that male gender was associated with longer DUP. Our study found no significant difference between genders. This may be due to the small sample size or family reluctance to seek help for women (or a combination of both).

Stigma has a significant role (as expected) and will continue to do so until it is adequately addressed. An Egyptian study showed that a programme addressing school students' attitude towards individuals diagnosed with mental illness achieved a positive change (Fahmy *et al*, 2004). Thus, a large-scale anti-stigma programme is needed. Sadly, financial factors play a significant role in delayed access to care. Although every individual in Egypt is entitled to free healthcare and open access to the National Health Service, the reality may be different. The effect of mental illness on the patient and lack of insight seem to have less influence than other factors. In rural Egypt, it is culturally acceptable for the family rather than the individual him/herself to make the decision to seek help, and children, whatever their age, have to respect the wish of their elders. In one case the in-patient facility was considered to be inappropriate for admitting a teenager, who was treated as an out-patient.

Table 1 Gender, geographical area and age of participants

	Male (n = 16)	Female (n = 24)	Total (n = 40)
Geographical area			
Rural	11 (27.5%)	22 (55%)	33 (82.5%)
City	5 (12.5%)	2 (5%)	7 (17.5%)
Age (years)			
14–20	2 (5%)	6 (15%)	8 (20%)
21–30	8 (20%)	11 (27.5%)	19 (47.5%)
31–40	2 (5%)	4 (10%)	6 (15%)
41–50	3 (7.5%)	0 (0%)	3 (7.5%)
> 50	1 (2.5%)	3 (7.5%)	4 (10%)

Table 2 Factors associated with delayed access to care

	Percentage of sample
Cultural	36
<i>specific cultural reasons</i>	
female gender	28
jinn/spirit	44
traditional healing	28
Knowledge	28
Stigma	14
Financial	14
Effect of mental illness	7.4
Service	0.6

Family was the main source of referral (45% of cases), whereas general practitioners referred 20% of cases only, and so were shown to have a lesser role in the pathways to psychiatric care. This is contrary to the important role of primary care in high-income countries (Edwards & McGorry, 2002; Shiers & Lester, 2004).

The study results may not provide an accurate reflection of DUP. However, the factors found to be associated with delayed access to care are important and need to be carefully addressed to improve access to psychiatric care for those with an FEP. Larger, longer studies are needed.

Conclusion

The study results indicate that cultural factors, lack of knowledge about mental illness and services, stigma and financial factors probably influence help-seeking behaviour, which in turn may play a significant role in delayed access to care in rural Egypt. Programmes to improve public awareness of mental illness and the available services and to address stigma are needed. Further development of the healthcare system and service model in Egypt is likely to help.

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ORIGINAL PAPER

Bagh regrows – earthquake survivors as catalysts of community and personal reconstruction

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In our age of frequent natural disasters in this increasingly interdependent world, there is a pressing need to understand better the processes of societal adjustment. The Kashmir earthquake of 8 October 2005 brought human suffering on a massive scale. High rates of psychiatric morbidity have been reported (Niaz et al, 2006; see also <http://emdrpakistan.com>). Whereas the relevance of the application of Western, secularised, psychological treatment models to this group is outside the scope of this paper, survivors have faced catastrophe and destruction of both their internal and external realities.

More can be learnt about how some survivors who are in crisis achieve the transition to active helpers. Points for

consideration are the many studies that document the psychiatric and psychological impact of disasters on survivor populations (Van Griensven et al, 2006), as well as the significant risks that accrue to emergency and rescue personnel mobilised to respond to major incidents (Cetin et al, 2005; Hagh-Shenas et al, 2005).

A special opportunity to investigate early subjective accounts of how such developments can occur arose at a local competence and resource re-building initiative for survivors in December 2005 organised by the Qatar Red Crescent Society's Psychological Support Programme in Bagh (Urdu for 'garden'), the disaster-struck capital of Bagh District, Pakistan-Administered Kashmir.

Table 1 Respondents' characteristics

Characteristics	Sample
<i>Gender</i>	
Number of males	11
Number of females	10
<i>Age (years)</i>	
Range	23–48
Mean	33.8
<i>Participants' level of education</i>	
Number with secondary education	2
Number with university education	19
<i>Profession</i>	
Number of school teachers	17
Number of religious teachers/leaders	4

Method

Sample

Participants were volunteers attending the Qatar Red Crescent Society's Psychological Support Programme during late December 2005. Two schools in and near Bagh were used for the training and interviews. Participants were paid transport expenses to be able to attend the programme. Of 96 attendees, 21 consented to be interviewed.

Interview

Semi-structured interviews in Urdu were audio-recorded approximately 2 months after the disaster, at a time when small tremors were still occurring. Interviews were carried out in the schools, and no adaptations were made to the original

format. Questions used as cues covered demographic information and coping strategies used in the aftermath of the earthquake, as well as observations of how other survivors adjusted. Responses were recorded in their entirety. Female participants were interviewed with a female chaperone present. Recordings were translated and transcribed into English.

Analysis

Transcripts were initially examined independently by both authors to identify and label key elements in survivors' narratives using QSR N6 Qualitative Data Analysis software (QSR International Pty Ltd, Victoria, Australia), with differences reconciled by consensus. The most salient themes were then agreed and transcripts were reanalysed to extract statements describing how coping and adjustment were achieved. Statements were grouped into the salient themes and emergent progressions postulated.

Results

The respondents' characteristics are summarised in Table 1. All participants reported huge personal and communal losses during and after the earthquake, which evoked significant distress, hopelessness and despair. From situations of devastation and loss, survivor imperatives reached beyond those of addressing basic physical survival needs (food, water, shelter). Two recurrent themes emerged in survivors' narratives of coping and adjustment. Reports point to the importance of both *social cohesion* and *narrative coherence* for those

Table 2 Summary of the postulated social cohesion and narrative coherence phases

Phase of survivor progression	Quotes from respondents
1 The phases of social cohesion	
<ul style="list-style-type: none"> • The impact: observed disintegration, chaos and feeling overwhelmed • Personal survival imperatives: personal coping and reconstruction for survival 	<p>'after the earthquake ... people were numb. Each household was occupied with itself...'</p> <p>'people had nothing ... there was nothing to eat, to drink, and it was the month of Ramadan...'</p> <p>'we kept steadfast. We rebuilt our homes...'</p> <p>'I kept working to get a school shelter built ... it helped to raise my spirits ... my confidence increased by itself and now I am fine...'</p>
<ul style="list-style-type: none"> • Broadening awareness: shared adversity as an integrating force 	<p>'they stopped asking what was their loss ... the community-wide situation became apparent; people felt better able to cope when we realised that everyone was affected...'</p> <p>'as teams of doctors and other volunteers arrived, people started to feel that we need to do something to keep living...'</p>
<ul style="list-style-type: none"> • Reconstruction through strengthening social bonds 	<p>'we have to continue our lives ... we have seen that there have been many marriages after this.'</p> <p>'I give a lot of encouragement to the children here ... if I can help even 10–15 of them to return to their normal lives this would be a big thing for me.'</p>
<ul style="list-style-type: none"> • Reconstruction through concerted practical actions 	<p>'I kept working to get a school shelter built...'</p> <p>'people are building temporary shelters because this is a very cold region...'</p>
<ul style="list-style-type: none"> • Confirming elements of 'normality' 	<p>'education is being continued in school, and the children ... don't want to waste a year'</p> <p>'I also started to go to school so that life returns to normality and help children cope.'</p> <p>'we try to help ourselves ... we teachers are making great efforts so that the children's minds become better and their educational attainments improve...'</p> <p>'it is in this way that they are trying to return to [life as it was] before, building like it was...'</p>
2 The phases of narrative coherence	
<ul style="list-style-type: none"> • Spiritual identification: confirming belief in higher power's actions and purpose 	<p>'the biggest thing in these situations is than one reaffirms belief in God. If He wants to keep us alive, He will find a way and if He wants us to die... He gives life...'</p> <p>'the immediate thing was confidence in God...'</p> <p>'we told [the children] that this was God's test for us.'</p> <p>'after being steadfast, after a period of difficulty, things get easier. So God again brings our lives towards normality...'</p>
<ul style="list-style-type: none"> • Spiritual reconstruction: engendering hope, morale and a new sense of purpose 	<p>'I reasoned that those who have gone, the loss that has happened, that is not going to return. What should be done is to save that which remains...'</p> <p>'to normalise things we have to increase each other's spirits...'</p>
<ul style="list-style-type: none"> • Regaining emotional composure: making time to process emotions, feelings and memories 	<p>'The grief is there and comes to my mind sometimes. But we have struggled a lot, especially in the school. I have given more time to it...'</p> <p>'after the earthquake they were saying, "Who needs to live now? Who needs to die now?". Every home had tears...'</p> <p>'after the earthquake we were affected. Slowly, when the grief lessened, we found strength...'</p>

adjusting to losses, living with continuing threats to safety and security, being vulnerable, trying to meet the challenges of day-to-day survival and so on. Quotes from respondents are grouped into the emergent progression in Table 2.

Phases of social cohesion

Initial feelings of being utterly overwhelmed by disaster appear to evolve into a series of tentative practical steps to create circumstances conducive to continued personal survival. An element described by participants driving co-ordinated responses to crises was an explicit recognition of shared loss, suffering and the need once again to feel safe. These statements suggest that immediate survival calls for an individualistic response, but soon thereafter, survival imperatives are served through communal actions and the reaffirmation of normality.

Phases of narrative coherence

Unprecedented destruction in living memory provoked significant challenges to previously held spiritual beliefs, personal values and psychological attitudes. In the face of massive suffering and destruction, some realignment had to be made to the premises and values by which life had previously been lived. The psychological imperative (for both individuals and groups) was to search for ways of reinterpreting established beliefs in the light of new realities. Once achieved, this engendered a sense of meaning and purpose relevant to ongoing survival. Participants' statements demonstrate that continued coherence of beliefs and values both parallels and dovetails with physical reconstruction for primary needs and fosters social cohesion.

Discussion

All respondents spontaneously described great personal and societal loss. Interviews were held more than 2 months after the earthquake, when survivors were still in the early stages of adjustment but late enough to minimise psychological debriefing effects. However, emphasis was also placed on capturing these narratives at a time when they were still fresh and therefore arguably more valid. Respondents were in general highly educated and of standing in the community (Table 1), which may reflect in the experiences reported, as they inherently had roles to fit into.

These narratives shed interesting light on the processes of progression from immediate personal despair through accommodation and eventual adjustment to new realities of post-disaster survival (Janoff-Bulman, 1992). They also reaffirm, in line with the literature in this field, the importance of the essential emergency response supporting survival by prioritising basic physical provisions (e.g. food, water, shelter, healthcare).

Survivor narratives bear witness to already present reservoirs of personal, familial and community resilience and resourcefulness in the face of mass disaster. Our understanding of its constituent parts may help improve future disaster-preparedness work (Norris *et al*, 2008). The evidence of this investigation points to the essential role of institutional (religious, spiritual) and organisational (schools) rituals in facilitating the redevelopment of credible personal and community narratives that confirm affiliations and create hope

and feelings of group cohesion. Survivors are indeed 'first responders'; it is therefore important that emergency relief work and humanitarian agencies recognise and work through local groups and affected persons whenever possible. The findings lend support to previously published work (Makdum & Javed, 2006).

Some of Durkheim's observations on religion as a source of social integration (Durkheim, 1912) resonate with the quoted survivor narratives. This also lends support to more recent publications about the importance of religion and spirituality in fostering adaptive coping strategies after disaster and trauma (Taylor, 2001; Ford *et al*, 2003). To this end, the objectives of the emergency response should specifically include community leaders and their affiliated institutions. Practical, action-oriented programmes that bolster community cohesion and facilitate emotional processing are required to re-establish a shared sense of personal and community cohesion (Simonsen & Reyes, 2003).

Limitations of the study

Participants in this study were teachers and religious leaders selected to attend a training workshop to develop their roles as post-disaster helpers in their local communities. By implication they are likely to have higher educational achievement than other community members, and are less likely to be severely physically injured and not functionally debilitated by trauma-related reactions. Consequently, however, they were in a position to be those who had adjusted, and therefore provide insights as to what helped them in that process. Their descriptions may be biased towards minimising past and current adjustment difficulties. Furthermore, this group did not include children and adolescents.

Conclusion

The implementation of disaster relief programmes in areas like Kashmir present great challenges to planners and providers of emergency assistance. Our interviews, though limited in number, lead to these observations. Survivors emphasise the importance of emergency relief efforts prioritising primary needs. Communities show resilience and can be strengthened when emergency relief and humanitarian aid organisations work through local groups, such as schools and religious community leaders. The early adjustment of key survivor helpers can assist societal recovery.

Acknowledgements

We are indebted to the people of Bagh who consented to being interviewed and related their experiences. T.R.A. was a member of the Psychological Support Programme Team of the Qatar Red Crescent Society visiting Bagh.

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Introducing competency-based training in Europe: an Anglo-Dutch perspective

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There are striking and significant differences in psychiatric training across Europe and procedures for the assessment of trainees vary widely (Strachan, 2007). The introduction of competency-based training represents a major shift in medical education and a challenge to harmonising psychiatric training in Europe. This paper discusses the development and implementation of competency-based training in the Netherlands and the UK and focuses on its effects on trainees.

Structure of training

The structure of medical training and postgraduate training in psychiatry in the UK and the Netherlands is largely similar. However, the minimum duration of postgraduate training is 1.5 years shorter in the Netherlands and there are fewer subspecialties that Dutch trainees can qualify in.

Drivers for change

In 2004, the Dutch health minister adopted recommendations made by a committee investigating the reorganisation of healthcare. It was recommended that the training of health professionals be more focused on everyday practice and that professionals with a high degree of skill and experience be used to perform only certain tasks, those that could not be done by other, less well-trained, and thus less expensive, professionals. These recommendations were also related to a Dutch report on the division of tasks among mental health professionals (Vleugel *et al*, 2008). Conceptually, this is similar to 'New Ways of Working' in the UK, which aims to use the skills, knowledge and experience of consultant psychiatrists to best effect by concentrating on those patients with the most complex needs and encouraging other team members to take on increased responsibility (Department of Health, 2005).

In the Netherlands, it has been felt for some time that trainees should not be judged only on their knowledge and practical skills, but also systematically assessed on broader competencies, such as team-working skills, communication skills and professionalism. Additionally, more emphasis on the transparency of healthcare organisations, not only regarding financial aspects, but also regarding training and treatment strategies, has led to greater use of care pathways (diagnosis and treatment combinations) and records of activities performed by health professionals. Organisations receive their funding according to predefined tariffs that are based on diagnosis–treatment combinations, and this puts more pressure on professionals to perform certain tasks in a limited amount of time. Training is not part of these provisions and so in 2008 the funding of training will be changed. In the UK, financial arrangements for healthcare funding are also changing along Dutch lines, with the introduction of payment-by-results, which essentially bases funding on predefined tariffs for care pathways. Once again, there are no set tariffs for training and the manner in which training is funded centrally may change.

In 2005, the Postgraduate Medical Education and Training Board (PMETB) became the UK's statutory body for quality and standards in postgraduate medical education. The new competency-based curriculum approved by the PMETB (Royal College of Psychiatrists, 2006) focuses achievement in medical training on the attainment of specific competencies related not only to clinical care but also to broader skills, as mentioned above. Consequently, the performance of the doctor in the workplace will provide a more robust measure of overall competence. The PMETB is required to approve all aspects of the curriculum and assessment programme, and has recommended an overarching assessment strategy consisting of workplace-based assessments and examinations of knowledge and clinical skills (Bhugra, 2006). A variety of workplace-based assessments (WPBAs) have been developed to allow trainees to demonstrate the required competencies.

Recommendations

In the Netherlands and the UK, similar recommendations were drawn up for competency-based training.

- Competencies that psychiatrists have to acquire and demonstrate in their everyday practice should be defined.
- These competencies must be assessed in the workplace.
- Trainees must keep a portfolio.
- A trainee's progress must be assessed regularly by the trainee and trainer.
- There must be a combination of formative and summative assessments.

In the Netherlands the competencies were developed following the domains of the CanMEDS model: medical expert, communicator, collaborator, manager, health advocate, scholar and professional (Frank, 2005). In the UK the competencies were developed following the domains of *Good Medical Practice*: good clinical care, working with colleagues, probity and health (General Medical Council, 2001).

Trainee involvement

The Dutch Psychiatric Foundation charged a committee of trainers and trainees with the task of changing the curriculum and assessments. The leadership of both the Dutch and the British psychiatric trainees' associations were very involved in the development of the competency-based training model. In August 2006, 15 pilot sites across the UK began using at least one of the WPBA tools. This allowed trainees around the country the opportunity to give feedback on the feasibility of using the new tools and aid their further development.

Assessments

In the Netherlands, regular tests of theoretical knowledge will be combined with WPBA. Training has been divided into themes according to work settings and during each placement a trainee will have different competencies assessed. The most important means of testing is with 'brief clinical encounters', where the trainee and supervisor will agree upon a specific competency to be tested, see a patient together and afterwards fill in an assessment form. Brief clinical encounters should be completed eight times a year, as this is the minimum number required to guarantee validity. The brief clinical encounter is equivalent to the mini-assessed clinical encounter in the UK, where a 15-minute aspect of a doctor-patient interaction is considered. In the UK, the WPBA tools will be used in conjunction with the Membership examination, the structure of which has been modified for 2008. There are detailed mandatory requirements regarding WPBAs for each year of postgraduate psychiatric training in the UK. The other WPBA tools being used are listed in Table 1.

Trainee concerns

On the whole, Dutch psychiatric trainees are not very aware of the upcoming changes, which are being implemented this year. The Dutch Psychiatric Trainees' Association is trying to address this issue and inform trainees. Although the Association is enthusiastic about the implementation of competency-based training, it is concerned that not specifying

Table 1 Comparison of workplace-based assessment tools used in the Netherlands and the UK

Assessment tools in the Netherlands	Assessment tools in the UK
Brief clinical encounter	Mini-assessed clinical encounter
360-degree appraisal	Mini-peer assessment tool
Evaluation of a medical file	Case-based discussion
Case presentation	Case presentation
Critical appraisal presentation	Journal club
Writing a legal report	–
Presenting patient problems to colleagues after having been on call	–
Evaluation of a discharge summary	–
–	Assessment of clinical expertise
–	Assessment of teaching
–	Directly observed procedural skills

the minimum number of hours of training will lead to a reduction in quality of training in the future. The specification of hours has served as an important tool for trainers in negotiating adequate educational staff numbers with their employing organisations. The Association will therefore strive to make some concrete requirements that organisations have to comply with in order to obtain the right to teach trainees.

Similarly, in the UK trainees are not very knowledgeable about the new requirements for WPBA, as it has been overshadowed by the introduction of 'Modernising Medical Careers' (MMC) and the difficulties of the Medical Training Application System (MTAS). The failures of MTAS for specialty selection caused a great deal of anguish for trainees and resulted in low morale. Unfortunately, the unpopularity of MMC and MTAS mean that the introduction of WPBA is viewed by some as another unwanted, centralised imposition.

There are common concerns among psychiatric trainees in the UK and the Netherlands about the implementation of WPBAs. Both trainees and trainers need to be better informed about the implementation of competency-based training, its assessments and the potential benefits. There needs to be sufficient training for all professionals who will be used to assess trainees in the workplace, to ensure that the assessments are correctly undertaken and meaningful. It is felt that the time spent completing assessments may be in conflict with the amount of time spent treating patients, and it may be difficult to balance the time required for assessment with that for service delivery. If WPBAs are going to be used as summative assessments and thus decide trainees' progress through training, it is imperative that they are reliable and valid. Clearly, this will need to be monitored as the tools are implemented.

The future

The trainees' associations are trying to ensure that trainees have greater access to information about competency-based training and are aware of the changes. They will both have an important role in monitoring the implementation of competency-based training and how it affects trainees and their training. It is crucial that feedback from trainees and trainers is used to develop and improve the existing assessment tools. It is likely to be several years before the assessment tools are sufficiently reliable and valid.

Competency-based training elsewhere in Europe

The overall emphasis in postgraduate psychiatric training in Western Europe is shifting towards a competency-based model. Other countries, including Sweden and Denmark, are also developing their systems of training and assessment. Close collaboration between the various national systems will enhance the quality and validity of all the new competency-based models. This should be promoted not only bilaterally but also multilaterally, through international organisations such as Union Européenne des Médecins Spécialistes (UEMS) and the European Federation for all Psychiatric Trainees (EFPT). Both these organisations are already actively discussing competency-based training.

Conclusion

Competency-based training, once properly implemented, will allow a doctor's performance in the workplace to be reliably assessed. As this new model of training is implemented, the assessment tools need to be carefully evaluated and

improved. It is hoped that competency-based training will lead to enhanced standards in postgraduate medical education, resulting in better training for trainees and better care for patients. The experiences of trainees in the Netherlands and the UK will be useful for trainees in other parts of Europe as competency-based training is implemented there.

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NEWS AND NOTES

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

Reduced membership rates

The Royal College of Psychiatrists has reduced its annual subscription rates to £30 for members working in countries classed as B and C or D according to the World Bank criteria if their monthly income in 2008 is below £1000. Further details are available from the College Membership Office.

Bursary for psychiatrists from low-income countries

The College's Faculty of the Psychiatry of Old Age has a bursary for psychiatrists practising in low-income countries in the field of mental health in older people, to attend the annual residential meeting in Barcelona on 5–6 March 2009. Further information is available from kkottasz@rcpsych.ac.uk.

Specialist Associateship

In July 2008 the College launched a new grade of membership, Specialist Associateship, open to registered specialists who qualified abroad but who currently work in the UK. Further information is available from latkinson@rcpsych.ac.uk.

The launch of BACAMH

The Bangladesh Association for Child and Adolescent Mental Health (BACAMH) was launched in May 2008. Its mission is to promote the mental health of children, adolescents and their families through training, research, prevention and collaboration. See the Association's website, <http://www.bacamh.99homepages.com>.

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A visit to Iraqi Kurdistan

Sir: The Iraq Subcommittee (ISC) of the Board of International Affairs organised a visit to Iraqi Kurdistan to help support mental health services within the province. Four members of the Subcommittee took part in the visit, on 8–15 June 2007. Our official meetings started on the day of our arrival. We met with the dean of Hawler Medical

School, the president of Hawler Medical University and the dean of Hawler Nursing School, as well as the Minister of Health and the Minister of Higher Education (Hawler is the Kurdish name for Erbil, capital of the province). We also visited the mental health unit in Hawler Hospital and met with the consultants, psychiatric trainees and other staff. We also visited a newly commissioned long-stay psychiatric facility.

Global challenges facing psychiatric training

Sir: At the annual meeting of the Royal College in July, British psychiatrists were treated to a taste of the trainee's lot in France, the Czech Republic and the USA. It was reassuring to hear that UK training often compares favourably with that overseas.

Olivier Andlauer, a delegate from France, reported that the French have a *laissez-faire* approach to postgraduate training. Interestingly, according to statistics, this manages to produce the greatest patient satisfaction in Europe! There are no formal postgraduate assessments or examinations, and training can vary enormously across France, largely according to the enthusiasm of the trainers. It is up to trainees to make the most of their attachments, and the very enterprising have even initiated local teaching programmes. Training generally lasts 4 years, at the end of which trainees can call themselves 'psychotherapists' as well as 'psychiatrists', even with no formal psychotherapy training.

The next speaker was Jan Vevera, from the Czech Republic, where psychiatric practice is still overwhelmingly based in dated asylums. There are roughly 1000 psychiatrists serving a population of 10 million, well below the European average. Community practice is in its infancy, with out-patient services representing the only real alternative to hospital care. Trainees are paid little more than a UK teenager's pocket money, though in relative terms they earn enough to get by. There is an ongoing debate as to who is responsible for paying trainees during their training: the medical school or the hospitals. There is a full assessment at the end of training that includes a clinical long case. Trainees also gain neurology training and usually have access to psychotherapy, as well as a clinical supervisor throughout.

Abigail Donovan was, until recently, a 'member in training' trustee of the board of the American Psychiatric Association. She had been elected to this position to represent the interests of all psychiatric residents in the USA – a model very similar to the chair of the Psychiatric Trainees' Committee (PTC) in the UK. US trainees have a tradition of spending most of their residency on site, on call. It was only relatively recently that a campaign was won to cut down to an 80-hour working week; this followed a scandal where the exhaustion of a trainee led to the death of a patient. Dr Donovan also lamented how finances dominate practice. The skill of dealing with insurance companies has emerged as part of core training. She described weekly telephone battles with untrained insurance company staff, where she fights for basic funding for patients. If her paperwork is not filled in correctly, money does not follow treatment. On the plus side, there is a syllabus for training and centres are encouraged to develop comprehensive teaching programmes, and assist in compiling training portfolios, which allows trainees to work systematically towards local and national assessments. There is also a strong US trainees' network.

Although there are many challenges to training in the UK, it is reassuring to know that, at least in some areas, things could be a lot worse!

Meinou Simmons

PTC member and specialist trainee, Cambridge

After this we travelled to Sulaimanyia (the second largest city in Iraqi Kurdistan), where we met with the president of the university, the deputy dean of the medical school, the dean of the nursing school and the governor of the province. We also visited a primary care centre, a centre for the Heartland Foundation (an international non-governmental organisation).

Despite the shortage of material resources, the limited infrastructure, a shortage of staff of every discipline and an almost complete lack of community services, we saw examples of innovative practice. For example, we noted the use of both radio and television as an aid to mental health education and an effective means of raising community awareness of mental health issues in general. However, there was clearly a continuing sense of professional isolation from the rest of the world.

There was very strong support from all levels of the Kurdistan Regional Government (KRG), from the top executives right through to the mental health professionals on the ground, for the establishment of a formal link between the College volunteer programme and the health and higher education ministries within the KRG. They undertook to provide every assistance to any volunteers arriving through the College. Furthermore, most of the officials we met showed an acute appreciation of the value of mental health services for the population of Iraqi Kurdistan and for Iraq as a whole, especially given the traumatic recent history. The areas identified as priorities for future volunteers to Iraqi Kurdistan include: curriculum review for medical schools; advice on mental health service structure; as well as teaching, training and examining of undergraduate and postgraduate students.

The security situation within Iraqi Kurdistan was surprisingly benign. We travelled at various hours of the day and night without any guards or precautions and never once felt in the least threatened.

Finally, we took part in an Iraq-wide event for continuing medical education (CME) on mental health that took place over 2 days in Hawler and where we, together with a US colleague, were the main speakers. About 65 participants attended this event, mainly from the three KRG governorates but with a few from the rest of Iraq, which made it the largest mental health educational event ever held within Iraqi Kurdistan.

The ISC delegation achieved its aim of establishing a formal link between the College volunteer scheme and the KRG. This has been formalised by the signing of a memorandum of understanding between the College and the KRG at the College headquarters in London on 6 December 2007. Also, we are gratified to learn of the formation of a High Committee for Mental Health in Iraqi Kurdistan following the visit tasked with the planning and oversight of these services in the area covered by the KRG. The next stage will require the ISC of the College to ensure that this link is activated and kept alive through the encouragement of volunteers to travel to Iraqi Kurdistan and to offer their expertise to mental health colleagues within that country.

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Forthcoming international events

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: Professor 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/

1–3 November 2008

4th SPF International Conference
Dhaka, Bangladesh
Organiser: Bangladesh Association of Psychiatrists
Contact: Dr Mustafizur Rahman
Email: bap@agni.com

6–8 November 2008

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

8–10 November 2008

4th SPF International Conference
Dhaka, Bangladesh
Organiser: Bangladesh Association of Psychiatrists
Contact: Dr Mustafizur Rahman
Email: bap@agni.com

17–20 November 2008

Annual Meeting, International Society of Addiction Medicine (ISAM)
Capetown, South Africa
Organiser: WPA Section on Addiction Psychiatry; International Society of Addiction Medicine
Contact: Marilyn D'Ozorio
Email: office@isamweb.com
Website: http://www.ISAM2008.com

19–22 November 2008

XXV Congreso de la Asociacion Psiquiatrica de America Latina (APAL)
Isla Margarita, Venezuela
Organiser: Latin American Psychiatric Association (APAL)
Contact: Dr Edgard Belfort
Email: belfort.ed@excite.com
Website: http://www.apal.2008.org

26–29 November 2008

Annual Congress of the German Society of Psychiatry, Psychotherapy and Nervous Diseases
Berlin, Germany
Organiser: German Society of Psychiatry, Psychotherapy and Nervous Diseases
Contact: Dr Juergen Zielaske
Email: uergen.zielasek@lvr.de
Website: http://www.dgppn-kongress.de

27–29 November 2008

First International Congress Inter-School Forum on Child Analysis (ISFCA)
Milan, Italy
Organiser: ISFCA
Email: isfca2008@mzcongressi.com
Website: www.isfcacongress.org

28–30 November 2008

Annual Conference of the Indian Association for Social Psychiatry
Delhi, India
Organiser: Indian Association for Social Psychiatry
Contact: Dr Roy Abraham Kallivayalil; Dr Rakesh K. Chadda
Email: roykallivayalil@dataone.in; drrakeshchadda@hotmail.com

13–15 December 2008

1st Joint International Conference of the Hong Kong College of Psychiatrists and the Royal College of Psychiatrists
Advancing Psychiatric Care in the Emerging World: East Meets West
Hong Kong
Email: psychconference@hkam.org.hk
Website: http://www.psychconference.org.hk/

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